‘Trying to get through the day’: Exploring the social contexts of alcohol and pregnancy

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I, Annie Taylor, declare that this thesis is my own work and that no material contained in it has been submitted for another academic award.

Signed: Annie Taylor

Date: 30/03/2022

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Abstract

Background: Many factors, including alcohol consumption, may affect a baby's likelihood of being born with Foetal Alcohol Spectrum Disorders (FASD), yet most qualitative research does not explore contextual factors or the perspectives of women who drink at 'high risk' levels.

Aim: The aim of this study was to explore the views and experiences of women who drink (or drank) during pregnancy, and professionals who provide treatment and care for pregnant women drinkers, including how various aspects of women's lives intersect with one another and with alcohol consumption.

Methods: Drawing on feminist standpoint theory, intersectionality theory and feminist fractured foundationalism, semi-structured photo-elicitation interviews and focus groups were undertaken with 14 women, including 3 who had been involved with specialist services, and 10 specialist practitioners in the UK. These were analysed using a narrative-informed approach to reflexive thematic analysis.

Findings: Participants described a range of interconnected contextual factors as important in relation to drinking during pregnancy, including poverty, trauma, and social factors. Women who had been involved with specialist services during pregnancy had all experienced multiple intersecting adversities, mediated by structural inequalities, which affected every part of their lives including their drinking. This thesis demonstrates the importance of taking women's contexts into account when attempting to understand and respond to drinking during pregnancy, but suggests that current structures, policies, and narratives based around individual responsibility, reproductive citizenship and child protection render services unable to offer intensive support for women's complex contexts. The current policy approach may instead add further adversity and exacerbate women's powerlessness.

Conclusion: This thesis reframes drinking during pregnancy as a social issue. It argues for a social approach to drinking during pregnancy based on principles of anti-oppressive policy and practice, to provide effective care and support for women who may be at a higher risk of having a baby with FASD.

List of abbreviations

A&E..... Accident and Emergency

ABI……. Alcohol Brief Intervention

ACEs……. Adverse Childhood Experiences

ADHD……. Attention Deficit Hyperactivity Disorder

ASD……. Autism Spectrum Disorder

AUDIT……. Alcohol Use Disorders Identification Test

BMA……. British Medical Association

BMI……. Body Mass Index

CASP……. Critical Appraisal Skills Programme

CG……. Clinical guideline

CMO……. Chief Medical Officer

CPO……. Child Protection Order

DSM……. Diagnostic and Statistical manual of Mental Disorders

DWP..... Department for Work and Pensions

FAS..... Foetal Alcohol Syndrome

FASD..... Foetal Alcohol Spectrum Disorders

FFF..... Feminist Fractured Foundationalism

GUS..... Growing Up in Scotland study

ICD-10..... International Classification of Diseases and Health Problems, Tenth Revision

MeSH..... Medical Subject Headings

MUP..... Minimum Unit Pricing

NAS..... Neonatal Abstinence Syndrome

ND-PAE..... Neurobehavioral Disorder associated with Prenatal Alcohol Exposure

NHS..... National Health Service

NICE..... National Institute for Health and Care Excellence

ONS..... Office for National Statistics

OST..... Opioid Substitution Therapy

PIS..... Participant Information Sheet

PRISMA..... Preferred Reporting Items for Systematic Reviews and Meta-Analyses

REC..... Research Ethics Committee

RTA..... Reflexive Thematic Analysis

SES..... Socioeconomic Status

SGA..... Small for Gestational Age

SIGN..... Scottish Intercollegiate Guidelines Network

SIMD..... Scottish Index of Multiple Deprivation

WHO..... World Health organization

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Chapter 1 – Introduction and orientation

1.1 Introduction

This thesis is a qualitative, feminist exploration of drinking alcohol during pregnancy. It takes a sociological approach to the topic, exploring the ways in which various aspects of women's lives intersect with one another and with alcohol consumption. It aims to inform policy and practice in relation to the care of pregnant women who drink alcohol, and in particular women who drink at a 'high risk' level during pregnancy.

This short chapter will introduce and contextualise the thesis. There are four sections in this chapter: rationale; summary of the thesis; researcher position; and finally, structure of the thesis.

1.2 Rationale

Alcohol is a teratogen – an agent which can affect the formation of the embryo and development of the foetus. The consumption of alcohol during pregnancy has been associated with Foetal Alcohol Spectrum Disorders (FASD), an umbrella term describing a range of effects associated with drinking during pregnancy, including increased risk of miscarriage, reduction in foetal growth, birth defects, developmental delay, and neurological abnormalities (British Medical Association (BMA), 2007). The most visible form of FASD is Foetal Alcohol Syndrome (FAS), a birth defect involving growth deficiency, specific facial abnormalities, and central nervous system damage (Astley et al., 2000; Jones & Smith, 1974).

Alcohol consumption is not the only factor that affects a baby's likelihood of being born with FASD (Abel & Hannigan, 1995; Armstrong, 2008; Armstrong & Abel, 2000; Drabble et al., 2011), yet most of the existing qualitative research does not explore broader contextual factors such as socioeconomic status (SES), multiple adversities, or the role of women's partners. Despite evidence that risk of FASD increases with dose, there

appears to be little qualitative research, especially in the UK, which includes the perspectives of women who drink at 'high risk' levels during pregnancy (see section 2.6.2 for definition of 'high risk' drinking). This is concerning because women drinking at 'high risk' levels are more likely than others to have a baby with FASD, and without understanding why women drink during pregnancy, and how current services are working from women's perspectives, it may not be possible to provide effective care and support.

1.3 Summary of thesis

Although the impact of drinking during pregnancy has been extensively researched, sociological analyses of women's perspectives on drinking during pregnancy appear to be lacking, paving the way for a predominance of medicalised psychological research and policy perspectives which focus on women's behaviour, centring individual women as the source of risk and harm to their children. This thesis explores the topic from a feminist perspective, enabling me to challenge these dominant individual-focused perspectives and approach it from a different angle, which has resulted in a socially focused analysis of drinking during pregnancy.

This thesis demonstrates the importance of taking women's contexts into account when attempting to understand and respond to drinking during pregnancy, but suggests that current structures, policies and narratives based around individual responsibility, reproductive citizenship and child protection make it difficult for women and practitioners to do so. The current policy context, which focuses on women's drinking behaviour rather than their wider needs, renders services unable to offer intensive support for women's complex contexts, and may instead add further adversity and exacerbate women's powerlessness, particularly for women involved with specialist services.

This study's unique contribution to knowledge lies in its focus on women's views and experiences of drinking during pregnancy, and its inclusion of women who have been involved with specialist services, who drink/ drank at 'high risk' levels, and who have low SES. By exploring why women drink during pregnancy, and how current services are working from women's perspectives, it reframes drinking during pregnancy as a social issue, raising questions about how to provide effective care and support for

women who drink during pregnancy. It emphasises the importance of taking a social approach to drinking during pregnancy. This new knowledge and understanding will have implications for policy makers, practitioners, and researchers.

1.4 Researcher position

When I started this PhD, I was concerned to find that women's voices – and particularly the voices of women who drank during pregnancy – were largely absent in dominant narratives around drinking during pregnancy. It seemed unfair to me that a debate that had been so public and so judgemental, and that affected pregnant women in a unique way, had not adequately engaged with women's views and experiences. Although I was concerned by this lack of engagement with women, I was not particularly surprised by it: as the mother of two young children, and having been working in children's policy, I was immersed in narratives about child development, being a good mother, and the crucial importance of children's early years. Even as a relatively privileged, white, ostensibly middle-class woman with a supportive partner, I had experienced the pressure and guilt associated with these narratives and had observed their power to silence women when they were at their most vulnerable. I did not, and still do not, dispute that it is crucial to prioritise and care for children, but I argue that it is also important to consider the impact of societal perceptions of and assumptions about motherhood.

In my professional life, too, I noticed mothers being subtly, and sometimes directly, blamed for their children's difficulties. The birth parents of looked after children I worked with had often been all but erased from their children's day-to-day lives, and women's 'behaviour' before, during and after pregnancy was often cited by practitioners as the reason for their children being removed from their care. Many of these families had been harmed by decades of government policy which failed to address structural problems such as poverty, inadequate housing and lack of educational and employment opportunities, but had been encouraged to see themselves and their 'choices' as responsible for their problems (see section 2.5.1 for discussion of choice and agency).

Having completed my undergraduate and postgraduate studies in social sciences with a focus on sociology, I had spent a decade working with children and families in

education and social care and was angry about inequality and injustice. I came to this research with a strong view that a focus on individual decision making, behaviour, and agency was not enough to inform meaningful responses to social issues, instead only serving to focus blame on the people who held the least power, rather than holding those responsible to account.

Through my work with children and families in various settings, I had experienced the challenges of being critical of a system while working within it, and the singular exhaustion that comes from trying to meaningfully support families within poorly organised and under resourced systems. I knew that despite my best efforts I had probably been complicit at times in a system which silences and oppresses many people, and this troubled me, and still troubles me, deeply. Thus, while I value the opportunity this PhD has provided for me to step outside the system to critique it, I emphasise here that any criticism is aimed at the system and not at the individuals within it. I have the utmost respect for those who have not stepped outside but instead have stayed and tried to do their best for people every day.

Much has happened in the almost five years since I started this PhD, including one of my children receiving a life-changing health diagnosis, and a worldwide pandemic. Although these events have made me revaluate my understandings of the world in ways that there is neither the time nor the wordcount for here, ultimately they have made me more, rather than less, determined to focus on the structural inequality that underpins individuals' experiences.

1.5 Structure of thesis

Chapter 2 explores how despite problematic drinking often being intertwined with structural inequalities, neo-liberal ideals of self-regulation, good mothering, and individual responsibility situate women's drinking as the sole cause of FASD. This positions FASD prevention strategies as primarily concerned with ensuring women's abstinence, and frames maternal drinking as a child protection issue.

Chapter 3 critically reviews and synthesises existing qualitative research including the accounts of women who report drinking at a 'high risk' level during pregnancy. It demonstrates that despite evidence that risk of FASD increases with dose, there

appears to be little qualitative research, especially in the UK, which includes the perspectives of women who drink at 'high risk' levels during pregnancy; the impact of the current policy and practice approach on women who drink at a 'high risk' level or women with multiple confounders associated with FASD is not well understood.

Chapter 4 offers a reflexive account of my explorations into ontological and epistemological concerns, and the effects these had on my eventual study design. I drew on feminist standpoint theory, intersectionality theory and feminist fractured foundationalism to aid the design of the research, which emphasises the production of 'moral knowledge' (Stanley & Wise, 2006).

Chapter 5 introduces and discusses the methods I used to generate and analyse the data. Despite some practical challenges, I completed semi-structured photo-elicitation interviews and focus groups with women and practitioners and analysed these using a narrative-informed approach to reflexive thematic analysis (RTA). I explored the views and experiences of women who drink (or drank) during pregnancy, and professionals who provide treatment and care for pregnant women drinkers, including how various aspects of women's lives intersect with one another and with alcohol consumption, in order to inform policy and practice in relation to the care of pregnant women who drink alcohol.

Chapter 6 is the first of three findings chapters. It explores the interconnected contextual factors such as trauma, poverty and social factors that women and practitioners described as important in relation to drinking during pregnancy. The women who had been involved with specialist services during pregnancy had all been affected by multiple interconnected adversities and marginalisation, and their accounts usually framed drinking as a way of coping with these, which contrasted with the accounts of other women, who mainly framed drinking as a choice.

Chapter 7, the second findings chapter, demonstrates how despite the powerlessness and adversity which characterised the accounts of women who described drinking to cope, women's and practitioners' accounts still reproduced dominant narratives about individual responsibility, reproductive citizenship, and child protection. These accounts emphasised women's responsibility to keep their babies safe and positioned women's behaviour as the cause of risk and harm. This emphasis on women's individual

responsibility required them to control risks that were beyond their control, contributing to a climate of mother blaming, and justifying and reinforcing the UK's largely individual level, rather than structural, responses to drinking during pregnancy.

Chapter 8, the final findings chapter, considers how the UK's current policy approach to drinking during pregnancy, which focuses on abstinence and child protection, exacerbates the powerlessness and marginalisation of pregnant women who drink. Current approaches, which focus on mothers as the main source of risk to babies, compel some women to hide their drinking, which may further increase risk to mothers and babies. Those who do access specialist services, although ostensibly positive about services, may be rendered powerless within systems that consider the needs and interests of babies separately from their mothers, and which prioritise medical treatment over practical support and are therefore unable to offer intensive support for women's complex contexts.

Chapter 9 highlights the contribution of this study to wider knowledge on the topic of drinking during pregnancy, including how it relates to previous research on this topic, and critically evaluates the approach I took.

Chapter 10 concludes the thesis by outlining how it has met my aims and objectives, and considering the recommendations arising from this thesis, for policy, practice, and further research.

Chapter 2 – Setting the scene

2.1 Introduction

This chapter explores how neoliberal ideals of self-regulation, good mothering, and individual responsibility relate to understandings of drinking during pregnancy. It argues that these ideals ignore the social and political context in which both drinking and family life take place, thereby blaming parents for the adversity they and their families experience. This positions some parents, especially those experiencing poverty, especially if they drink, as potential sources of risk and harm to children.

Neoliberal expectations are particularly strong during pregnancy, and FASD is individualised to women's bodies, situating women's drinking as the source of risk and harm to their babies, who need to be protected from their mothers. This individualisation positions FASD prevention as primarily concerned with advising and screening for abstinence, strategies which are unlikely to be effective for women who drink at a 'high risk' level or women with multiple cofounders associated with FASD.

There are six sections in this chapter: first, drinking in the UK; second, defining problematic drinking; third, understanding women's drinking; fourth, neoliberal parenting; fifth, defining FASD; and finally, preventing FASD.

2.2 Drinking in the UK

2.2.1 Drinking as culture, drinking as harm

The role of alcohol in contemporary UK culture is complex and contested; drinking is often portrayed in research and policy as either harmful and problematic or as an important aspect of society and culture; it is rarely understood as both (Jayne et al., 2008).

Alcohol consumption is associated with many health problems, for example liver disease, cancer and strokes. Alcohol consumption in the UK is higher than the European average consumption (World Health Organization (WHO), 2018) and people in Scotland purchase more alcohol per week than those in other UK jurisdictions (Giles & Richardson, 2020). Scotland consistently has the highest rate of alcohol-specific deaths in the UK, although the difference between the UK jurisdictions appears to be reducing over time (Giles & Richardson, 2020; Office for National Statistics (ONS), 2019).

Whilst acknowledging the alcohol related harm that occurs in the UK, sociologists have studied the ways in which drinking and drunkenness are embedded in and an expression of UK and Scottish culture (Thurnell-Read, 2016), and have resisted the oversimplified use of alcohol as a scapegoat to explain complex social problems. Sociological approaches to alcohol highlight the aspects of drinking that can strengthen community ties and connections between people, and the ways in which drinking is often a social activity and takes place alongside other leisure pursuits (MacGregor, 2020). Sociologists such as Thurnell-Read (2016) argue that drinking should not simply be dismissed as harmful and dangerous, but that we should seek to understand its role in society by looking beyond individual drinking to explore the connections between individuals and structural aspects of society.

A neoliberal emphasis on self-control and individual responsibility means that alcohol is treated by the government and drinks companies as an ordinary commodity for which individuals are responsible for controlling their own use. Drinks companies and policymakers frequently advise people to 'drink responsibly' (a message found on many alcohol advertisements and labels), and UK government guidelines specify safe levels of drinking (UK Chief Medical Officers, 2016). Critics argue that the UK government allows too much industry influence on alcohol policymaking, enabling the drinks industry to make a huge profit from the production and sale of alcohol, much of which comes from the sale of alcohol to those drinking above guideline levels. The 'drink responsibly' approach responsibilises individuals for avoiding alcohol related harm, while policymakers and the drinks industry do little to limit this harm (Bhattacharya et al., 2018; Hawkins et al., 2012).

Throughout this thesis the term 'neoliberalism' indicates the ongoing process of moving towards a post-industrial, consumption-based economy, in which individualisation is key, individuals are held responsible for all aspects of their lives, and free markets, consumerism and competition are prioritised (Featherstone et al., 2019; Room, 2011; Salmon, 2011). Self-regulation throughout the life course is a key aspect of neoliberal governance; individuals are held responsible for their own health, and expected to discipline themselves, through regulating and controlling their bodies, and each other, through monitoring and surveillance (Foucault, 1979; Ruhl, 1999). Although neoliberalism has sometimes been criticised for being invoked as an overarching explanation of public health problems, sometimes without adequate scrutiny or definition (Bell & Green, 2016), it can be a useful tool to help to explore the links between individual behaviour and structural aspects of society.

2.2.2 Health inequalities and alcohol

Despite the neoliberal construction of health as something that individuals could and should control, a range of research spanning political science, epidemiology and sociology highlights the links between inequality and poor health, suggesting that the neo-liberal social policy approach of prioritising the production of profit by enabling a free market has led to inequality, including health inequalities (Wilkinson & Pickett, 2010). The Westminster government's recent regressive austerity policies are associated with rises in foodbank use, infant mortality, mental health problems, and homelessness (Marmot, 2020; Taylor-Robinson et al., 2019; Walsh et al., 2020).

The difference in health outcomes between Scotland's richest and poorest areas is stark. In 2018 the premature mortality rate was four times higher in Scotland's most deprived areas than in its least deprived areas, inequalities in premature mortality and drug related hospital admissions were increasing, and people living in deprived areas were more likely than others to die of heart disease and cancer (Scottish Government, 2020a), despite the Scottish Government prioritising health inequalities as a key policy aim since devolution (Scottish Parliament, 2015). This trend follows the pattern of increasing health inequalities across the UK, with mortality rate improvement slowing down across the UK in recent years because mortality has worsened among those with the lowest SES (Walsh et al., 2020). SES can be defined and measured in a range of

ways, usually incorporating measures of income, education and occupation, measured at individual, household, or area level (Braveman et al., 2005; Katikireddi et al., 2017; Savage, 2000). Due to the complexity and challenges involved in measuring these aspects of SES, SES is not defined and measured consistently between or within disciplines, which affects the outcome of studies which focus on SES or use it as a 'control' measure (Braveman et al., 2005). While acknowledging these limitations, for the purposes of this thesis I define SES as a measure of an individual's combined economic and social status at the time of measurement, incorporating income, education, occupation, and wealth, which reflects the consequences of intersections between class, ethnicity, gender and other social structures. Similarly, there is no clear consensus of the definition of poverty. For the purposes of this thesis, I define poverty as 'a general lack of sufficient material resources' (Goulden & D'Arcy, 2014, p.8). Although I acknowledge the importance of aspects other than financial resources – for example, the Scottish Index of Multiple Deprivation (SIMD) includes non-financial measures such as access to healthcare services and education (Scottish Government, 2020b), I use the term 'poverty' specifically to emphasise the crucial importance of financial resources which has been emphasised by those with lived experience of poverty (Rose & McAuley, 2019; Shildrick et al., 2016).

Despite strong evidence that health inequalities are caused by inequality more broadly, critical public health scholars have noted that policy action and public narratives in the UK consistently understate the impact of social determinants on health, instead focusing on individual responsibility (Elwell-Sutton et al., 2019). Responses to health inequalities often focus on individual behaviour change such as smoking cessation programmes and advice about diet, rather than addressing the more difficult to tackle issue of structural inequality (Bambra et al., 2019; Blaxter, 1997; Garthwaite et al., 2016; Smith et al., 2016). Research into health inequalities often focuses on the local rather than taking a political economy approach which would enable exploration of the political processes that shape health inequalities to be explored and challenged (Bambra et al., 2019). Critical public health researchers argue that although some aspects of inequality can be addressed at a local level, for example housing, local authorities' ability to do this is constrained by broader national policy (Walsh et al., 2017). As such, researchers should 'scale up' their approach to health

inequalities research by acknowledging macro-level determinants (Bambra et al., 2019).

Although people with low SES experience more alcohol related harm, it appears that the quantity of alcohol consumed does not differ significantly by SES, in countries across Europe including Scotland (Katikireddi et al., 2017); this is known as the alcohol harm paradox. Health inequalities related to the impact of alcohol consumption are evident across Europe, with those with lower SES more likely to experience alcohol related harm, and for this harm to be worse, than those with higher SES (Mackenbach et al., 2015). In Scotland, alcohol related hospital admissions are four times higher, and alcohol-specific deaths five times higher, in the most deprived areas in Scotland than in the least deprived areas (Scottish Government, 2020a).

A range of hypotheses about the cause of the alcohol harm paradox have been proposed, many of which have focused on individual behaviour. These include: people with lower SES are more likely than others to under-report their alcohol consumption in self-reporting studies; those with low SES more likely to 'binge' drink than others; the harm caused by drinking is compounded in those with lower SES because it is combined with differences in other health behaviours such as diet and exercise; drinking causes poverty by making it harder to work (Alcohol Research UK, 2015; Bellis et al., 2016). In contrast with these individual- level hypotheses, geographical research suggests that the increased alcohol related harm experienced by those with lower SES is compounded by environmental factors. 'Environmental bads' (outlets selling alcohol, fast food, tobacco, gambling) cluster in areas with lower SES (Macdonald et al., 2018). Outlet density has more impact on those living in lower SES areas because people while people with higher SES are more likely to move beyond and between different areas and contexts, those with lower SES are often more constrained and less able to move beyond these contexts, emphasising the importance of place (Shortt, 2016).

In Scotland, a recent large-scale study explored explanations for the alcohol harm paradox using cross-referenced Scottish Health Survey data with data on alcohol attributable deaths, prescriptions, and hospital admissions. It found that the differential alcohol harm experienced by those with lower SES could not be accounted for by smoking, Body Mass Index (BMI), drinking patterns such as binge drinking, or drinking causing downward social mobility. This led the authors to conclude that

poverty itself may make people more susceptible to alcohol related harm (Katikireddi et al., 2017). This suggests that disproportionate alcohol related harm may, like other health inequalities, be caused by broader structural inequalities.

Minimum Unit Pricing (MUP) came into force in Scotland in May 2018 and has been hailed by many public health researchers as a way of reducing alcohol related health inequalities because it was expected to reduce alcohol consumption in lower SES groups (Katikireddi et al., 2017). Since MUP came into effect, there has been a reduction of 4-5% in the amount of alcohol purchased in Scotland, and this reduction appears to have mainly occurred in the households that bought the most alcohol (O'Donnell et al., 2019; Public Health Scotland, 2020), although it is too early to identify whether this has led to changes in alcohol related harm or inequalities, or whether it has had any unintended consequences. Qualitative studies with people with severe alcohol dependence and who were socially isolated, experiencing poverty and poor health, suggest that MUP could have unintended negative consequences for this group of drinkers, who are most likely to be affected by alcohol related harm (O'May et al., 2016). Dependent drinkers cannot simply stop drinking when they run out of money and may therefore experience severe health consequences if adequate support is not available following the implementation of MUP, resulting in potential widening, rather than reducing, of health inequalities (O'May et al., 2017; O'May et al., 2016).

2.3 Defining problematic drinking

Definitions of and approaches to problematic drinking are situated within wider approaches to health. For the purposes of this thesis, I define the biomedical model as an approach to health which attempts to be objective, conceptualises the body separately from the mind and from society, and views illness as a sign of a dysfunctional body (Nettleton, 2013). Sociologists, critical public health scholars, and feminists have highlighted the continued dominance of the biomedical model in discourse and practice relating to various aspects of health, and have argued against biomedical reductionism and for a social model of health (Barnes & Mercer, 2010; Beresford, 2002; Ettorre, 2018; MacKenzie Bryers & van Teijlingen, 2010; Martin, 1989; Nettleton, 2013; van Teijlingen, 2005). Although there is no single definition of a social model of health, I define it for the purposes of this thesis as an approach to health

which acknowledges the impact of social structures, social relationships and inequalities on experiences and perceptions of health.

2.3.1 Disorder and disease

Social historians argue that ideas about problematic drinking throughout history have reflected changing concerns about social order, health, and the economy (Nicholls, 2009). In the 19th century, for example, alcohol was believed to cause societal 'degeneration', and the temperance movement perpetuated the idea that alcohol, rather than poverty and poor housing, was responsible for the problems in society (Armstrong, 2008). Drinking was explicitly constructed as a moral failing and a cause of social problems, and the solution was therefore portrayed by the temperance movement as population-level abstinence (see figure 1).

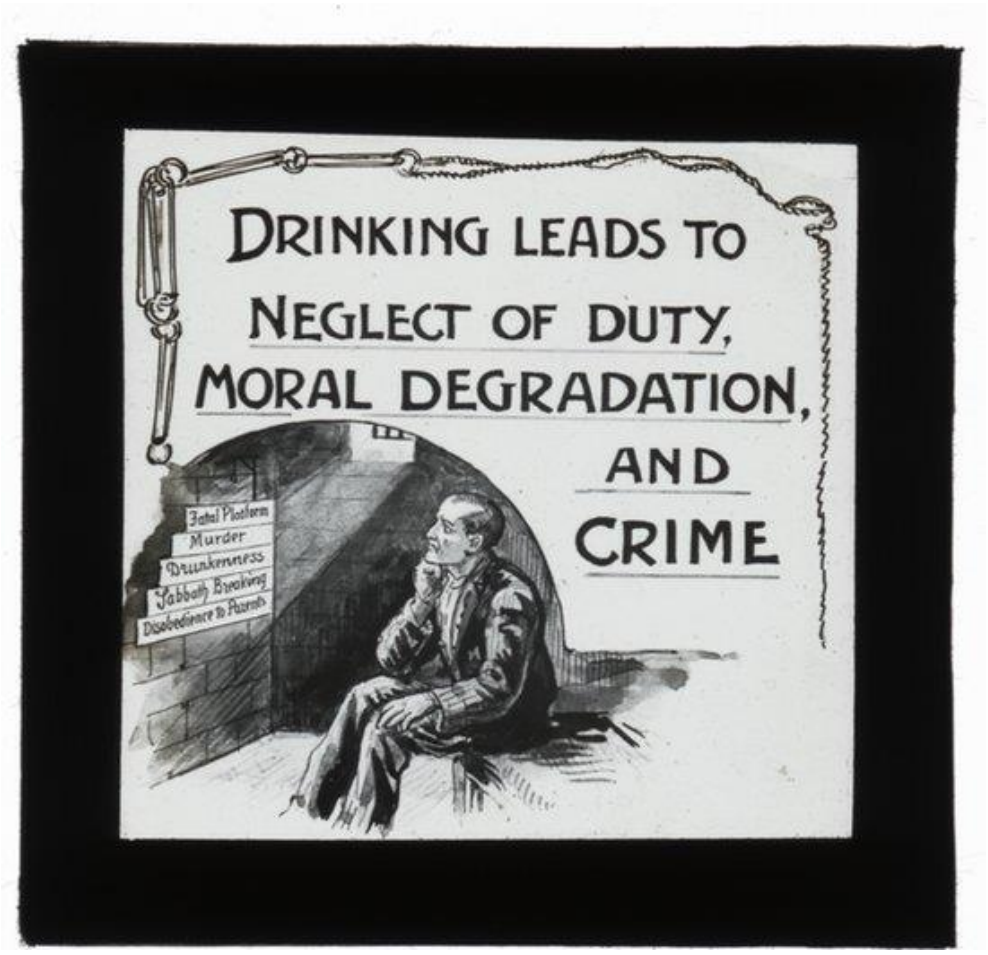


Figure 1: A poster from the North West UK Temperance Movement (Source: University of Central Lancashire, 2020)

In the 1950s, the concept of drinking as a moral failing began to shift towards understandings of alcohol addiction as a treatable disease (Armstrong, 2008). In the intervening decades, biomedical approaches, which draw on medical and scientific discourse to explain problematic alcohol use, have become highly influential as the dominant narratives surrounding addiction (Fraser et al., 2014; Li et al., 2007). In contrast to temperance approaches, biomedical approaches do not problematise all alcohol consumption; instead, some types of drinking are constructed as medical problems. The International Classification of Diseases and Health Problems (ICD-10), for example, lists 'dependence syndrome' as a chronic and relapsing medical disorder described as: 'a cluster of physiological, behavioural, and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value.' (World Health Organization, 2010b; p5). Various tools such as the alcohol use disorders identification test (AUDIT) are available to help practitioners screen for problematic alcohol use and dependence (Public Health England, 2020).

Critics argue that biomedical approaches oversimplify a multifaceted phenomenon by representing it as a simple biological problem, placing the source of the 'problem' within the individual which avoids having to consider the complex social problems that are connected with it (Hammersley & Reid, 2002). This pathologises individuals, who are then viewed as ill, wrong, and defective, and are therefore alienated and marginalised (Staddon, 2016). Despite biomedical approaches ostensibly being more about illness than morality, sociologists have noted that the concept of alcohol dependence may be more about social control than health (Staddon 2013), simultaneously constructing alcohol dependence as a loss of control or lack of discipline and therefore a moral failing, and as an illness (Armstrong, 2008; Fraser et al., 2014). This perpetuates the idea that certain 'types' of drinking by certain 'types' of people (those who do not 'drink responsibly') are problematic. Framing some drinkers as problematic enables the alcohol industry to continue to make a profit while othering those who experience alcohol related problems (Room, 2011). Psychiatrists and sociologists have argued that we should ask questions about why some things and not others become defined as diseases or disorders, and that it is often socially deviant behaviours that become defined as diseases (Miles, 1991). Defining behaviour as

disease serves the social function of defining and delineating deviant behaviour and thereby controlling and containing it (Foucault, 1979; Hammersley and Reid, 2002).

2.3.2 Coping and self-medication

Self-medication theories build on biomedical approaches by seeking to understand what it is about the individual that makes them prone to 'addiction'; addiction is still framed as an illness, but the focus is on understanding its psychological causes. Self-medication theories frame dependence as a coping mechanism by which individuals use alcohol or other substances to relieve 'psychological suffering' (Khantzian, 2017). Proponents argue that it is a more empathetic approach because by asking what makes people need to drink rather than simply diagnosing an illness it avoids stigmatising those experiencing dependence. Its focus on psychological suffering means that treatment is therapeutically focused, seeking to understand the origins of the feelings that lead people to drink.

Recent research around Adverse Childhood Experiences (ACEs) has found a strong association between ACEs and later substance use with those who reported four or more ACEs being four times more likely than others to report 'problem drinking' (Hughes et al., 2019). Although this finding supports self-medication theories, suggesting that adults drink to cope with childhood trauma, it should be interpreted with a degree of caution. The ACEs agenda, like the self-medicating theory, is fundamentally a psychological approach which underplays the significance of structural and political factors on the lives of children and their families (Critchley, 2020a; Walsh, 2020) (see section 2.5.2).

2.3.3 A social model

The sociologist Patsy Staddon (2013; p6) argues that instead of defining alcoholism narrowly as an illness, we should take a social approach in which we seek to understand what makes people want or need to drink in order to understand 'alcohol as potentially helping people to deal with a variety of social issues, some of which might become more problematic either with or without its use.' This, she argues, would enable us to attempt to understand the complex interactions between individuals and society that are often involved in problematic drinking.

Although Staddon's social model may initially appear similar to self-medicating theories, its difference lies in its acknowledgement of the structural factors influencing alcohol use. Having experienced severe alcohol dependence herself, she acknowledges the negative impact that some drinking can have and highlights the importance of exploring and acknowledging the links between inequality and problematic drinking. Staddon argues that focusing on these structural factors is a political act because the way in which the 'problem' of drinking is defined affects how it is responded to. She emphasises the importance of working to address the structural inequalities that are often intertwined with problematic drinking and its disproportionate impact on people who experience multiple intersecting social inequalities (referred to hereafter as 'marginalised' people).

Staddon argues that biomedical depictions of dependence as a chronic and often relapsing medical problem misrepresents the complexity involved in many people's experiences of drinking, ignores the importance of wider structural factors on individual drinking, and over-emphasises the impact of treatment (Staddon, 2012, 2013, 2016). Instead, she cites research suggesting that many people move between different ways of drinking throughout the life course, going from heavy drinking to mild, moderate, and severe dependence and back again, with periods of abstinence, and that people often 'recover' from problematic alcohol use without any treatment. This, she argues, suggests that broader social contexts are related to drinking (Staddon, 2012; Willenbring, 2010).

2.4 Women's drinking

2.4.1 Explaining women's drinking

A range of studies suggest an upwards trend in drinking among women of all ages in the UK and it appears that women are more likely to 'binge drink' than they were in the past (Office for National Statistics, 2018; Smith & Foxcroft, 2009). Although an increasing number of young people aged 16-24 report being abstinent from alcohol (Ng Fat et al., 2018; Office for National Statistics, 2018), young people, male and female, who do report drinking are more likely than other age groups to report 'binge' drinking (Emslie et al., 2009; Office for National Statistics, 2018). Although men in the

UK still drink more than women, epidemiological studies suggest that the gap between men and women's drinking is decreasing globally, including in the UK, due to an increase in women's drinking (Slade et al., 2016).

There has been a cultural shift in the UK in the last fifty years making female drinking in public spaces more socially acceptable and economically viable (Plant, 2008; Staddon, 2012, 2016). Alcohol marketing and product design has shifted from sexualising women to sell alcohol to men, towards targeting women as consumers by focusing on empowerment, independence, and female friendship. Although this shift of alcohol marketing towards – rather than using – women, is 'cynical alcohol marketing' aimed at the maximisation of profit (Emslie, 2019), it reproduces concepts which are also evident in women's accounts of drinking. Ethnographic accounts of women's drinking, although acknowledging the stigma and commodification sometimes associated with female drinking, often highlight the pleasure, fun, freedom, and autonomy some women describe experiencing whilst drinking, and the opportunity drinking can afford women to challenge social boundaries and roles (Blackman, 2016; Staddon, 2013).

Gender is not a fixed, biologically determined state, but a social construction, through which bodies categorised as 'male' or 'female' become associated with behaviours, personalities, and characteristics, such as men being naturally dominant and women naturally submissive (Butler, 2006; Connell, 1987; Connell and Messerschmidt, 2005). These perceived differences between men and women are reproduced and reinforced over time until they become legitimised as natural and normal, with men and women often defined in relation to each other as oppositional, and behaviour that threatens this opposition stigmatised and sanctioned (Butler, 2006; Schippers, 2007). Gender is therefore not only an identity but a social structure which, like other social structures, varies across time and context and is produced and contested through 'on-going, dynamic, social processes' (Schippers, 2007).

Qualitative sociological studies with women who drink suggest that for many women, gender roles must be carefully navigated whilst drinking, in order to avoid being considered masculine, out of control, or unrespectable (Emslie et al., 2015; Lennox et al., 2018; Lyons, 2009; Rolfe et al., 2009). Women's accounts suggest that the balance between drinking, being perceived as feminine and having fun, and remaining

perceived as respectable, is more challenging for those with lower SES because they are judged more harshly than those with higher SES (Griffin et al., 2012; Lennox et al., 2018).

Research around women's drinking has not generally engaged with the many intersecting inequalities that women experience, and the systems of oppression which shape their experiences of gender and drinking, possibly because feminist research is under-represented in the alcohol research field (Hunt et al., 2016; Miller & Carbone-Lopez, 2015). Elizabeth Ettore argues that the reason for this lack of engagement with the impact of structural factors on women who use substances is due to the continued dominance of biomedical approaches, which enables the perpetuation of the dominance of medical and scientific forms of knowledge. These forms of knowledge do not leave space for the development of feminist knowledge exploring women's own understandings of their experiences, or seeking to understand how gender, class and race, as well as other inequalities, affect the lives of women who drink (Ettorre, 2004, 2018).

Research with women who drink has generally over-represented white, heterosexual women with higher SES, so it is unsurprising that it has not adequately explored the impact of systems of power and oppression. Power is a complex and contested concept, variously defined as a finite resource used as a structural tool of oppression (Marx & Engels, 1961), and as constantly shifting (Foucault, 1979). While there is no single definition used by feminist researchers, many feminist researchers conceptualise power as complex and multi-layered, highlighting the structural, institutional aspects of power (Katz et al., 2020; Young, 1994), while also seeking to understand how women experience and resist relationships of power (Deveaux, 1994). For the purposes of this thesis, I use Patricia Hill Collins' theory of power. Hill Collins argues that power and domination can be understood through a 'matrix of domination' (Hill Collins, 2002, p276) involving four interrelated domains of power: structural (social structures and institutions), disciplinary (organisational practices and surveillance), hegemonic (culture and ideology), and interpersonal (routine practices and interactions with others). Research around women's drinking that does attend to these broader structural issues suggests that drinking can be a response to living within these systems of oppression, and that women whose drinking becomes defined

as problematic have often experienced multiple adversities including gender-based violence such as domestic abuse, poverty, and powerlessness (Galvani & Toft, 2015; Williams, 2005).

2.4.2 The problematisation of women's drinking

Although men still drink more than women, experience more alcohol related problems, and are twice as likely as women to experience alcohol related mortality (Office for National Statistics 2015), women's drinking has been the focus of much media attention. The problematisation of women's drinking through the media has been explored recently by Patterson et al. (2016), who undertook a content analysis of 308 articles published in seven UK newspapers and the BBC news website over two years. They found that articles presented women's drinking as more problematic than men's, that women's drinking was more likely than men's to be described as 'binge' drinking, and that women were more likely to be portrayed as out of control or placing themselves in danger, whereas men's drinking was often portrayed as fun. Patterson et al. (2016), also found that there was a focus on the physical appearance of women who drink, both in terms of moralistic descriptions of women's clothing, and the perceived harm women were doing to their physical appearance by drinking. Although these studies cannot tell us how people perceive and consume these news articles, they demonstrate gender bias in media reporting.

It is not only media representations that problematise female drinking; policy responses to drinking have often problematised drinking generally, and failed to acknowledge the positive, as well as negative, consequences of alcohol, with women's drinking often presented as inherently problematic and women drinkers pathologised (Ettorre, 1986; Hunt et al., 2016; Plant, 2008; Thom, 1997). In their exploration of the historical context of binge drinking, contemporary historians Berridge et al. (2009: p600), examined a wide range of historical sources and concluded that the focus on women's 'binge' drinking in recent years was not solely based on changes in gendered drinking patterns, but also represented 'an issue of perception'. The current focus on women's drinking "…is less a reflection of reality and more a representation of long-standing trends. It carries with it connotations of women's classic role within public health as both 'innocent victim' and 'vector of infection.'" (Ibid. 2009 p. 600). This

'classic role' has also been evident in earlier periods, with anti-drinking campaigns (for example, during the 'gin epidemic' in the 18th century, and later during the temperance movement in the 19th century) often focusing on women's drinking, despite evidence that male drinking was more widespread (Berridge et al., 2007).

Social class, as well as gender, has been key in the problematisation of alcohol use throughout history. Social class is a complex, contested and shifting concept which has no universal definition. Classical approaches to class focused largely on employment relations, while subsequent sociologists have explored the wider cultural, status and power aspects of class, and the meanings ascribed to and by class groups, which are not determined solely by occupation (Bottero, 2004). Measurements of class, however, have tended to remain focused on occupation as a proxy for class (Savage, 2000, 2016; Scott, 2013). Sociologists have questioned the utility of this occupation-based approach to class in the context of the changing shape of occupation, for example the decline in manual jobs, in recent decades (Bottero, 2004; Platt, 2011; Savage 2000). Despite recent changes in the shape of occupation, 'class' is still a useful term which can be used to describe the unequal distribution of resources and can therefore be used to challenge inequality (Savage, 2016; Tyler, 2015). For the purposes of this thesis, I define class as one of the key social structures, incorporating economic and cultural aspects, through which, in conjunction with others such as gender and ethnicity, inequalities are reproduced and reinforced. For example, historical evidence about the increased gin consumption and resulting moral panic about gin-based crime and disorder in the 18th century known as the 'gin epidemic' suggests that it came about largely due to policy changes aimed at invigorating the distilling industry (Berridge et al., 2007). Although there is evidence that many middle and upper class people also drank heavily at this time, the focus of the moral panic was working class drinking, which has led historians to question the motivation of the political elite who led this moral panic (Berridge et al., 2007; Warner, 2003). Berridge et al. (2007) argue that this moral panic was motivated by economic requirements; changes in technology and urbanisation had led to a need for the working class to work efficiently, and soft drinks such as water and tea had become more readily available. Warner (2003; p4) points out that "Concerns over drunkenness bore very little correspondence to actual

consumption, begging the question of whether a reforming elite was reacting to gin per se or rather to larger more intractable threats to their society and way of life.”.

Similarly, recent media coverage of ‘binge’ drinking is not a simple reflection of drinking behaviour. Women have been over-represented in media discussions around binge drinking, but media stories about ‘binge’ drinking have largely focused on public behaviour rather than drinking in private (Patterson et al., 2016), even though only 27% of alcohol sales in Scotland take place in bars and clubs (Giles & Richardson, 2020). This has had the result of problematising the drinking of young, working class women when middle class women may be drinking just as much but may be more likely to drink in private and less often in public spaces (Mackiewicz, 2015). Feminist sociologists have argued that women’s bodies – particularly working class women’s bodies - have often been represented as messy, leaky and unpredictable in comparison with men’s bodies, which are often represented as standard, tidy and boundaried (Martin, 1989; Shildrick, 1997), and this appears to be reflected in media portrayals of women’s drinking. This suggests that not only are women with lower SES likely to experience alcohol consumption differently to women with high SES, but they may be more likely to experience moral judgment.

2.4.3 Responding to women’s alcohol consumption

Feminist critiques of mainstream treatment approaches have since the 1980s argued for an approach which understands that the problems experienced by women using substances including alcohol reflect the inequalities experienced by women (Ettorre, 2018). Treatment services for dependent drinkers are still, however, often focused on individual drinking (Hunt et al., 2016). Demographic data about those seeking treatment for alcohol problems is not published in Scotland, however National Health Service (NHS) data suggests that there is a steep SES gradient among those receiving treatment for alcohol problems, with five times as many people being prescribed drugs for alcohol dependence living in the most deprived areas compared to the least deprived areas (NHS Information Services Division Scotland, 2019).

When alcoholism is defined as a disease and concurrently a moral failing it is considered treatable by treating the individual, because the problem lies within the person, responsibilising individuals for the difficulties they experience and absolving

policy makers and corporations from responsibility for any harm that may be caused by structural inequalities and alcohol policy and marketing (Room, 2011). It constructs 'recovery' as possible, but only if people accept their 'illness' as the source of their problems and accept personal responsibility for their 'recovery', usually through lifelong abstinence. This requires adherence to a moral framework in which individual responsibility is accepted by the person attending (Staddon 2012, Ettorre 2007).

For those whose drinking is intertwined with experiences of abuse, poverty and powerlessness, or are unable to engage with recovery services in this way, this approach to 'treatment' can be a source of further shame, stigma and marginalisation. Women who have experienced abuse have often been blamed by their abusers for the abuse and requiring women in this situation to take responsibility and 'make amends' for the harm that their own drinking has caused can cause further harm (Galvani & Toft, 2015; Hammersley & Reid, 2002; Staddon, 2012, 2013, 2016). Besides the moral implications of punishing women for being abused, it may have practical consequences, potentially encouraging women to avoid telling practitioners about abusive situations, which could put women and children at further risk. Galvani and Toft (2015) argue that women with alcohol problems and who experience domestic abuse face a double stigma; their drinking is stigmatised because they are women, and they are also stigmatised because of the abuse they face and their perceived 'failure to avoid their own victimisation' (p91).

Similarly, the self-medicating theory of addiction centres traumatic experiences and ACEs as the cause of drinking but does not make connections with the structural inequalities which make these experiences, and their impact, more common and more severe for those experiencing multiple inequalities. It frames therapy as the 'solution' to problematic drinking but does not usually take broader contexts such as poverty, gender inequality, and racism into account (Moon, 2016).

In contrast, a social model of alcohol consumption involves understanding the ways in which women's problematic drinking is related to other aspects of women's lives, including systems of oppression (Staddon, 2012). Staddon's research with women who had experienced alcohol 'problems' and treatment found that women preferred women-only spaces providing mutual support and friendship rather than treatment, reflecting their view that inequality and social injustice, rather than drinking itself,

were the problem: 'We often felt that it was society that needed 'treating', rather than us. Between us, we had experienced racial hatred and homophobia, sexual and domestic abuse… chronic poverty… We saw ourselves as fortunate but determined survivors of an unjust society.' (Staddon 2012, p197). In line with this, studies exploring women's experience of drug and alcohol treatment have argued that drug and alcohol use should not be 'treated' separately from the contexts in which women live; services should meet the practical needs of women. Women's parenting status is a crucial aspect of these contexts and should be a major consideration in service provision, with women who are mothers requiring services that enable them to remain in a family environment with access to practical parenting and other support (Kelly Cardona, 2016).

2.5 Neoliberal parenting

2.5.1 Drinking and motherhood

Concerns about women's drinking are often focused on women's ability to fulfil their roles as future or current mothers (Armstrong, 2008; Staddon, 2013), reflecting the idealisation of the role of 'mother'. Ann Oakley's influential work on women's roles as housewives and mothers (1976, 1979) highlighted the crucial role motherhood played in '…erecting those gender divisions that construct women as an oppressed social group' (Oakley, 2019, pv). Oakley and other feminists have since continued to resist dominant narratives about women being inherently nurturing, and happy and fulfilled by caring, and therefore naturally better suited to being primary carers for children (Klee et al., 2002; Miller, 2007; Oakley, 2019). Although mothers are more likely to be in paid employment than they were during Oakley's initial studies in the 1970s, and caring for children is sometimes now acknowledged as work, 'mother' is still a culturally idealised role with accompanying societal pressures and expectations (Klee et al., 2002; Maushart, 1999; Oakley, 2019). The neo-liberal ideology of a 'good mother' is a woman who is seen as devoted to her husband, children, and home, is self-sacrificing and disciplined, and puts others before herself (Bell et al., 2009; Salmon, 2004, 2011). Staddon argues that mothers' drinking is often problematised because it can be seen as a cultural challenge (Staddon 2012) to these notions of 'good mothering'.

Qualitative research with mothers who drink suggests that for some women, drinking can be integrated as an acceptable part of 'doing' motherhood – as long as women remain able to fulfil iconic role of the 'good' mother. Emslie et al. propose that drinking provided a way for mothers to resolve 'multiple co-existing femininities while keeping a coherent sense of self and identity' (Emslie et al., 2015, p444). Similarly, Killingsworth, in an ethnographic study of a white middle-class Australian playgroup, found that reference to alcohol was used by mothers to reconcile their identities as mothers and as independent women. This was navigated carefully by the women; care was taken to ensure they were not considered to be heavy drinkers, and that they were seen as good, caring mothers, but not 'reducible' to this role (Killingsworth, 2006). Although the women in these studies described their ability to navigate motherhood and drinking, it is likely that their class status rendered their drinking, and their mothering, less problematised than women with lower SES.

A strong body of feminist scholarship has explored how idealised notions of the 'good mother' are unrealistic and fail to take into account the power relations and structural conditions that mediate women's experiences of motherhood (Bell et al., 2009; Miller, 2007; Oakley, 1979). Those who cannot conform to the idealised 'good mother' role are often pathologized, blamed, and stigmatised (Klee et al., 2002). Amy Salmon's research with Aboriginal women highlights that some women are more likely than others to be considered bad mothers. Salmon's policy analysis and qualitative research finds that Aboriginal women more likely than others to be presented in policy and practice as bad mothers who present a threat to their families and wider communities because they are less likely to conform to the ideology of a good mother. This ideology is itself the product of racialised, ableist and classist narratives, and women's ability to conform or not conform to these ideologies of motherhood is, Salmon argues, not simply a matter of choice: women's ability to choose is located within the broader contexts in which women live. For the Aboriginal women in Salmon's research, this means colonial oppression and its continuing racist legacy (Salmon, 2004).

Salmon's work highlights that the concept of choice is complex. Neoliberal dominant discourse highlights the importance of individual choice and freedom (Foucault, 1979; Ruhl, 1999), echoing rational choice theory which posits that people are rational actors who weigh up options and make decisions based on their best interests (Health, 1976).

Sociologists generally take a more critical view of the concept of 'choice', pointing out that individuals do not act alone; any choices made are made in specific contexts and conditions, including social conditions and structures (Blau, 1997; Bourdieu, 1977; Brannen & Nilsen, 2005; Crenshaw, 1991; Hill Collins and Bilge, 2016; hooks, 1997; Layder, 2006; Mills, 1970; Salmon, 2004). For the purposes of this thesis, I take a critical view of the concept of choice, acknowledging that individuals' ability to make choices, and the outcomes of these choices, are located within the broader contexts in which they live, and are affected by multiple, complex, intersecting factors including systems of structural oppression.

Understandings of choice also reflect ideas about the concept of agency, which is central to sociological analysis. For the purposes of this thesis, I define agency as the ability of individuals to act in ways not determined by social structures (Emirbayer & Mische, 1998; Sewell, 1992). The degree to which agency shapes social life is highly contested, with some social theorists arguing that individuals create and reproduce the social world in which they live (for example Mead, 1967), and others that social structures determine the way individuals experience the world (for example Marx & Engels, 1961). In recent years, theorists have been more concerned with exploring the relationships between structure and agency, including how behaviour is constrained by structure and power relationships, and how individuals resist these constraints (Bourdieu, 1997; Emirbayer & Mische, 1998; Hill Collins, 2002; Layder, 2006).

Although Scotland's historical and political context is not the same as Canada's, Salmon's work emphasises how the social acceptability of drinking, and its potential implications, vary according to women's ability to adhere to dominant ideologies of the 'good mother'.

2.5.2 ACEs, attachment, and the early years

The move towards neoliberalism has had an impact on how childhood and parenting are constructed (Featherstone et al., 2019). The goal of reproduction under neoliberalism is to produce 'economically and socially active citizens' (White, 2017) so that children can 'fulfil their potential' (Gillies et al., 2017), and investment in children's early years is an important part of this. This emphasis on the importance of the 'early years' is reflected in narratives around prevention; also reflected by

children's organisations and charities, who are often dependent on government funding. The WAVE Trust, for example, a UK charity focusing on children's early years, explicitly states the goal of productive citizens: 'we must focus on prevention if we want healthy, hardworking citizens' (Wave Trust, Accessed March 2021). The UK government has used mathematical modelling and brain scanning to emphasise the importance of children's early years for children's future 'success', and to make economic savings (Edwards et al., 2015), and in the UK and Scotland recent years have seen an increased policy focus on 'early years' (0-3) as key in determining a child's future outcomes. Claims about the importance of intervening early have in the UK rested on the idea that children's brains are at their most malleable in their earliest years, and that 'good' parenting can enable children's brains to be better developed, ideas that are based on neurological studies about how children's experiences affect their brain development that have been transferred to some policy and practice contexts without adequate scrutiny (Critchley, 2020a; Edwards et al., 2015; White, 2017).

In the UK, 'early intervention' and 'prevention' strategies have largely constructed parenting as the key determinant of child development, to the exclusion of other factors, without examining the broader contexts in which family relationships occur (Featherstone et al., 2019; White, 2017). This focus on parenting is reflected in the dominance of the ACEs model, an influential psychological model which stipulates that the more ACEs a child experiences, the worse their health and educational outcomes are likely to be (Hughes et al., 2017). Standard ACEs lists focus on family-based adversities such as abuse, neglect, parental substance use, and growing up in a single parent family, but do not explore the impact of structural factors such as poverty, race, and gender, thus reducing adversity to individuals and their families (Callaghan, 2018, 2019; Critchley, 2020a, 2020b; Walsh, 2020).

Decades of sociological work have, however, demonstrated that adversity is not simply about family life; since the beginning of the 20th century, sociologists have highlighted the social determinants of trauma and distress (Brown et al., 2011; Rose, 2020). Adversity – including ACEs, trauma and domestic abuse - is not equally distributed, and is not a matter of luck (Tyler & Slater, 2018) – the deliberate neo-liberal social policy approach of prioritising the production of profit by enabling a free market has led to

inequality, including health inequalities (Wilkinson, 2010), which increases the chance that those experiencing poverty will experience further adversities, but also that the impact of these adversities will be greater; the 'distribution of distress' (Davies, 2017) in our society is not equal. The ACEs model and its associated 'prevention' ideology depoliticise trauma and distress by reducing them to tick boxes, thereby obscuring the wider socio-political causes of the adverse experiences they measure (Callaghan, 2018).

A focus on parenting as the cause of children's adversity is also evident in the use of attachment theory by policymakers. Early years' policy constructs attachment as having a critical role in the development of children's brains. Child development is framed as determined by poor attachment, which is determined by parenting, thus constructing parenting as the key to improving children's development and outcomes in later life (Edwards, 2015). This focus on parenting has led to a focus on 'bonding' with babies, and the largely unchallenged idea that it is harmful to child development if bonding does not happen 'properly' (Lee, 2014). Critical psychologists and sociologists have challenged the assumption that maternal attachment is the main determinant of child development, highlighting how these assumptions about attachment pathologise ways of caring for children which do not take place in a 'typical' nuclear family, and is underpinned by a white, western concept of the 'ideal' family with exclusive parental care (Callaghan, 2019; Callaghan et al., 2015). This reliance on brain science discourses misuses attachment theory by framing parenting capacity as a clear and obvious outcome of women's own experience of being parented. This simplistic explanation is concerning as it assumes that women who practitioners consider not to have been parented 'well' will be unable to care for their own children (Featherstone et al., 2014), using neuroscience in a deterministic way to justify inequality (Edwards, 2015).

2.5.3 Pregnancy as responsibility/ reproductive citizenship

The neoliberal focus on children's 'early years' includes the prenatal period, with childhood extending back into pregnancy, and narratives around the importance of parenting, attachment and ACEs applied to unborn babies. Feminist sociologists have

observed that the self-regulation required of everybody within neo-liberalism (Foucault, 1979; Ruhl, 1999) is particularly evident during pregnancy (Lee et al., 2014; Lupton, 2012; Salmon, 2011). Women's bodies can be seen as particularly unpredictable and uncontained during pregnancy (Lupton, 2013b) (Lupton, 2012), and the pregnant body is positioned as a 'threatening Other' to the 'defenceless Self' of the unborn; a risk and threat, rather than protective and nurturing (Lupton, 2013a). Women are expected to exert control over their risky, unruly bodies throughout pregnancy by following government guidelines, and those who do not do this are not considered responsible mothers (Bell et al., 2009; Lupton, 2013a).

Women are required to avoid all risk to the foetus during pregnancy (Ruhl, 1999) in order to protect the child-to-be, thus ensuring its future productivity in society (Lupton, 2013; Salmon, 2011). This expectation on women to behave appropriately during pregnancy, including following medical advice about how to protect their unborn children from harm, is presented as their personal responsibility as reproductive citizens (Lupton, 2012; Salmon, 2011). Expectations of reproductive citizenship individualise risk to women's bodies, placing the sole 'blame' for risk on women, and ignoring the social and political context. This perpetuates the 'discourse of risk' (Lupton, 2013a), in which the unborn baby, not the woman, is positioned as at risk, and it reproduces dominant narratives around mother-blaming, in which mothers are blamed and held accountable for harm inflicted by others, for example through domestic violence (Carlton et al., 2013).

Lee notes that women are now not only required to minimise risk but are expected to bond with their babies before they are born; mothers are seen as responsible for ensuring their foetuses are comfortable, for example by minimising stress during pregnancy. Lee (2014) states:

> A powerful system is in place that demands women change how they live in an array of ways, on the grounds that everything the pregnant woman does and feels (or does not do and does not feel) will impact on the foetus, for better or worse (p131).

Research around prenatal attachment suggests, however, that it is far from straightforward, with the definition of maternal-foetal attachment and the tools used

to measure it varying widely across studies, reflecting various conflicting theoretical understandings of attachment, and qualitative studies with women have also emphasised the complexity involved in maternal-foetal bonding (McNamara et al., 2019; Lupton, 2013b). More recent understandings of prenatal attachment have attempted to situate it within its broader contexts, reflecting the importance of women's wider circumstances on her ability to 'attach' to the foetus – with factors such as stress and partner support appearing to influence attachment (McNamara et al., 2019).

2.5.4 Neoliberal child protection

The intense neoliberal focus on parents' responsibility for their children has, amidst the erosion of the welfare state, led to a focus on target setting, monitoring and surveillance of individual families, instead of the provision of practical support (Featherstone, 2019; Featherstone et al., 2014; Lonne et al., 2009; White, 2017). In the UK including Scotland, child protection is framed as paramount (the 'best interests of the child' come first), and Scottish Government policies such as 'Getting Our Priorities Right' and 'Getting It Right For Every Child' (see Scottish Government, 2012; Scottish Government, n.d.) frame Child Protection as something which practitioners should be ensuring through surveillance and assessing parents' abilities to keep children safe. This individualises risk and harm to parents, ignoring the impact of living in poverty on parents' ability to meet middle class expectations of parenting, instead centring parents as the cause of risk and harm to children (Featherstone, 2019; Featherstone et al., 2019; Featherstone et al., 2014; Hyslop & Keddell, 2018; Whittaker et al., 2020). Alcohol use is a common concern listed on the child protection register in Scotland, listed as a concern in 686 of 2,599 case conferences last year (Scottish Government, 2020c). Child protection interventions with parents who use alcohol or drugs often emphasise the 'recovery' of the parents, requiring them to demonstrate that they are abstinent, at the expense of understanding and providing support for contextual factors affecting their drinking (Boreham et al., 2018; Chandler et al., 2013).

Morriss points out that decisions about child removals are frequently made on the basis of imagined future harm; harm that has not yet happened, but which courts pre-empt and attempt to legislate for (Morriss, 2018). This imagined future harm is

particularly pertinent in relation to pre-birth child protection. In Scotland children can be registered on the child protection register before birth, and last year 98 'unborn children' were registered on the Child Protection register. This represents 4% of all children on the Child Protection register, and although this is a 1% drop since the previous year, the overall trend is for increasing pre-birth child protection referrals (Scottish Government, 2020c). Research into practitioners' and parents' experiences of pre-birth child protection is lacking, although it appears that substance use is frequently cited as a contributory factor in these cases (Critchley, 2018).

Poor children in the UK including Scotland are consistently more likely to be the subject of child protection and care proceedings and to be removed from their families by the state (Bywaters et al., 2018; Featherstone et al., 2019). Those living in Scotland in one of the most deprived areas in the UK are 10 times more likely to have their children removed than families living in one of the least deprived areas (Bywaters et al., 2018). Evidence suggests that there is a strong relationship between poverty, abuse, and neglect (Bywaters et al., 2018), but there has been resistance from the UK government to exploring this relationship, with some politicians going so far as to say that it is irresponsible to suggest a link (Gove, 2013). Mixed-methods social work research has found that practitioners may avoid acknowledging links between poverty and abuse as a way of avoiding stigmatising poor families (Morris et al., 2018).

The refusal to engage with conversations about the complex connections between poverty and parenting depoliticises parenting and motherhood, effectively arguing that mothers are responsible for their children's development and denying that structural factors beyond women's control affect women's ability to parent their children (Featherstone et al., 2019; Gupta, 2017). This focus on individual responsibility is a key part of neoliberalism, in which free enterprise and individual responsibility are prized and poor people are blamed for – and, crucially, encouraged to feel ashamed of – the poverty they face, despite this poverty, which results from inequality, being a logical and inescapable function of neoliberal society (Featherstone et al., 2019; Shildrick, 2018; Tyler & Slater, 2018; Wilkinson & Pickett, 2010). Concurrently, austerity and local authority budget cuts have, in a social care version of the inverse care law, disproportionately affected deprived local authorities because they have

fewer resources with which to do more work (Marmot, 2018; Webb & Bywaters, 2018), worsening the impact of poverty on families.

2.5.5 Impact of child protection

Framing risk and harm as caused by parents enables and reproduces a child protection system in which it is justifiable and acceptable for families to be dehumanised. Qualitative research with families who have experienced child protection procedures highlights the dehumanising impact of the child protection system, with parents describing feeling coerced, not treated as equal decision-makers, and silenced (Smithson & Gibson, 2017). This is compounded by the fact that women who have had a child removed in the past are likely to experience subsequent child removals (Broadhurst et al., 2015). Women who have experienced child removals may therefore avoid seeking help or disclosing subsequent pregnancies, as an attempt to keep future children, which may contribute to the likelihood of the removal of the baby at birth (Morriss, 2018; Tyler, 2013). Morriss notes how it is almost impossible for mothers to resist this silencing, stigmatisation, and dehumanisation because to do so may jeopardise their chances of keeping their children and increase chances of future child removals (Morriss, 2018).

Child removals have a profound and permanent impact on women's lives, by causing trauma, shame and stigma to women who are often already marginalised (Broadhurst & Mason, 2013, 2017; Kenny et al., 2015; Morriss, 2018; Tyler, 2013). This is reflected in cohort studies which have found that women whose children are removed are significantly more likely to attempt or complete suicide than women whose children are not removed (Wall-Wieler et al., 2017). Women whose children are removed are usually no longer eligible to receive support from services, because they are no longer responsible for an 'at risk' child, and they are therefore left alone to deal with the trauma caused by child removals, thus exacerbating the exclusion they already face (Broadhurst & Mason, 2017; Kenny et al., 2015; Morriss, 2018). In a situation reminiscent of some FASD prevention programmes in Canada which focus on reducing the reproduction of indigenous communities (Tait, 2008), the UK services that do engage with women who have experienced child removals often require women to

comply with stipulations around contraception, implying that 'it is not deprivation and inequality which need to be "reduced", but the poor themselves' (Tyler, 2013, p. 193).

Critical social work scholars argue that the current approach to child protection is unethical and ineffective, and that an alternative approach to child protection requires a paradigm shift away from neoliberal ideas about individuals fulfilling potential and being productive, and towards a humanising model promoting social good, with a focus on ethics, relationships, and social justice (Featherstone, 2019; Gillies et al., 2017; Hyslop & Keddell, 2018). A humanising model would require policy and practice to take into account the structural aspects of adversity including the ways that systems of oppression affect families; support families, rather than narrowly assessing risk within them; and explicitly address poverty as a problem of financial deprivation caused by neoliberal capitalism, rather than an individual or community deficit (Featherstone, 2019; Skinner et al., 2020; The Promise Scotland, 2020).

2.6 Defining FASD

Like other aspects of parenting, the policy and public discourse around FASD emphasises the behaviour of individual mothers over other risk factors. There are multiple confounding factors which affect women's chances of having a baby with FASD. These factors have not been given as much research, policy or publicity as the topic of women's drinking. Instead, women's drinking during pregnancy is constructed as a hidden problem, which causes harm to children.

2.6.1 Diagnosing and measuring FASD

Alcohol is a teratogen – an agent which can adversely affect the formation of the embryo and development of the foetus. The consumption of alcohol during pregnancy has been associated with Foetal Alcohol Spectrum Disorders (FASD), an umbrella term describing a range of effects associated with drinking during pregnancy, including increased risk of miscarriage, reduction in foetal growth, birth defects, developmental delay, and neurological abnormalities (BMA, 2007). The most visible form of FASD is Foetal Alcohol Syndrome (FAS), a birth defect involving growth deficiency, specific facial abnormalities (often called sentinel features), and central nervous system damage (Astley et al., 2000; Jones & Smith, 1974).

While FAS is a medical diagnosis included in the ICD-10 (World Health Organization, 2010), FASD has never been included in the ICD due to the lack of evidence with which to develop reliable diagnostic criteria (Brown et al., 2019; Scottish Intercollegiate Guidelines Network, 2019). In 2019, the Scottish Intercollegiate Guidelines Network (SIGN) published SIGN 156, a clinical guideline for practitioners working with children and young people exposed prenatally to alcohol (SIGN, 2019). SIGN 156 recommends the introduction of two diagnostic categories: FASD with sentinel features and FASD without sentinel facial features. This guideline anticipates the introduction of an additional category of 'neurodevelopmental syndrome *due to* prenatal alcohol exposure' (p5) in the 2022 ICD update; a subtly yet perceptibly more authoritative version of the current definition included in the Diagnostic and Statistical manual of Mental Disorders (DSM) since 2014, in which the link between maternal drinking and FASD is less definitively causal: 'Neurobehavioral Disorder *Associated With* Prenatal Alcohol Exposure (ND-PAE)' (Doyle & Mattson, 2015). Although SIGN 156 recommends that until the new ICD category is available, the term 'FASD' should be used as a descriptor rather than a diagnostic term, it repeatedly refers to FASD to as a diagnosis, and the National Organisation for FASD website lists FASD with or without facial features as 'new diagnostic terms' representing a neurodevelopmental condition for which 'FASD is the overarching diagnosis' (National Organisation for FASD, 2020a).

FASD symptoms are broad, often being argued to involve over 400 co-occurring conditions (National Organisation for FASD, 2020b). This means that there is no typical FASD presentation, and because of this breadth, many of these co-occurring conditions such as sensory and attention issues overlap with other diagnoses such as Attention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Disorders (ASD), and some, such as infant feeding problems and frequent baby crying, are commonplace for people without any diagnoses. Despite this, diagnostic guidelines and FASD prevalence studies represent FASD as a definitive, diagnosable condition, which is recognisable to those who understand it well enough (Armstrong, 2008; Brown et al., 2019).

The importance of diagnosis is emphasised throughout SIGN 156 and on charity and NHS websites. This emphasis on diagnosis assumes that FASD is under-diagnosed, and that diagnosis is helpful for children and families. It is difficult to measure rates of FAS and FASD due to differences in definition, 'diagnosis' and measurement across the

world (Drabble et al., 2011) (see section 2.7.2 for fuller discussion on the difficulties with FASD research). SIGN 156 states that prevalence of FASD in the UK is 32.4 per 1,000 (SIGN, 2019), although prevalence estimates vary widely depending on definition and methodology, with a recent birth-cohort study in England estimating that 17% of the population could have FASD (McQuire et al., 2019). The number of women reporting alcohol consumption during pregnancy contrasts strongly with these estimates of FASD prevalence: although data on how many pregnant women are referred to alcohol treatment services does not appear to be available in Scotland (NHS Information Services Division Scotland, 2020), data from the longitudinal Growing Up in Scotland (GUS) study suggests that of the 20% pregnant women in Scotland who report alcohol consumption whilst pregnant, 1% report consuming 5 or more UK units per drinking day (Bradshaw et al., 2013).

It is likely that some pregnant women do not disclose their drinking due to fear of stigma (Phillips et al., 2007), and that some underreport their alcohol consumption during pregnancy (Symon et al., 2017). There is, however, a risk that assumptions about underreporting perpetuate a vicious cycle, in which women are assumed to under-report drinking during pregnancy because of the number of children being diagnosed with FASD, and the number of children with FASD is assumed to be too low because prevalence studies judge it to be much higher. This would cause prevalence studies to be used as a proxy for knowledge about, and evidence of, maternal drinking during pregnancy, framing FASD as a 'hidden epidemic' for which women are individually responsible. This 'hidden epidemic' narrative is often evident in media coverage and charities' literature around FASD (NOFAS-UK, 2018; Skeates, 2018).

Getting a diagnosis is often presented as important because it aids understanding of what to expect and how to support people with FASD in order to aid their development, including for parents, clinicians and schools (SIGN, 2019; National Organisation for FASD, 2020c; Domeij et al., 2018). Carers of children with FASD report that diagnosis is currently necessary to access support, and that even after diagnosis appropriate support may not be readily available (Domeij et al., 2018). The benefits of diagnosis, however, are not straightforward. A recent exploration of the ethical aspects of FASD diagnosis found that there are practical advantages to diagnosis such as access to additional support at school, but due to the very wide range of symptoms

associated with FASD, a diagnosis does not guarantee access to tailored support for the particular set of symptoms each individual experiences. Similarly, many of the symptoms associated with FASD overlap with symptoms associated with other diagnoses including ADHD and autism and therefore appropriate supports and interventions overlap too (Gert et al., 2018), so if approaches to support provision were made less diagnosis-focused this could enable access to pre-existing support without requiring a diagnosis.

Diagnosis with FASD, with its focus on maternal drinking, stigmatises birth mothers, who are blamed for FASD (Corrigan et al., 2019; Gert et al., 2018), and possibly also children, who are framed as lazy, burdensome, and hopeless (Corrigan et al., 2019). Research considering the implications of diagnosing neonatal abstinence syndrome (NAS, commonly associated with opioid use during pregnancy) argues for understanding NAS as a 'social diagnosis', thus reframing responses to focus on supporting babies on the basis of their individual needs, rather than focusing on diagnosis (Chandler et al., 2020). Although there are differences between NAS and FASD, this approach is pertinent here because needs-based support could allow individually tailored support to be provided to children and their mothers whilst avoiding the stigma and blame associated with FASD diagnosis. Sociologists who focus on the sociology of diagnosis highlight the social aspects of diagnosis, arguing for the importance of acknowledging the contexts in which diagnosis takes place: 'Social diagnosis… connects an illness… to a set of political, economic, cultural and social conditions or factors.' (Brown et al., 2011, p939). The social aspects of FASD as a diagnosis have not generally been reflected in dominant narratives around FASD, and it has instead been individualised to women's bodies and behaviour.

2.6.2 The individualisation of FASD

Those seeking to raise awareness of FASD suggest it can be caused by any level of alcohol consumption during pregnancy. SIGN 156, for example, states that FASD can be caused by any maternal drinking during pregnancy. However, systematic review evidence suggests that, during pregnancy, as the quantity of alcohol consumed increases, so does likelihood of FASD (Bay & Kesmodel, 2011; Henderson et al., 2007a and 2007b; Patra et al., 2011). Thus, women who drink at 'high risk' levels - defined by

the World Health Organization as the equivalent of 35 or more UK units per week (World Health Organization, 2000) - may be more likely than others to have a baby with FASD.

For women drinking at a 'high risk' level during pregnancy, risk is not evenly distributed (Abel, 1995; Henderson et al., 2007b; Jones & Smith, 1974). In line with research around the alcohol harm paradox (see 2.2.2), factors such as (but not limited to) SES, smoking, diet, other health conditions, parity, genetics, domestic violence, stress, and other drug use may affect a woman's likelihood to give birth to a baby with FASD, even when drinking behaviour is comparable (Abel & Hannigan, 1995; Armstrong, 2008; Armstrong & Abel, 2000; Drabble et al., 2011). Similarly to large scale studies with women who use illicit drugs during pregnancy, which find that drug use appears to be a marker for other issues, rather than the sole cause of poor birth outcomes (Lyons & Rittner, 1998; Marcellus, 2003; Schempf & Strobino, 2008), studies of birth mothers of those with FASD suggest that these women have often experienced abuse, are socially isolated and living in poverty (Astley et al., 2000; Badry, 2008; Bell et al., 2009).

These and other social contexts are not subject to the same level of scrutiny in research, policy, and practice as women's drinking behaviour (Armstrong, 2008; Bell et al., 2009; Lowe & Lee, 2010; Salmon, 2011). Studies exploring FASD rarely take these factors into account, so it is impossible to claim with any degree of certainty that maternal alcohol consumption is the *sole* cause of FASD, yet it is often portrayed as the only cause of FASD, and only preventable by abstaining. News articles and public health information do not tend to mention the possible role of structural determinants of health such as poverty, inequality, violence, SES, or chronic stress, but focus instead on drinking (and occasionally smoking) (SIGN, 2019; National Organisation for FASD, 2020).

Although this reluctance to engage with conversations about the impact of structural factors may stem from a well-meaning desire to avoid stigmatising poor women in the way that indigenous women have been stigmatised and over surveilled in some countries such as Canada (Tait, 2008), its impact is to move the debate away from structural problems and towards women's individual behaviour. The uncritical acceptance of FASD as caused solely by women's drinking has consequences for all pregnant women but has some additional impacts on women who are already

marginalised. It reinforces the positioning of women's behaviour as responsible for the health or otherwise of their children; FASD 'diagnosis' tells us about whether women are considered to have appropriately 'done' reproductive citizenship, or met the 'good mother' ideal or not. Within this neoliberal parenting context, women who are judged not to adhere to the 'good mother' ideal, who are more likely to be judged in this way if they are already marginalised - are more likely than others to experience more intense monitoring and surveillance and child protection interventions (Bell et al., 2009). This intensified monitoring is possibly reflected by the fact that many children who receive a diagnosis of FASD appear not to be in the custody of their birth mothers (Astley et al., 2000; Sood et al., 2001).

Individualisation is evident in debates about the bioethics of drinking during pregnancy. In an article exploring the ethical and legal challenges around responding to women's alcohol consumption during pregnancy, Wilkinson et al. (2016, p425) argue that 'even if the foetus is regarded as having no legal or moral status, there is an ethical and legal case for intervening to prevent serious harm to a future child'. In the US, criminal justice policies have sometimes linked maternal drinking with child abuse, imprisoning women who drink during pregnancy for child abuse (Badry, 2008). This evidences Lupton's theory about the portrayal of the pregnant woman as a threat to the foetus. In Wilkinson et al.'s article, women are described as choosing to consume substances that they know are harmful to the foetus, described as a future child. Although Wilkinson et al. undertake a detailed examination of the ethical questions raised by this way of thinking, they do not question the positioning of the mother as the cause of the harm, consider how other factors may be involved in outcomes for the 'future child', or question the meaningfulness of the concept of 'choice'.

Women's drinking during pregnancy has been positioned as a major cause of social problems, ranging from men's violence to adults' drinking and smoking in later life (NHS Scotland, 2011). SIGN 156, for example, highlights that 'for many children PAE [prenatal alcohol exposure] is not considered and/or acknowledged as a possible cause of their neurodevelopmental disorder, particularly those with …ADHD and …ASD.' (SIGN, 2019; P.2). This implicitly constructs maternal alcohol consumption as a cause of ADHD and ASD. Similarly, Scotland's former Chief Medical Officer (CMO), Sir Harry Burns, appeared to attribute men's violence towards women to prenatal drinking,

when he spoke at the Scottish Parliament's Health Committee in 2008: 'I bet that [FASD] prevalence is very high in the young men and boys who are out on the streets committing violence…. If we can identify the risk factors, we can definitely intervene' (Burns, 2008, column 749). Burns' 2011 CMO report also appeared to attribute ACEs to maternal drinking, stating that:

> …persons with multiple categories of childhood [ACE] exposure were likely to have multiple health risk factors later in life. The interventions that have been shown in multiple studies to reduce this pattern of risk include action in pregnancy to reduce smoking and consumption of alcohol. (NHS Scotland, 2011; p.11)

Framing drinking during pregnancy as a cause of ACEs, violence, and ADHD constructs pregnant women's drinking as the cause of a range of social problems, rather than considering broader structural issues as contributory factors. This is reminiscent of the way drug policy has framed parents' illicit drug use as responsible for the problems experienced by families, with structural aspects/social determinants of family life downplayed, therefore justifying intervention and surveillance in family life (Whittaker et al., 2020). Complexity and nuance are avoided, and the problems are constructed as fixable by stopping pregnant women from drinking.

2.7 Preventing FASD

UK public health responses to FASD have remained focused on drinking behaviour rather than contextual factors and have overwhelmingly taken place at a population-health level. Guidance for all women who are, or may become, pregnant focuses strongly on the need for abstinence, reflecting the precautionary approach. The impact of this approach on women who drink at a 'high risk' level or women with multiple cofounders associated with FASD is not well understood, but it is possible that this approach could cause harm.

2.7.1 Overview of UK policy/ guidance regarding alcohol and pregnancy

Since 1995, when the first UK guidelines for pregnant women about alcohol consumption during pregnancy were published, there has been a shift towards abstinence-focused advice (see Appendix 1 for a summary of UK guidance regarding alcohol and pregnancy).

In 1995, an inter-departmental group was set up by the Department of Health to 'carry out a review of the Government's sensible drinking message' (Department of Health, 1995); a message that had existed since 1976 but had not previously included any reference to pregnancy. The resulting guidelines included a recommendation for pregnant women for the first time in the UK:

> In the light of the evidence… our conclusion is that, to minimise risk to the developing foetus, women who are trying to become pregnant or are at any stage of pregnancy, should not drink more than 1 or 2 units of alcohol once or twice a week, and should avoid episodes of intoxication. (Department of Health, 1995, p27)

The National Institute for Health and Care Excellence (NICE) published clinical guideline 6 in 2003, recommending that pregnant women should be advised to limit consumption to no more than one UK unit of alcohol per day, on the basis that 'Research evidence is consistent in finding no evidence of foetal harm among women who drink one or two units of alcohol per week' (National Collaborating Centre for Women's and Children's Health 2008, p348).

In 2006, a review of the evidence on the effects of alcohol on the foetus was commissioned by the Department of Health (Gray & Henderson, 2006). Despite the findings of this review being largely consistent with previous evidence, the advice given to pregnant women shifted towards an abstinence approach soon afterwards:

> Women who are pregnant or trying to conceive should avoid alcohol altogether. However, if they do choose to drink, to minimise the risk to the baby, we recommend they should not drink more than 1-2 units once or twice a week and should not get drunk. (Department of Health and Social Care, 2007)

The press statement released at the time made clear that this change in focus was not due to new evidence, but to a perceived need to make the message clearer: 'While scientific basis for our advice has not changed… a slightly stronger message is aimed at those who do not reduce their consumption to appropriate levels' (Department of Health and Social Care, 2007).

At this time in Scotland, the focus on abstinence became more pronounced, with the Scottish Government website stating in 2007 that 'there is no 'safe' time for drinking alcohol during pregnancy and there is no 'safe' amount' (Department Of Health, 2016). Concurrently, NICE Clinical Guideline 6 (CG6) was reviewed and replaced with CG62, which, as a result of NICE's own evidence review which focused on the Department of Health-commissioned review, came to a different conclusion about appropriate advice. NICE recommended advising pregnant women to avoid drinking in the first trimester due to a possible increased risk of miscarriage, to drink no more than 1-2 units once or twice per week throughout pregnancy, and that binge drinking '…may be harmful to the unborn baby.' (National Collaborating Centre for Women's and Children's Health, 2008, p16). It did not advise abstinence throughout pregnancy because the evidence did not suggest that drinking 1-2 units once per twice per week could be harmful. CG62 was reviewed in 2011 and remained unchanged.

In 2012 the House of Commons Science and Technology Committee published an inquiry stating that a thorough review of the evidence informing alcohol guidelines for the general population should be undertaken as alcohol guidelines for the general population had not been reviewed since 1995 (House of Commons Science and Technology Committee, 2012). The UK Chief Medical Officers (CMOs) established two expert working groups, including the Health Evidence Expert Working Group, to review the evidence and develop joint UK-wide alcohol guidelines. At this stage the Department of Health acknowledged that although it considered that the then current guidance '…adequately balances the scientific uncertainty with a precautionary approach' (House of Commons 2012, p21), a consistent message across the UK was desirable.

In November 2013 and January 2014, a review of the systematic review level evidence on the effects of drinking was published for the Health Evidence Expert Working Group (Jones & Bellis, 2014; Jones et al., 2013). The remit of this review was to map the

worldwide systematic review level evidence of the health impacts from alcohol. Seven research questions informed the review, one of which related to pregnancy and alcohol: 'Are there any changes in the direction, form or strength of the evidence on alcohol and pregnancy since the 2008 NICE review?' (Jones et al. 2014 p4).

The evidence provided to the Health Evidence Expert Working Group in the summary of findings did not include any findings that substantively differed from the findings considered when the NICE guidelines were updated in 2008 (Jones & Bellis, 2014). In the same year that the summary review was published, NICE's CG62 was placed on the static list in 2014 because it was reviewed and considered to not require updating (NICE, 2017). Despite this lack of new evidence, the guidelines concerning drinking during pregnancy went on to change significantly as a result of the UK guidelines review, with a clearer focus on abstinence. In 2016 the new guidelines were published, stating:

> If you are pregnant or think you could become pregnant, the safest approach is not to drink alcohol at all, to keep risks to your baby to a minimum. Drinking in pregnancy can lead to long-term harm to the baby, with the more you drink the greater the risk. (UK Chief Medical Officers, 2016, p8)

In 2017, an exceptional review of NICE guideline CG62 was announced, partly because '…the alcohol guidelines review by the Department of Health… includes recommendations that are now in conflict with NICE guideline CG62' (NICE, 2017). The updated guideline is expected to be published in 2021, and in the meantime the online version of the guidance currently links to the abstinence-based 2016 CMO alcohol guidelines.

2.7.2 Does the evidence support the shift towards abstinence-focussed advice?

Five systematic reviews relating to 'pregnancy and conditions originating in the perinatal period' (Jones et al. 2013 p6) were included in the 2013 review (Bay & Kesmodel, 2011; Henderson et al., 2007a; Henderson et al., 2007b; Latino-Martel et al., 2010; Patra et al., 2011). The systematic reviews included in the report explored a range of outcome measures including low birthweight, preterm birth, small for gestational age (SGA)/ intrauterine growth restriction, miscarriage, stillbirth,

malformations, and neurodevelopmental outcomes, and considered a range of reported alcohol consumption (see Appendix 2 for a summary of these systematic reviews).

The systematic reviews included in Jones et al.'s 2013 review found no consistently significant effects of low-moderate drinking or binge drinking on any of the outcome measures. Some found an association between 'heavy' drinking (which was not defined consistently across the studies) and low birthweight and preterm birth (Patra et al., 2011) and motor skills (Bay & Kesmodel, 2011). There are several limitations in this evidence base, which are pertinent to research examining the effects of alcohol on the foetus:

1. Heterogeneity of studies

Many of the studies within the systematic reviews measure specific outcomes such as motor skills. Each outcome, however, can be defined and therefore measured in a variety of ways, using a range of tools. Studies that appear to measure the same outcome can often be measuring something quite different: the studies included in Bay and Kesmodel's 2011 systematic review, for example, variously measure motor skills in 3 day old infants and 26 year old adults. This heterogeneity, which is common across the reviews, can make it difficult to compare studies and draw meaningful conclusions. For this reason, three of the systematic reviews (Bay & Kesmodel, 2011; Henderson et al., 2007a; Henderson et al., 2007b) did not include meta-analyses.

2. Potential bias

Some of the studies included in the systematic reviews require a diagnosis or suspicion of FASD for participants to be included. As sociologists studying diagnosis have pointed out, diagnosis involves more than a simple description of a range of symptoms; it is a process as well as a category (Jutel & Nettleton, 2011). Diagnosing an individual with any condition therefore involves various clinical practices, practical judgements and decisions by individual clinicians, and is a complex process often rife with tensions and ambiguities, even when validated tests or diagnostic tools are used (Gardner et al., 2011; Jutel & Nettleton, 2011; Schubert, 2011). Due to the complex nature of diagnosis, studies requiring a diagnosis of FASD are problematic. They are heavily reliant on the individual clinicians involved, who, depending on geographical area;

their own training, specialisms, and interests; knowledge of the family; and other factors, may be more or less likely to make a diagnosis of FASD (as opposed to another condition or no condition at all). Further limitations arise when studies use clinicians who are aware which children have been alcohol-exposed to test the outcome measures.

3. Possible confounding factors

Many of the studies included in the systematic reviews did not control for potential confounding factors such as SES, smoking, diet, experiences of violence and stress, and drug use. Not controlling for these factors could inaccurately represent the impact of alcohol on the foetus by attributing results to alcohol when they could relate to other factors. Those studies that did claim to control for these factors often did not provide detailed information about how this was done, which is problematic because factors such as SES, violence and stress are complex and can be defined and measured in multiple ways (Baxter & Taylor, 2014). In the example of SES, studies usually use measures of limited aspects of SES such as income, local area, or education level as proxies for SES, and are unlikely to take into account factors such as wealth (as opposed to just income) and past experiences of poverty (Braveman et al., 2005).

Some critical public health researchers and sociologists question whether it is ever possible to control for complex factors such as SES, arguing that it is crucial to acknowledge that 'real world' research is different from decontextualised research such as RCTs and laboratory science, which are 'grounded in linear models of cause and effect' (Rutter et al., 2017 p2602). They argue that the complexity resulting from 'real life' research should be explicitly considered in studies' findings, not simply 'bracketed out' by attempting to control for it and then never mentioning it again (Braveman et al., 2005; Shoveller et al., 2016).

4. Reporting of alcohol consumption

Studies use a range of ways to collect data about maternal alcohol consumption, including interviews with mothers during pregnancy or postnatally, self-completion questionnaires, and use of data from maternity services, all of which rely on women's self-reporting of alcohol consumption. One of the difficulties with self-reporting of alcohol consumption is that due to the stigma attached to drinking during pregnancy,

women might under-report (Muggli et al., 2015; Phillips et al., 2017). In addition, some of the studies are retrospective (asking women whether/ how much they drank during pregnancy some time later), while others are prospective (asking women how much they drink during pregnancy and following them up after delivery). Both approaches have potential limitations – there is potential for participants in retrospective studies to forget the details of past drinking (Muggli et al., 2015) while prospective studies, in which women are still pregnant when they are asked about alcohol consumption, may lead to under-reporting due to anxieties about child protection and other implications of disclosure (Phillips et al., 2017). It is therefore possible that the amount of alcohol consumption reported in the studies does not reflect actual drinking behaviour because participants may under or over report their drinking depending on the context in which it is reported and who asks the question (Brown et al., 2019; Schölin & Fitzgerald, 2019).

5. Measurement and definition of alcohol consumption

The studies define alcohol consumption in various ways and use different comparators. Some compare any drinking with no drinking, while others describe 'low' 'moderate', 'heavy' and 'binge' drinking, defining these terms in various ways. There is not a consistent discussion around measurement of alcohol throughout the studies, which makes it difficult to compare them. The meaning of the term 'binge drinking', for example, does not have a universal meaning, so a systematic review of its effects will be limited by the definitions used by the researchers designing the original studies.

Overall, the evidence included in the 2013 report (Jones et al., 2013) appears to include no evidence that alcohol consumption of 1-2 UK units, once or twice per week, as per the previous UK guidelines (Department Of Health, 1995), is harmful (Jones & Bellis, 2014). However, the limitations outlined above – many of which are unavoidable - make it difficult, and perhaps impossible, to ascertain a 'safe' or 'unsafe' level of drinking during pregnancy. Policymakers appear to have responded to this uncertainty by adopting an approach, which seeks to avoid all risk by advising women not to drink at all during pregnancy.

2.7.3 The precautionary principle – making uncertainty certain

As explored above, guidance from the UK Chief Medical Officers advises that abstaining from drinking alcohol is the safest approach during pregnancy (UK Chief Medical Officers, 2016). This represents a precautionary approach which seeks to eliminate risk. This precautionary advice is based on the precautionary principle; the idea that risk can be avoided by preventing certain behaviours. The precautionary principle was first used to consider how to prevent environmental dangers (Winter, 2016), but has now become associated with public health. In the context of alcohol consumption during pregnancy, it is based on the idea that no alcohol means no risk, and that abstention is therefore the best recommendation to make.

The assumption that all drinking during pregnancy is potentially harmful to the foetus, and that FASD is caused solely by women's drinking, is reflected in UK discourse around pregnancy. In their analysis of UK guides to pregnancy, Marshall and Woollett (2000) found that even those claiming to be advocates for pregnant women presented drinking during pregnancy as an inherent risk which responsible mothers should seek to avoid (Marshall & Woollett, 2000). In their 2010 analysis of UK policy on alcohol and pregnancy, Lowe and Lee (2010; p301) argued that in advising abstinence, policymakers 'formalise a connection between uncertainty and danger'; the absence of proof that alcohol consumption is safe during pregnancy is portrayed as meaning that alcohol consumption during pregnancy is inherently risky: 'policy makers have decided it is best to circumvent uncertainty associated with evidence and simply associate any alcohol consumption with harm. This… approach to risk [is] based on seeking to make uncertainty certain.' (Lowe & Lee, 2010, p306).

This precautionary approach can seem intuitively sensible – after all, if all risk can be eliminated, harm is avoided. There are, however, several significant limitations of this approach. Firstly, it is based on a simplistic view of alcohol related harm, which assumes everyone is equally affected by alcohol consumption. This is not the case (Katikireddi et al., 2017), as, similarly to other potentially harmful substances such as environmental toxins and air pollution, alcohol related harm does not affect everybody

equally, and not all women who drink even at a 'high risk' level will have a baby with FASD (Abel, 1997; Henderson et al., 2007b) (see 2.6).

Secondly, the precautionary approach avoids complexities. In her sociological critique of the development of FAS, Elizabeth Armstrong argued that despite the complexity of the issue, FAS has become 'democratized', so that any alcohol consumption, during any pregnancy, is presented as a FAS risk (Armstrong, 2008, p202). This democratization has arguably created a situation in which FAS is a 'marker of maternal misbehaviour' rather than an indication that some women who drink may need more support (Golden, 2005). Mothers' drinking is thereby situated as the sole cause of harm to babies, orienting the UK's practice towards abstinence and surveillance-based child protection and away from maternal and family support. This abstinence-based approach gives the impression of addressing FASD without taking any meaningful action, for example by providing intensive support for women with 'high risk' drinking or multiple confounding factors for FASD. The democratisation of FASD is also evident in SIGN 156, which positions FASD as a condition which can be caused by any drinking during pregnancy, not just 'high risk' drinking, and contends that women's drinking should be routinely screened at all antenatal appointments and any prenatal alcohol consumption should be recorded in the child's health record when the baby is born in order to aid subsequent FASD diagnosis (SIGN, 2019). The children's and adult's rights and data protection implications of this approach do not appear to have been considered.

The third – and arguably most concerning – problem with the precautionary approach is its potential for unintended negative consequences. For women who may need support to cut down their drinking, there is a possibility that FASD prevention efforts, which raise awareness about the potential harmful effects of drinking during pregnancy prevent women from disclosing their alcohol use, and pregnancies, or from seeking care, if they do not also offer the 'comprehensive supports' that some women may need (Bell et al., 2009). It is clear through previous research with those who are alcohol dependent that simply advising them to stop drinking does not work (Willenbring, 2010; Young, 1994), and that social policy that idealises abstinence can lead drug users to hide their behaviour (Chandler et al., 2013). The precautionary approach, while possibly encouraging those who previously drank at a low-risk level to

abstain, may cause harm to the most marginalised women by making it harder for them to seek support. This may be particularly likely in the context of neo-liberal mothering expectations and a child protection system in which mothers may be at risk of having their baby removed if they report their drinking or their pregnancy (Morris et al., 2018; Tyler & Slater, 2018). Despite this potential for unintended harm, women's views, and particularly the views of those who are the most vulnerable, do not appear to have been explicitly sought or included while reviewing evidence around pregnancy guidelines.

2.7.4 The Scottish approach to FASD prevention

In Scotland, all pregnant women who attend antenatal appointments are routinely asked questions to screen for alcohol consumption during and before pregnancy, usually during the booking appointment. Guidance for antenatal professionals advises that women in Scotland should be reminded of the abstinence guidance if they report drinking any alcohol during pregnancy and offered an Alcohol Brief Intervention (ABI) if they report drinking more than 1-2 units of alcohol once or twice per week during pregnancy, or if the practitioner considers it appropriate. (NHS Health Scotland, 2017). ABIs are alcohol-specific conversations based on motivational interviewing techniques, intended to 'motivate and support the individual to think about and/or plan a change in their drinking behaviour in order to reduce their consumption and/or their risk of harm' (Scottish Government, 2015, P2-3). Since 2008 NHS health boards in Scotland have targets for the number of ABIs to achieve across primary care, Accident and Emergency (A&E) and antenatal settings, and report progress to the Scottish Government quarterly (Fitzgerald et al., 2015). Evaluations of ABI delivery in antenatal settings have, however, found that small numbers of women were identified as appropriate for ABIs in antenatal care and that this meant ABI delivery was lower than expected (Doi et al., 2015). In addition, these evaluations suggest that midwives' professional and personal views about drinking affect their approach to screening and ABIs: some midwives are reluctant to provide ABIs, believing that women are unlikely to disclose their drinking during pregnancy if it is not already known to services, while others want to give all women who report any drinking during pregnancy an ABI (Schölin & Fitzgerald, 2019).

Despite this comprehensive approach to alcohol screening, guidance on supporting women who may be higher risk of having a baby with FASD (those drinking at a 'high risk' level, or who have multiple confounding factors), is lacking in Scotland and the UK (Lui et al., 2008; Stade et al., 2009). Practitioners are encouraged to use screening tools such as TWEAK or T-ACE, as well as NHS Scotland screening tools, to help them decide whether to refer women who are drinking at a level that may indicate dependence to specialist alcohol services (Scottish Government, 2015; NHS Health Scotland, 2017). Evaluations suggest that some health board areas have adapted these screening tools for local use or rely more on informal discussions in order to be more approachable and flexible for women (Schölin & Fitzgerald, 2019). It is recommended that professionals do not use ABIs with pregnant women who may be dependent on alcohol (Doi et al., 2015; NHS Health Scotland, 2017), but clinical guidelines do not state the type of treatment women who are 'misusing' alcohol should receive, other than to say they should be referred to an appropriate service (NICE, 2010).

Scotland's 2009 alcohol strategy stated increased investment in specialist treatment services as one of its aims (ScottishGovernment, 2009), but treatment for alcohol dependent pregnant women was not mentioned in the strategy or associated guidance (Scottish Government, 2011) or clinical guidelines (SIGN, 2003). The 2018 update of this strategy does specifically mention drinking during pregnancy, but focuses on FASD awareness-raising, diagnosis, and treatment, mentioning nothing about supporting women who drink, which frames women's drinking as the sole cause of FASD and implies that awareness-raising could be sufficient FASD prevention (Scottish Government, 2018). It is likely that health boards have their own policies for supporting drinking pregnant women at a local level, but localised policies will always be limited in their abilities to tackle the issues faced by families at a structural level (Douglas, 2015).

Evidence about the effectiveness of interventions for pregnant women who are alcohol dependent is sparse and poorly reported (Lui et al., 2008; Stade et al., 2009; Symons et al., 2018; Ujhelyi-Gomez et al., 2020). It is estimated that only[1] one in eight people experiencing alcohol dependence in Scotland accesses specialist services

[1] after sensitivity analysis is undertaken due to the difficulties of ascertaining the real prevalence figure for alcohol dependency

(Beeston et al., 2016), and some third-sector intensive residential services which used to be available for pregnant women are no longer available, for example rehabilitation services previously run by children's charity Aberlour in Glasgow and Edinburgh. It is therefore possible that women who may be at risk of having a baby with FASD are not being identified and adequately supported.

2.8 Conclusion

This chapter has explored the ways in which neo-liberal ideals of self-regulation, good mothering, and individual responsibility permeate the construction of the problem of drinking during pregnancy, and therefore responses to it. Situating women's drinking as the sole cause of FASD positions FASD prevention strategies as primarily about advising and screening for abstinence and protecting children from harm. Women who are identified as at risk of having a baby with FASD are therefore likely to experience child protection interventions before and after the birth of their baby, as well as abstinence-based treatment services, but may not be able to access practical or psychological support to navigate the multiple complex contexts in which their drinking takes place. The impact of this approach on women who drink at a 'high risk' level or women with multiple cofounders associated with FASD is not well understood, but it is possible that this approach could cause more harm than good.

In order to begin to understand the impact of this approach on women who drink at a 'high risk' level during pregnancy, the next chapter will examine the existing qualitative research evidence, which explores the views and experiences of those who report drinking at this level during pregnancy, as well as the practitioners who work with this group of women.

Chapter 3 – Meta-ethnography of qualitative research with women who drink at ‘high risk’ level during pregnancy

3.1 Introduction

The previous chapter explored how despite problematic drinking often being intertwined with structural inequalities, neo-liberal ideals of self-regulation, good mothering, and individual responsibility situate women’s drinking as the sole cause of FASD. This positions FASD prevention strategies as primarily concerned with ensuring women’s abstinence, and frames maternal drinking as a child protection issue. The impact of this approach on women who drink at a ‘high risk’ level or women with multiple confounders associated with FASD is not well understood.

In order to explore the impact of this approach to FASD prevention on women who drink at a ‘high risk’ level during pregnancy, I undertook a meta-ethnography aiming to critically review and synthesise existing qualitative research including the accounts of this group of women. This was challenging due to the lack of studies that included women who reported drinking at this level, and because of the lack of clarity about the alcohol consumption of participants in the included studies. Despite these challenges, it was possible to conclude that the contexts in which women drink during pregnancy, including multiple adversities, social norms, and women’s partners, are crucial yet under-researched and poorly understood.

This chapter presents the process and findings of the meta-ethnography, and includes three sections: first, scoping the literature; second, methods used in the meta-ethnography; and third, findings of the meta-ethnography.

3.2 Scoping the literature

Before deciding on the inclusion criteria for the meta-ethnography, I undertook a scoping review to explore the qualitative studies including women's and practitioners' perspectives on drinking during pregnancy. This initial scoping highlighted that although some studies explored drinking during pregnancy, very few included women who reported drinking at a 'high risk' level.

3.2.1 Studies worldwide including women who report any drinking during pregnancy

My search of ten databases identified 36 qualitative studies worldwide since the year 2000 exploring drinking during pregnancy with women (see Appendix 3 for data extraction from these studies). The studies varied widely in theoretical perspective, location, inclusion criteria, methods and aims. Studies often did not describe participants' reported drinking, which made it difficult to understand or compare the experiences of women drinking at different levels, despite evidence that suggests alcohol related risks to the mother and foetus increase with dose of alcohol (Bay & Kesmodel, 2011; Henderson et al., 2007a and 2007b; Patra et al., 2011).

The methods used in these studies varied widely, although semi-structured interviews and focus groups were the most common methods. Some of the interviews were short (for example Jones and Jones' telephone interviews lasted between 10 and 25 minutes). One study was ethnographic and used observation (Cloete & Ramugondo, 2015), two took a narrative approach (Ford, 2013; Frost-Pineda, 2009), one used creative techniques including sandboxing (Grant, 2019) and two analysed comments made on internet forums (Toutain, 2010, 2013).

Many studies included discussion about advice received by the women regarding drinking and pregnancy, and some of the studies explored women's views of public health messages and alcohol interventions around drinking during pregnancy. The role

of social norms in maintaining or changing drinking behaviour was considered key across many studies (for example Brahic et al., 2015; Coathup et al., 2017; Crawford-Williams et al., 2015); some of these studies explored the role of women's partners in women's drinking behaviour (for example Scholin et al., 2018a); others explored the ways in which special occasions or friends and family affect women's drinking behaviour; while some focused on what women felt was considered acceptable or unacceptable drinking behaviour during pregnancy. Despite this focus on social norms and social context, few studies acknowledged that confounders other than maternal drinking were relevant to maternal and infant health, instead centring mothers' drinking as the key problem. This focus on alcohol consumption at the expense of broader contextual factors may reflect the theoretical perspective of the studies, or the funding and publication opportunities available to researchers studying pregnancy and alcohol, which were usually health and social care focused rather than sociological.

3.2.2 Studies in Scotland and the UK

Ten of the 36 studies were undertaken in the UK (Bauld et al., 2017; Coathup et al., 2017; Doi, 2012; Grant et al., 2019; Laing, 2015; Raymond et al., 2009; Ross, 2012; Scholin et al., 2018a; Thomas & Mukherjee, 2019; Wahab, 2014), three of which took place in Scotland (Doi 2012, Ford 2013, Ross 2012). The quantity of alcohol consumption reported by women was unclear in most of the UK studies. Doi included women who drank at a 'low' level (Doi, 2012), Ford and Laing did not state how much or how often the women reported drinking (Ford, 2013; Laing, 2015), and Raymond et al. included one woman who reported drinking more than 1-2 drinks per week but did not state how much she reported drinking (Raymond et al., 2009). Two studies (Doi, 2012; Laing, 2015) excluded alcohol dependent women, and, crucially, only one UK study (Thomas & Mukherjee, 2019) included participants who drank at 'high risk' levels during pregnancy, which means that this group of women, arguably the most likely to have a baby with FASD, is currently unrepresented in UK research. This is concerning because without understanding why women drink during pregnancy, and how current services are working from women's perspectives, it may not be possible to provide effective care and support.

Most UK studies asked about advice that women had been given about alcohol and pregnancy and reported that women found public health and medical messages

confusing. Since these studies took place, new, abstinence-focused guidelines have been introduced across the UK (see section 2.7.1), so women's perspectives on public health guidance may have changed during this time. Four UK studies were published since the new UK guidelines were introduced (Coathup et al., 2017; Grant et al., 2019; Scholin et al., 2018; Thomas and Mukherjee, 2019): fieldwork for two (Coathup et al. and Scholin et al.) took place before the change in guidelines but were published afterwards; Grant et al. began fieldwork 4 months after the 2016 change in guidelines and found that women did not know exactly what the new guidelines said. Although Thomas and Mukherjee's fieldwork took place after the change in guidelines, the study was retrospective, so participants' pregnancies had taken place before the new guidelines. Thus, no published studies could be identified that explored women's views of the new UK guidelines after they were embedded in routine clinical practice.

Exploration of the social contexts of women's lives was limited in the UK studies. Doi (2012) focused on the effectiveness of ABIs, whilst Wahab (2014) focused on women's 'health beliefs'. Ford (2013) aimed to explore the social and cultural context of drinking during pregnancy in Scotland but framed the single question in her narrative research around lifestyle and health choices, and recruited participants through mother and toddler groups, which are likely to over-represent women with higher SES. Similarly, Ross recruited women through a pregnancy and parenting charity which is likely to over-represent women with higher SES, and Scholin et al. acknowledged the high educational status of their participants. Grant et al. specifically recruited women with low SES and acknowledged the importance of social context, although this appeared to be defined narrowly, mainly focusing on the impact of the drinking behaviour of family and friends. This study was interesting methodologically, using creative methods with women and a reflexive approach, with researchers sharing their experiences of pregnancy with participants as part of the research.

3.2.3 Studies including practitioners

The initial scoping identified nine studies including the perspectives of practitioners on drinking during pregnancy, but none focussed specifically on 'high risk' drinking and most focused on lower level drinking (Pati et al., 2018; France et al., 2010; Gilchrist et al., 2012; Herzig, Danley, et al., 2006; Herzig, Huynh, et al., 2006; Jones et al., 2011;

Loxton et al., 2013; Schölin et al., 2018; van der Wulp et al., 2013). Additionally, there were some studies including the perspectives of practitioners working in specialist drug and alcohol services but these studies did not report separately on drug and alcohol use so it was not possible to include them in this literature review because it was unclear whether participants were talking about drug use or alcohol use during pregnancy.

Four studies included some discussion about pregnant women whose drinking was variously described as 'risky', 'high risk' or 'high level', although these terms were not defined (Pati et al., 2018; France et al., 2010; Jones et al., 2011; Loxton et al., 2013). All four studies focused broadly on any alcohol consumption during pregnancy, so there was little discussion of the details of support and treatment for pregnant women who drank at a 'high risk' level. The participants in Jones et al. were midwives, none of whom appeared to be drug and alcohol specialists, so discussion about 'high risk' drinking focussed on referring women to appropriate services (Jones et al., 2011). France carried out focus groups with health professionals. Participants stated that women who drank at a 'high risk' level during pregnancy experienced a range of social and emotional problems, making them difficult to support due to the level and complexity of their need (France et al. 2010). Loxton included a broader range of professionals, including anyone who worked with pregnant women (for example housing and family support workers). She found that although professionals working in specialist drug and alcohol services may be more confident than others in discussing alcohol consumption with pregnant women (Loxton et al. 2013), some professionals lacked confidence in the availability and effectiveness of the referral options that were available, supporting the findings of France et al. (Loxton et al. 2013, France et al. 2010). Pati et al. conducted two focus groups with front line workers and community leaders in India, who argued that lack of knowledge about the risks, and the embeddedness of alcohol in day-to-day life were the key problems related to pregnant women's drinking (Pati et al., 2018).

The search identified a lack of research about professionals' perspectives on 'high risk' drinking during pregnancy, particularly from the wide range of staff/agencies who may come into contact with pregnant women. Although one study included a broad range of professionals (Loxton et al. 2013), the lack of focus on 'high risk' drinking in any

study means that the details of the advice and support offered to women drinking at this level have not been fully explored. In addition, three studies took place in Australia and one in India. Their findings are likely to be context-dependent, because the structure and organisation of maternity and other services depend on the surrounding policy and funding landscape, so the findings of these studies may not be transferable to a Scottish context, suggesting that further research with professionals who work with pregnant women drinking at a 'high risk' level is required.

3.3 Methods used in meta-ethnography

3.3.1 Approach

Overall, the initial scoping of qualitative studies including women and professionals highlighted a lack of studies including perspectives on 'high risk' drinking during pregnancy, and particularly a lack of inclusion of women who report drinking at this level. As this group of women may be more likely than others to have a baby with FASD (see section 2.6), it is crucial to understand their accounts of drinking during pregnancy and their perspectives on the current approach to FASD prevention. I therefore decided to do a meta-ethnography of qualitative research including women who report drinking at a 'high risk' level during pregnancy.

Meta-ethnography is a type of qualitative synthesis, introduced by sociologists Noblit and Hare in 1988, which aims to systematically compare concepts and data from included studies in order to move beyond aggregating studies on a topic. It is intended to enable the development of new understandings which may not be possible by looking at the individual studies separately (France et al., 2019; Noblit & Hare, 1988). Qualitative synthesis can make qualitative research more easily applicable to policy and practice by synthesising it and therefore moving beyond its 'often isolated and contextually distinct findings' (Finlayson and Dixon 2008, p1). I chose it because I wanted to use the findings to influence the direction of my own study by highlighting areas requiring further research.

Recent reviews of meta-ethnographies have found that they are often poorly reported, lacking in detail and transparency (France et al., 2014). For this reason, this section follows the eMERGe reporting guidance published in 2019, which underlines the importance of reporting on all stages of the meta-ethnography, not just the findings (France et al., 2019).

3.3.2 Search strategy

Noblit and Hare's original (1988) approach to meta-ethnography suggested that purposive sampling was sufficient. However, I decided that a comprehensive approach would be more suitable for my meta-ethnography, to make it as replicable as possible, and to ensure a broad range of theoretical approaches and disciplines were included in the review, to enable me to consider how various disciplines have explored this topic. It was possible to take a comprehensive approach because of the relatively small number of studies available.

I initially used MeSH (Medical Subject Headings) headings to find the most relevant papers. After testing the initial search strategy in Medline by checking for key papers that should have been included it became clear that not all papers were being captured because some papers had not yet been categorised under the headings and would therefore not show up unless a search with keywords was also utilised. For this reason, the final search strategy included a mixture of MeSH (or equivalent) headings and keywords, including identified synonyms and appropriate truncation. The search strategy was amended to fit the language and key terms used in each database (see Appendix 4 for example search strategy). Methodological keywords such as 'qualitative' were also included in the search to make the number of articles manageable and increase specificity.

Due to the complexities involved in defining and measuring levels of alcohol consumption, the terminology used to describe this was not consistent across studies, so it was not possible to search only for studies including 'high risk' drinkers. I therefore aimed to capture all qualitative studies exploring the consumption of alcohol during pregnancy, in order to ensure that all relevant studies were included. Databases spanning medical, health and social care, and social science disciplines were searched. Databases searched and numbers of papers identified are shown in table 1:

Table 1: Databases searched and number of papers identified

Database	Number of papers identified
Embase	475
Cochrane library	126
Assia	299
Sociological abstracts	209
Social services abstracts	209
CINAHL	315
Medline	352
Psycinfo	510
Pubmed	156
Proquest dissertations and theses	403
From other avenues	1

3.3.3 Screening and inclusion/ exclusion criteria

All papers were imported to endnote and screened by title after the removal of duplicates. Once duplicates were removed and titles and abstracts were screened, 88 articles were eligible for full-text screening (as at 14/12/2020).

After considering various approaches to the inclusion criteria, I decided that included studies should include the accounts of pregnant women who described themselves, or were diagnosed as, alcohol-dependent during pregnancy, or reported drinking at the level considered by the Word Health Organisation to constitute 'high risk' drinking (35 units per week). This also aligns with Bay and Kesmodel's 2011 systematic review of the effects of maternal alcohol consumption during pregnancy on child motor function, in which a 'moderate to high' level of daily drinking was defined as 4.5 – 7.5 UK units per day, which equates to 31.5 UK units per week minimum (Bay & Kesmodel, 2011). Papers that were published before 2000 were excluded, so that they took place in a more similar historical context (see Appendix 5 for full inclusion and exclusion criteria).

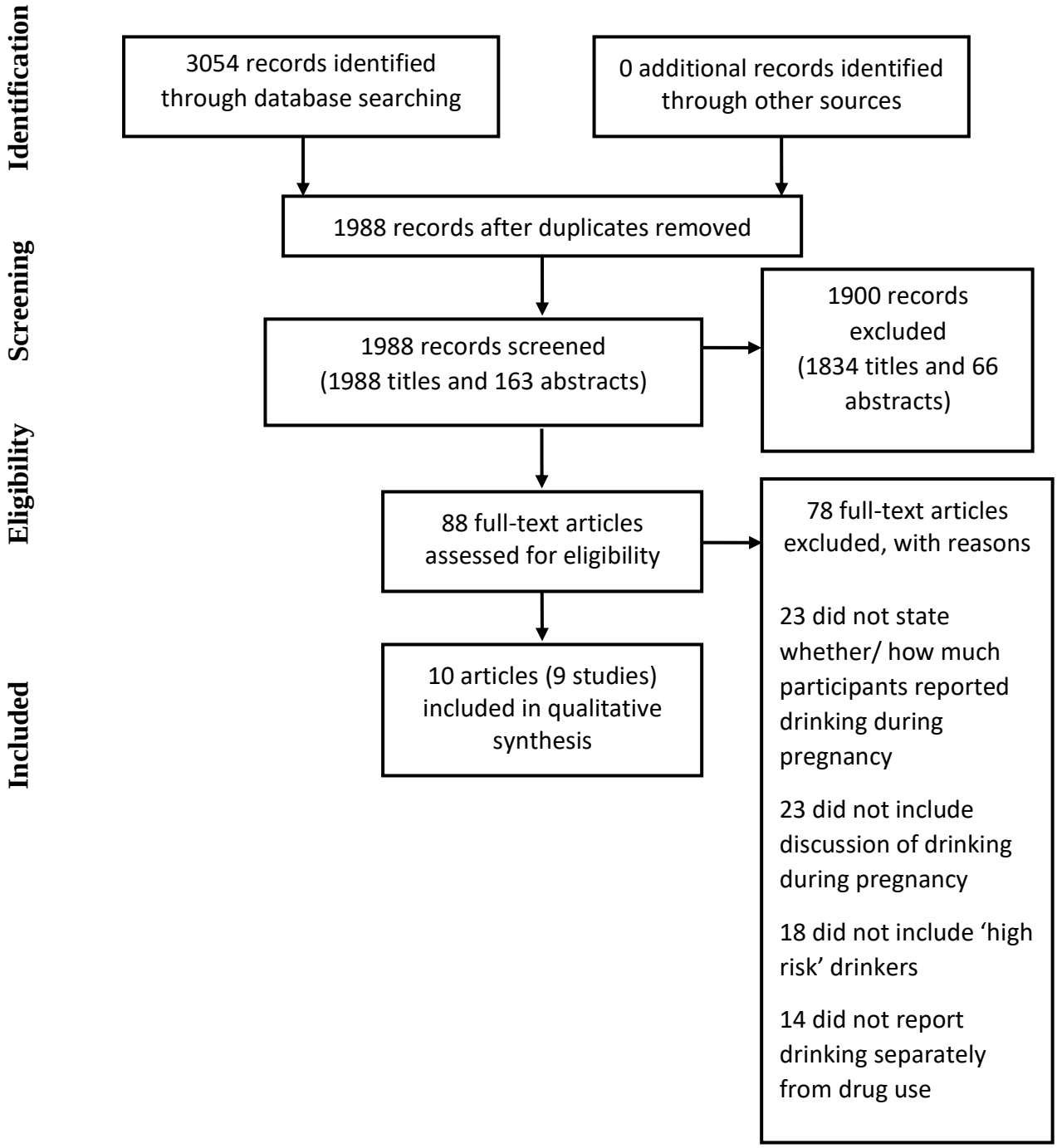
Decisions about exclusion or inclusion were not always straightforward, and sometimes judgements had to be made. It was sometimes not possible to tell whether a study population included women who drank whilst pregnant, for example Choi et al. (2015) discussed alcohol consumption during pregnancy with the general public, whilst it was not clear if respondents in Holland et al. (2014) were drinking or not. Laing (2015) included a participant who stated she drank until she was sick during a previous pregnancy, but there was no available information about how much alcohol this

involved, or whether it was an isolated incident, and the participant stated that she had not been alcohol dependent (this study explicitly excluded women who had been alcohol dependent). This paper was therefore excluded. Conversely, Salmon (2008) did not provide details of how much alcohol participants reported consuming, but they all had a child with a diagnosis of FASD or FAS. Although there are problems with relying on an FASD diagnosis to confirm the level of alcohol consumption (see section 2.6), I decided that as the children had a medical diagnosis and the participants described 'bingeing' and 'drinking every night of the week' (Salmon, 2008, p200-201), the article should be included.

The fact that it was at times difficult to decide which articles to include is symptomatic of the lack of consistency in the ways in which alcohol consumption is described, as well as the way in which a diagnosis of FASD is often used as a proxy for discussion about alcohol consumption (see section 2.6.1). Ultimately, I decided that it was important to include a range of papers, to ensure I did not unintentionally screen out those which were likely to be refutational (Noblit & Hare, 1988); it was important to allow for these in order to ensure consideration of different perspectives.

Ten papers fulfilled the criteria for inclusion in the meta-ethnography (see table 2 for data extraction and figure 2 for Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flowchart). Two papers reported different aspects of findings from the same study (Watt et al., 2014; Watt et al., 2016), and are therefore treated as one study in this review. The reference lists from these papers were examined to find further relevant studies for inclusion, but this did not lead to the inclusion of any further studies.

Figure 2: PRISMA flowchart



3.3.4 Critical appraisal

The Critical Appraisal Skills Programme (CASP)'s '10 questions to help you make sense of qualitative research' was used to critically appraise each of the papers included in the study. I decided to include all the papers in the review, regardless of critical appraisal, but to consider the limitations of each during the analysis. This was partly a pragmatic decision, because very few relevant studies were available, and partly a theoretical decision, as excluding studies based on subjective notions of quality could

introduce bias and therefore affect the findings of the meta-synthesis (Finlayson & Dixon, 2008). When Noblit and Hare first introduced meta-ethnography they did not express a view about critical appraisal, and although many meta-ethnographers now choose to critically appraise studies, there is no established convention about this.

3.3.5 Reading studies and data extraction/ noting of interpretive metaphors

I created a data extraction form and recorded the key information from each included article or thesis. This included identification of the population, methodological and theoretical approach and the concepts, themes or metaphors from each paper (see table 2). At this stage I retained the author's original wording to help preserve their interpretation and the meaning of the original text. This stage of the meta-synthesis is intended to capture the key findings of each study as intended by the original researchers, or, as Walsh and Downe (2005) state, 'the art of respecting and representing context as intended through the original research' (p209).

Once I had completed the data extraction, I revisited the excluded studies to check that no relevant studies had been missed. Although this did not lead to the inclusion of any additional studies, it was useful in confirming the inclusion or exclusion of the screened studies.

Study	*Country*	*Aim/ research question*	*Sample*	*methods*	*Theoretical perspective*	*Topics covered in topic guide*	*Themes identified in study*
Badry, 2008	Canada	Understanding lived experiences of birth mothers of children diagnosed with FAS	8 women aged 25-60 who had given birth to one or more child with FAS	In-depth interviews	Hermeneutic phenomenology, feminist perspective	No predetermined questions other than 'What was the lived experience of being a birth mother of a child with Fetal Alcohol Syndrome?'	The birth mother's childhood; experiences of alcohol; pregnancy experience; relationship with the father of the child diagnosed with FAS; trauma including violence; child welfare; the meaning of the child diagnosed with FAS to the birth mother
Cloete and Ramugondo, 2015	South Africa	Influence of contextual factors on alcohol consumption during pregnancy	3 women, all low SES, previously or currently 'drunk excessively' during pregnancy	Instrumental case-study using observation and semi-structured interviews	Takes 'a critical occupational therapy stance towards maternal alcohol consumption.' Alcohol consumption as imposed occupation	Interview questions included activities that related to the occupations of work, self-care and socialisation	Nothing comes easy; trying to make this life bearable; rekindling hope; baking bread with little. All the themes relate to the way cultural, economic and political conditions are related to alcohol consumption
Frost-Pineda, 2009	USA	Answer some of the 'why' questions surrounding addiction and fertility	5 women in residential treatment for addiction, one of whom drank during pregnancy	Life story interviews – 2 hour interviews, 5 times with each woman	Anthropological. Focuses on lived experiences	Focus on different stage of life (e.g., childhood/ adolescence) at each interview. Topics include happy memories, school, friendships, parental alcohol/drug use, family relationships, sex, risk-taking, religion, financial issues, contraception, alcohol treatment and relapse, childcare and parenting	Relevant to this review: Family history of addiction; availability of drugs and alcohol; violence, trauma and abuse; substance use by partners; loss, promiscuity, prostitution and arrests; relapse, illness, injuries and near-death experiences; social isolation

Study	*Country*	*Aim/ research question*	*Sample*	*methods*	*Theoretical perspective*	*Topics covered in topic guide*	*Themes identified in study*
Pati et al., 2018	India	Exploring perceptions and practices related to the consumption of alcohol by pregnant tribal women in India	19 women who reported alcohol consumption during pregnancy (all scored 3 or 4 on AUDIT test)	Face-to-face in-depth interviews	Cultural anthropology	Knowledge about alcohol; practice and opinion about consumption; alcohol and baby	Relevant to this review: Custom, tradition and rituals; indigenous, non-injurious and relaxant; curiosity, addiction and lack of knowledge
Salmon, 2000	Canada	Understand how a group of young Aboriginal mothers… articulate their own needs, interests, concerns and experiences, and how these may be similar to or different from the ways they are constructed in texts of the [FAS/FAE 'prevention'] initiative	6 women recruited from a community FASD prevention initiative, all had experienced substance/ alcohol use during pregnancy, most have either a child with diagnosis of or suspected FAS/FAE	Group interviews attended by all 6 women twice	Feminist, materialist, anti-colonial, anti-ableist	Reflect on experiences in lives and in communities that inform their understandings and experiences of FAS and FAE. Wanted to discss policy approach but women didn't want to talk about this, preferring to talk about experiences and contexts instead	Dis/abling citizenship: negotiating citizenship; claiming Dis/Ability: medicalization as a mechanism for securing substantive citizenship; Dis/Abling states: the contestations and contradictions of medicalization for substantive citizenship and social justice; Getting the information: what Aboriginal mothers want and need to know about FAS/FAE; the role of male partners and friends in women's substance use; Engendering "risk": education, intervention, and the roles of Aboriginal women and men; "Education" and "role modelling": strategies for sharing FAS/FAE knowledge in the context of Aboriginal women's lives
Salmon, 2008	New Zealand	Describe the lived experiences of birth mothers who are parenting a child with FASD	8 biological mothers whose children have FASD	Semi-structured interviews (up to an hour)	Feminist standpoint theory. Focus on lived experience	"Please tell me about your experiences of your pregnancy with your child with FASD": other topic areas related to labour, birth, post-partum period and onwards	Feelings of responsibility and guilt; lack of knowledge about FASD; drinking during pregnancy

Study	*Country*	*Aim/ research question*	*Sample*	*methods*	*Theoretical perspective*	*Topics covered in topic guide*	*Themes identified in study*
Thomas & Mukherjee, 2019	UK	Explore the experiences of birth mothers following a diagnosis of FASD in their children	5 women who are birth mothers of children diagnosed with FASD	Semi-structured interviews, IPA	Phenomenological (researchers are psychiatrist and FASD clinician)	Topic guide used, overarching question: "Please tell me about your experiences as a birth mother of a child with FASD." Also experiences before they became pregnant	Relevant to this review: To blame or not to blame?
Watt et al., 2014/2016	South Africa	Examine experiences of women, and knowledge and attitudes about maternal alcohol consumption	24 women pregnant or within 12 months postpartum, who drank during pregnancy	Semi-structured interviews (60-90 minutes)	Not stated. Used memoing in analysis (they ref Birke et al 2008), which is generally associated with grounded theory, but this is not explicitly stated	personal experiences with drinking during pregnancy, community norms and attitudes towards maternal drinking, and knowledge about FASD	Competing attitudes about drinking while pregnant; internalization of misinformation; dilemma of drinking; drinking patterns; factors that explain drinking during pregnancy; coping with stress; drinking as a social connection; social norms; lack of attachment to the pregnancy; addiction
Zabotka, 2012	USA	Describe and understand the feelings, coping behaviours and thoughts of biological mothers of a child diagnosed with FAS	11 biological mothers of children with FAS	Telephone interviews (60-90 minutes)	Not stated – focuses on psychological issues, is a Social Work PhD	Drinking and substance use before and during pregnancy, feelings about pregnancy and infancy, thoughts/ feelings re FAS causes and diagnosis, challenges/ services needed re child with FAS	Childhood trauma; separation and loss during childhood; partner abuse during adulthood; possible undiagnosed FAS among birth mothers; attempted moderation of alcohol consumption during pregnancy; lack of knowledge; social norms; denial about the amount of alcohol consumed; unplanned pregnancy

3.3.6 Determining how studies are related

The next stage of meta-synthesis involves comparing the research design, participant characteristics, study focus and other contextual factors. At this stage it was possible to see that there were some similarities and differences between the papers. The studies varied in the way they defined drinking: Frost-Pineda (2009) did not explicitly define levels of drinking but Pamela, the respondent who met the inclusion criteria for this literature review, was in residential treatment for alcohol addiction and described alcohol dependence during several pregnancies; Salmon (2008), Zabotka (2012), Thomas and Mukherjee (2019), and Badry (2008) included only women whose children had been diagnosed with FASD or FAS, which avoided the challenge of defining drinking levels, but was not unproblematic as the diagnosis of FASD is far from straightforward (see section 2.6); Watt et al. interviewed women who drank any alcohol during pregnancy, many of whom were described as 'binge', 'heavy' or 'hazardous' drinking.

The studies had a range of focuses reflecting their diverse aims and theoretical perspectives. Three of the studies described themselves as feminist (Badry, 2008; Salmon, 2000; Salmon 2008), two took a broadly psychological approach (Thomas and Mukherjee, 2019; Frost-Pineda, 2009), one was critical occupational therapy (Cloete and Ramugondo, 2015), one was cultural anthropology (Pati et al., 2018), and two did not state their theoretical perspective (Watt et al., 2014, 2016; Zabotka, 2012). Salmon (2008) and Thomas and Mukherjee, who both aimed to explore mother's experiences of their children's FASD, focused almost exclusively on post-birth experiences but included some information about family history and drinking during pregnancy; Watt et al. (2014, 2016) and Cloete and Ramugondo (2015) examined reasons for drinking during pregnancy in depth, with a focus on the current pregnancy rather than past experiences; and Zabotka (2012), Badry (2008), Salmon (2000) and Frost-Pineda (2009) included both past experiences and post-birth. Pati et al. (2018) focused on cultural aspects of drinking, reflecting their anthropological approach.

The studies were geographically diverse, taking place in New Zealand, South Africa, North America (Canada and the US), India and the UK. The cultural history of each place and population has potential implications for the way the data is interpreted and

understood, and for the meanings ascribed to discussions by both the women being interviewed and the researcher. Watt et al.'s (2014, 2016) study took place with Black or 'Coloured' (a term used in South Africa to describe those with mixed ancestry) women in South Africa against the backdrop of the post-apartheid 'dop' system whereby farmers paid workers with alcohol. Cloete and Ramugondo (2015) was also South African and focused on rural communities and low SES. The US studies (Zabotka, 2012; Frost-Pineda, 2009) took place within a country with a history of a moral panic about FAS and a biomedical approach to the condition; an approach which has become largely shared in Canada, where Badry's (2008) and Salmon's (2000) studies were situated. Salmon's study (2008) took place in New Zealand where, according to Salmon (2008), there was a culture of heavy alcohol use. Some findings were highly dependent on context, for example, the extent to which alcohol use during pregnancy was normalised, and child protection processes, so it was not possible to generalise about women's experiences of pregnancy. Only one study included in this review took place in the UK (Thomas & Mukherjee, 2019), but this study provided little contextual information about women's lives before or during pregnancy, as its focus was on women's experiences following FASD diagnosis, perhaps reflecting the researchers' medical perspective.

3.3.7 Translating studies into one another

Although it is clear from Noblit and Hare's (1988) work that this stage of a meta-ethnography involves comparing themes and metaphors from the included studies, it is unclear how exactly to do this. I wanted to avoid creating my own themes too early to 'fit' the existing studies, so after compiling the data extraction table I extracted all the raw quotes from all the studies into another form, initially keeping them under the headings (themes) in which the authors had placed them, in order to view all the raw data in the context in which it had been presented by the study authors. There is no consensus among authors of meta-ethnography about the order in which to do this, so I took a pragmatic approach and began with Badry, working through the studies alphabetically, regularly checking back to the original studies to ensure the context and meaning of the quotes were maintained.

Copying quotes familiarised me with the data and I started to identify similarities and differences between the studies which had not been immediately apparent during data extraction. Themes which I had originally considered different to one another I sometimes now understood as related; for example 'lack of attachment to the pregnancy', a theme identified in Watt et al. (2014, p122), when viewed alongside the quotes, could be conceptualised as similar to Badry's theme 'the birth mother's pregnancy experience' (Badry, 2008, p158), in a sub-theme which I categorised as 'feelings about pregnancy'.

Some of the themes which resulted from the meta-ethnography were not highlighted as themes in the original studies, but I saw as important when data from the studies were viewed together, either as 'reciprocal translations' (similar concepts), or 'refutational translations' (findings that appeared to contradict one another or offer alternative explanations) (Noblit & Hare, 1988, p36). I arrived at themes by grouping data across more than one study that appeared to be about a similar issue or meaning, taking a flexible, iterative approach to the production of themes. For example, Badry's themes included 'The birth mother's experience in their family of origin' (2008, p158), and I observed (and Badry stated) that much of the data that was included in this section related to violence, abuse and trauma. Cloete and Ramugondo's themes included 'nothing comes easy', which also included detail about women's experiences of trauma and abuse as children (2015, p36). As I re-read all the studies, I observed that although it was not highlighted as key in the studies, trauma and violence was a consistent topic, suggesting that trauma and violence may be a shared theme. See figure 3 for a concept map of the translation of themes, and table 3 for a summary of themes included in the final synthesis.

Figure 3: Translation of themes

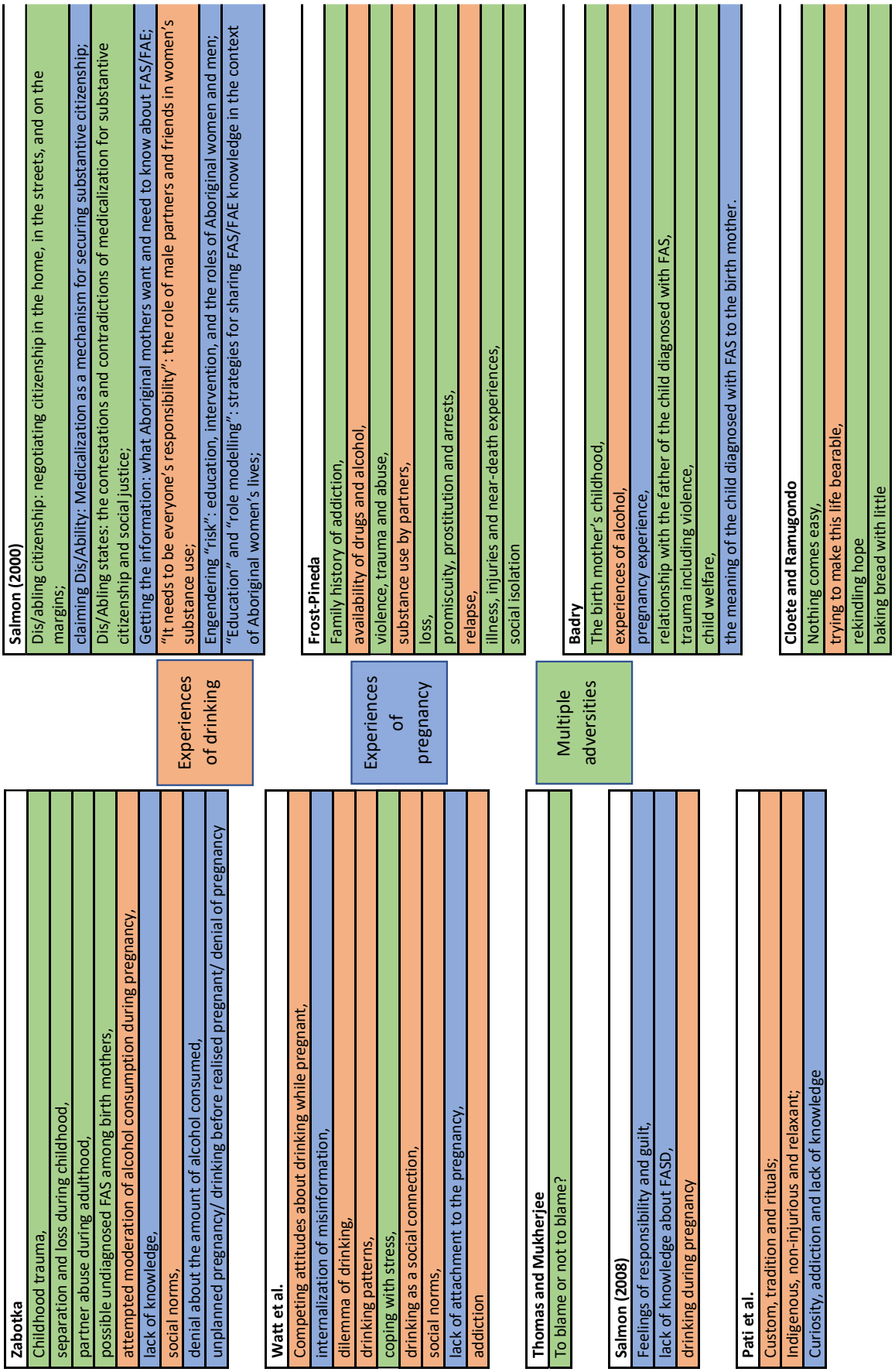


Table 3: Meta-ethnography themes

Theme	Badry	Cloete and Ramugondo	Frost-Pineda	Pati et al.	Salmon (2000)	Salmon (2008)	Thomas and Mukherjee	Watt et al.	Zabotka
Experiences of drinking									
Descriptions of drinking									
Social norms around drinking									
Experiences of pregnancy									
Feelings about pregnancy									
Knowledge of risks of drinking during pregnancy									
Advice about drinking during pregnancy									
Multiple adversities									
Traumatic experiences and repeat victimisation									
Poverty/ marginalisation									

3.4 Findings of meta-ethnography

Despite the disparate nature of the studies, it was possible to identify some common themes. Each theme is discussed in turn below and, alternative interpretations of findings are discussed where appropriate. These are not intended to replace the researchers' original interpretations, but to highlight the possibility of alternative readings (Sandelowski, 2006).

3.4.1 Experiences of drinking

The studies' descriptions of women's drinking varied widely, reflecting the heterogeneity of the studies, and there was little exploration of the care and treatment women had received during pregnancy. Women across the studies emphasised that the experiences of drinking during pregnancy were affected by social norms, social connections, and their partners.

3.4.1.1 Descriptions of drinking

With the exception of Pati et al. (2018), who used the AUDIT tool to screen women before inclusion, none of the studies specified how much alcohol the women in the study reported drinking, or have alcohol consumption related inclusion criteria, so few details were available about the quantity of alcohol consumed.

Women across all studies reported drinking before they became pregnant, and many women described drinking at an early age; some described drinking for many years before they became pregnant, although this was often not defined or discussed in detail. Most women across most studies described drinking throughout the entirety of their pregnancy, but some said they had stopped or attempted to moderate their drinking when they realised they were pregnant (Zabotka, 2012; Frost-Pineda, 2009; Salmon, 2000). Some women described previous or subsequent pregnancies in which they drank very little or abstained.

Women described their drinking in various ways across the studies; some described themselves as alcohol dependent, while others described themselves as people who used to do a 'normal' (Salmon, 2008) amount of drinking, or who used to 'binge drink' (Thomas and Mukherjee, 2019). Others did not describe themselves as dependent but

reported possible symptoms of dependence such as drinking as soon as they woke up in the morning. This variance may be partly due to the design, purpose and theoretical perspective of the studies; participants in Watt et al. (2014, 2016) and Pati et al. (2018) were all currently or recently pregnant, whilst Zabotka (2012), Frost Pineda, Salmon (2008) and Thomas and Mukherjee (2019) all undertook retrospective studies. It may also reflect varying understandings of drinking in the countries in which the research was undertaken: it is likely that the way women defined and described their drinking was influenced by the country and context in which they lived, their stage of life, whether they had sought treatment or support relating to their alcohol use, and dominant discourses of addiction in each country. For example, Frost-Pineda (2009), Badry (2008) and Zabotka (2012) all included women who described themselves as alcohol dependent, and they were all undertaken in the US where the dominant discourse around alcohol dependence is biomedical, in contrast to the South African studies, in which women described their drinking as a normal part of life (Cloete and Ramugondo, 2015; Watt et al., 2014, 2016).

Treatment or support for women who drink during pregnancy was not explored in detail in any study, possibly because treatment and support was not the key focus of any of the studies, although it could also suggest that many women had not received support or treatment for their drinking. Alcoholics Anonymous and the 12 steps to recovery was mentioned by women in the US studies, which may reflect the dominant biomedical approach to addiction in the US. In the UK, Thomas and Mukherjee (2019) mentioned that women reported a lack of interventions available to them in pregnancy, although this was not explored in the findings section of the paper, possibly because of the study's primary focus on women's experiences following their child's FASD diagnosis. Women in Salmon (2000) also mentioned a lack of support during pregnancy, saying that without meaningful material support, advice alone may be unhelpful.

3.4.1.2 Social norms

Across all studies the role of social norms in changing or maintaining drinking behaviour was key. Women described cultures in which drinking during pregnancy was normal and acceptable (Watt et al., 2014, 2016; Cloete and Ramugondo, 2015; Pati et al., 2018), their partners were drinking heavily (Salmon, 2000, 2008; Frost-Pineda,

2009; Watt et al., 2014, 2016; Cloete and Ramugondo, 2015; Pati et al., 2018), and friends told them they drank during pregnancy and it didn't do them any harm (Zabotka, 2012; Watt et al., 2014, 2016; Pati et al., 2018; Salmon, 2000). Watt et al. (2014, 2016) found that many women knew that drinking during pregnancy carried some risks, but social norms that support drinking during pregnancy were more powerful. There were cultural differences between the populations in each study and there were differences in drinking related social norms in each country. Watt et al.'s study (2014, 2016), for example, took place in post-apartheid South Africa, where past economic structures embedded the use of alcohol in everyday life, so it may be that pro-drinking cultural norms were particularly strong. Similarly, Pati et al. (2018) reported that traditional alcoholic drinks in the Odisha tribe were embedded in the culture of the tribe, and viewed by women as healthy and natural, and therefore a good drink during pregnancy.

Despite these cultural differences, women across the studies emphasised the importance of social connections, and many suggested that their support networks had comprised fellow drinkers. Women in Watt et al. (2014, 2016) and Cloete and Ramugondo (2015) suggested that drinking was an important part of their social lives, without which they would be excluded. Zabotka (2012) and Badry (2008) found that women relied on the support of their drinking friends due to lack of support from others.

Women described concerns about their drinking being allayed by the fact that the people around them were drinking too, and that those people also drank alcohol whilst pregnant (Zabotka, 2012; Watt et al., 2014, 2016). Some women described the way in which their social circles - consisting of other drinkers - affected their own perceptions of a normal amount of drinking (Zabotka, 2012). Conversely, women in Watt et al. talked about people in the community telling them they should not be drinking, and women in Salmon (2000) described how they had been encouraged to stop drinking by seeing women who abstained during pregnancy.

Women in Watt et al. (2014, 2016), Salmon (2000, 2008), Badry (2008), Cloete and Ramugondo (2015), and Frost-Pineda (2009) all talked about their partners' drinking behaviour. The woman in Frost-Pineda described a succession of relationships with men who drank heavily and used drugs; many of the women in Watt et al. talked about

drinking with their partners; all but one of the women in the Salmon (2008) study had alcohol dependent partners when they became pregnant, and they described drinking with them. Women in Badry (2008) and Salmon (2000) described partners who did nothing to encourage them to reduce their alcohol intake while pregnant, and who drank heavily themselves.

3.4.2 Experiences of pregnancy

All the studies explored women's knowledge about the risks involved in drinking during pregnancy, as well as the advice women had received. The studies varied in their assessments of women's 'knowledge' of the risks, and some used psychological theories to demonstrate that women continued to drink when they knew it was risky, rather than exploring how the lack of clarity in policy and research may have affected women's understandings of risk and harm.

3.4.2.1 Feelings about pregnancy

Women described a range of feelings about becoming pregnant, including shock and disappointment (Cloete and Ramugondo, 2015), not wanting or not accepting the pregnancy (Watt et al., 2014, 2016), and wanting or trying to induce miscarriage (Watt et al., 2014, 2016; Frost-Pineda, 2009). Other women described happiness and feeling positive about having someone to take care of (Badry, 2008). Other women expressed positive feelings about their pregnancies at a later stage of pregnancy (Zabotka, 2012), or later in life (Badry, 2008). It is possible that the study designs affected the feelings women were likely to share with the researchers; for example, studies in which women were looking back on their pregnancies many years later (such as Zabotka and Badry) may be more likely to elicit positive feelings, as the memory of the pregnancy was attached to a child, or shame and guilt if their children were diagnosed with FASD.

Watt et al. argued that the negative feelings women shared equated to a 'lack of attachment to the pregnancy' (2014, p122). This frames prenatal attachment as a normal aspect of pregnancy (see section 2.5.3) and underplays the impact of context on women's feelings about pregnancy; the women in this study described these feelings in the context of the challenging environment in which they lived. Badry (2008) acknowledged this when she noted that for her participants (US women who had given birth to one or more child with FAS), pregnancy was another difficulty in an

already difficult life. Thomas and Mukherjee (2019) and Pati et al. (2018) did not report on women's feelings about pregnancy.

3.4.2.2 'Knowledge' about the risks of drinking during pregnancy

Some women said they had not known about the risks of drinking during pregnancy and that the risks were not well understood by the general public (Salmon, 2000, 2008; Badry, 2008; Zabotka, 2012). Some women in Zabotka (2012) and Badry (2008) reflected on this, wondering whether they had, whilst pregnant, suspected that drinking could have caused harm to the foetus but convinced themselves otherwise. Watt et al. called this 'internalisation of misinformation' (2016, p48), suggesting that women relied on their intuition that women knew what was best for their babies, and that alcohol was therefore good for the pregnancy; this was similar to Pati et al. (2018), whereby women drank traditional alcohol during pregnancy with the belief that it would be good for the baby and alleviate pregnancy symptoms. Conversely, other women described thinking they should stop or cut down drinking during pregnancy and finding this difficult.

Women in Salmon's 2008 study (New Zealand mothers of children with diagnosed FASD) said they did not know that drinking could harm the foetus, whilst some of the women in the other studies acknowledged that they were aware whilst pregnant that drinking carried risks (Zabotka, 2012; Frost-Pineda, 2009; Badry, 2008; Salmon, 2000; Watt et al., 2014, 2016). There are several possible explanations for this refutational finding; Salmon's study was the only one based in New Zealand, so it is possible that messages about alcohol and pregnancy were different there, particularly as the youngest mother in Salmon's retrospective study gave birth in 1996, over 20 years ago (Salmon, 2008). In addition, Salmon's paper was a journal article with a focus on post-pregnancy, so in-depth exploration of this issue may not have been within its scope.

The studies tended to focus on individual psychological pathology to explain women's 'lack of knowledge' instead of structural and policy factors. Zabotka (2012), Watt et al. (2014, 2016), and Badry (2008) all described situations in which women avoided thinking about the risks or convinced themselves that their drinking was not risky. Zabotka (2012) attributed this to cognitive dissonance theory, suggesting that women convinced themselves that their drinking behaviour was normal to reduce the

discomfort (dissonance) they felt. Other explanations are possible, however; women who suspect they are causing harm may of course use psychological strategies to minimise their behaviour, but it could also reflect the confusion and contradictions that have surrounded advice and guidance around alcohol and pregnancy for many years in many countries. A woman in Zabotka's study, for example, described 'convincing herself' that she may not cause harm by drinking because she saw a sign saying drinking 'may' (as opposed to 'will') cause harm (2012, p66); in my view this was likely to be an accurate reflection of the evidence and messaging around the effects of drinking during pregnancy, and not necessarily only a psychological mechanism. Similarly, a woman in Badry's study said doctors used to advise women to drink during pregnancy, which is also accurate; prescribing stout such as Guinness during pregnancy was commonplace in the US and UK for many years (Royal College of Physicians, 2014), so should not be assumed to be a psychological strategy to reduce her discomfort about her behaviour.

3.4.2.3 Advice about drinking during pregnancy

Women recalled a range of advice about drinking during pregnancy. Women in Badry (2008), Salmon (2000) and Zabotka (2012) said doctors had not talked to them in enough detail about the risks of drinking alcohol whilst pregnant, and recounted being told by practitioners that drinking in moderation, or at certain times, would not do any harm. The women reflected on this advice to moderate rather than stop drinking, saying that it could be confusing for women who may be dependent on alcohol, although women in Salmon (2000) pointed out that for women in this situation, simply advising abstinence is not helpful either, because it is likely that support would be required to cut down or stop drinking. In contrast, women in Watt et al. (2014, 2016) said they had been advised by the clinic to stop drinking completely. These contrasting accounts of advice may be partly explained by study design, because Badry (2008) and Zabotka (2012) were both retrospective studies comprising women who have adult children, whilst the women in Watt et al. were all no more than 12 months postpartum in 2016, and practice is likely to have changed throughout this time. Practice may also vary by country, although guidance in the US (Zabotka, 2012), Canada (Badry, 2008) and South Africa (Watt et al., 2014, 2016) advocates abstinence during pregnancy. This finding could also be explained by differences in individual practitioners' approaches.

Women in Watt et al. (2014, 2016), Zabotka (2012), Pati et al. (2018), and Badry (2008) reported receiving advice from friends about drinking during pregnancy. Older women had advised some women in Watt et al. (2014, 2016) not to drink. Others, however, had been encouraged to drink; women in Zabotka (2012) had been advised by friends who had previously drunk during pregnancy that drinking would not harm the foetus, women in Pati et al. (2018) described being told by older women that alcohol would be good for their babies, and one woman in Badry (2008) described ending friendships with people who encouraged her to drink during pregnancy.

3.4.3 Multiple adversities

All studies mentioned adversity, although many did not explore it in detail or in their main findings, and most did not categorise it as a theme or concept. Some adversities were engaged with more than others; ACEs and trauma were often discussed, while the impact of poverty was not usually explored in-depth in individual studies. The studies did not usually emphasise the multiplicity and connectedness of adversities experienced by participants or relate these to systematic inequality or oppression, although my synthesis highlights the importance of these intersecting adversities.

3.4.3.1 Traumatic experiences and repeat victimisation

In the studies that enabled discussions about traumatic experiences, women described repeated, often ongoing violence, abuse, and trauma from multiple sources throughout childhood and adulthood, and sometimes described drinking to overcome or forget about problems or stress, or to escape or feel better for a while (Badry, 2008; Cloete and Ramugondo, 2015; Frost-Pineda, 2009; Watt et al., 2014, 2016). The impact of traumatic experiences was not explored in Salmon (2008) and Pati et al. (2018).

Women across the studies described a range of adverse childhood experiences (ACEs), including emotional, physical and sexual abuse (Badry, 2008; Cloete and Ramugondo, 2015; Frost-Pineda, 2009; Zabotka, 2012), domestic abuse, parental alcohol and drug dependence or mental health problems (Badry, 2008; Cloete and Ramugondo, 2015; Frost-Pineda, 2009; Salmon, 2008; Thomas and Mukherjee, 2019; Zabotka, 2012), and loss through bereavement or separation, often repeatedly (Badry, 2008; Frost-Pineda, 2009; Salmon, 2000; Zabotka, 2012). Although all the studies except Pati et al. and Watt et al. mentioned childhood trauma, Salmon (2008) and Thomas and Mukherjee

(2019) did not explore it in depth. This may reflect the studies' aim, which were about the experiences of birth mothers of children with FASD, with a focus on post-diagnosis, so they lack detail about pre-pregnancy and pregnancy experience.

Domestic abuse was common among the women in many studies (Badry, 2008; Cloete and Ramugondo, 2015; Frost-Pineda, 2009; Salmon, 2000; Thomas and Mukherjee, 2019; Zabotka, 2012). Women described extreme, repeated physical and mental abuse, often perpetuated by many men over many years, including during pregnancy. Zabotka argued that the childhood abuse experienced by women in her study may have 'set the stage for being victimized as adults' (2012, p57), which individualised domestic violence rather than exploring the structural factors that enabled its perpetuation. Similarly, Badry's (2008) feminist study largely framed domestic violence in terms of its impact on individual women, rather than as a form of gender-based violence. Cloete and Ramugondo (2015) highlighted the role of gender more than other studies, with women considering the difference between being a man or a woman in their community. This consideration of gender may have been possible for women in the Cloete and Ramugondo study because the design of the study allowed a less formal relationship to develop between the researcher and the women (Cloete and Ramugondo was the only study that included observation), but it is also possible that women in this study experienced gender differently to women in the other studies, given the studies' heterogeneity.

Many women across the studies had experienced the removal of children by the state or had been removed from their birth families as children themselves, although the impact of this was not explored in detail in any studies except Salmon (2000) and Badry (2009), which explored the context surrounding the removal of children, highlighting the trauma, lack of support, and complex power relations surrounding child removals, and their impact on women's drinking.

3.4.3.2 Poverty and marginalisation

Most studies did not explicitly explore poverty, SES and marginalisation, instead tending to focus on women's individual behaviour, understandings of advice or social norms. However, some studies did purposefully engage with poverty and marginalisation as systematic problems. Salmon (2000) set out to undertake a feminist,

anti-colonialist and anti-ableist study; the Aboriginal women participants belonged to a marginalised group which had been harmed by colonialization, and continued to experience multiple adversities including racism, sexism, and ableism, which made life challenging and made it harder to seek support. Similarly, Cloete and Ramugondo's (2015) study took a critical occupational therapy approach, and explicitly set out to understand how cultural, economic, and political conditions related to pregnant women's drinking in South Africa. Some other studies highlighted the impact of poverty and marginalisation but still foregrounded women's behaviour, for example Watt et al.'s framing of drinking as a 'maladaptive coping strategy' women used to cope with poverty (2014, p123).

Despite the diverse geographies and therefore social contexts of the studies, my synthesis highlighted poverty and marginalisation as key. Women throughout many studies described experiencing poverty and homelessness. Pamela, the participant in Frost-Pineda, described not being fed as a child, having sex for money and periods of homelessness as an adult; women in Cloete and Ramugondo (2015) had strategies to make food last longer; women in Watt et al. described worries about insecure housing; women in Badry (2008) were homeless; and seven of the participants in Pati et al reported living below the poverty line. Many of the 'stressors' described in Watt et al. (2014, 2016), Cloete and Ramugondo (2015), Badry (2008), Salmon (2000), and Frost-Pineda (2009) were related to housing and money. Women described chronic stress and precarity relating to money, housing, relationships, and the removal of children (Badry, 2008; Watt et al., 2014, 2016; Frost-Pineda, 2009). Cloete and Ramugondo (2015) described drinking in the context of a lack of other realistic or meaningful options as an 'imposed occupation' (p34), and this resonated with the accounts of many women across the studies, who did not appear to have other 'lifestyles' available to them. Many women described a lack of support from parents, partners, and friends, saying they had nobody to talk to about their problems, unsupportive partners, estranged or unsupportive parents (Badry, 2008; Cloete and Ramugondo, 2015; Frost-Pineda, 2009; Salmon, 2000; Watt et al., 2014, 2016; Zabotka, 2012), and a lack of support from the state and services (Frost-Pineda, 2009; Salmon, 2000; Badry, 2008).

Conversely, all the women in Salmon (2008) had medium-high SES. Their SES and their continued custody of their children may make them atypical as mothers of children

with FASD (Astley et al., 2000; Sood et al., 2001). The SES of participants may be due to Salmon's study design, which used an FAS organisation to find participants; this means that only women who had sought support could be included. The inclusion criteria in Salmon (2008) and Zabotka (2012) (women who had retained custody of their children with FASD) meant that women with higher SES, and those who were abstinent or 'in recovery', were likely to be over-represented.

3.4.4 Summary of findings

Only nine studies meeting the specified inclusion criteria were identified. The studies varied widely in theoretical perspective, location, and study aim, which made it difficult to draw conclusions from them, although the process of synthesis led to the development of some key findings.

Many women across the studies described being affected by multiple adversities including traumatic experiences, including those perpetuated by the state, and poverty. In addition, women across the studies emphasised that their experiences of drinking during pregnancy were affected by social norms around drinking, and social connections including their partners. Although not all the studies highlighted multiple adversities and social norms as themes or concepts, when synthesised, they appeared to be key. Since no studies explored these issues in the UK, it is not possible to transfer these findings to a UK context without further research.

This search identified a lack of research including the perspectives of women who drink at a 'high risk' level, and, with the exception of Thomas and Mukherjee (2019), none in the UK or Europe. Thomas and Mukherjee explored the post-diagnosis experiences of five women whose children had been diagnosed with FASD, and therefore included little exploration of pregnancy or pre-pregnancy, or the wider context in which drinking during pregnancy occurred. As explored in chapter 2, current guidance in the UK states that women should abstain from drinking alcohol during pregnancy, yet this meta-ethnography did not locate any UK studies exploring the impact of this guidance on the lives of women who drink at 'high-risk' levels during pregnancy.

The studies did not explicitly explore women's perspectives of treatment or support during pregnancy. This means there appears to be no evidence which explores the

treatment or care of women who drink at a 'high risk' level during pregnancy from their perspective.

3.4.5 Strengths and limitations

This review took a comprehensive approach to literature searching and therefore should include all relevant qualitative studies. The inconsistent measurement and definition of alcohol consumption made it impossible to apply strict inclusion criteria regarding the amount of alcohol consumed. Several papers were excluded because it was not possible to tell how much alcohol participants drank during pregnancy. It is therefore possible that some studies that included women who met the inclusion criteria but did not state this explicitly, and could have led to deeper understanding, were excluded. Conversely, the FASD studies (Zabotka, 2012; Salmon, 2008; Thomas and Mukherjee, 2019; Badry, 2008) were included based on the assumption that participants likely drank at a 'high risk' level during pregnancy as their babies were 'diagnosed' with FAS/ FASD; this assumes that FASD is a diagnosable condition, that it is caused by drinking, and that accurate diagnosis has taken place, which is a problematic assumption, as discussed in the background chapter. This problem could have been solved by excluding studies which did not clearly state how much alcohol women reported drinking during pregnancy, but this would have led to no studies being included and a synthesis being impossible.

This review is a meta-ethnography, which allows for new interpretations to be drawn when looking at the studies as a body rather than separately. This meant that the studies included in the review, which at first appeared disparate, could be synthesised and common and refutational themes identified. This is a strength as it identifies areas which require further research but required several judgements to be made at various stages, for example in the selection of studies for inclusion and the identification of themes. In retrospect the involvement of a second researcher may have improved the 'soundness in analysis' (Walsh & Downe, 2005).

The use of a meta-ethnographic approach can also be viewed as a weakness of this review, as it is a controversial approach which some argue can undermine the meaning of individual studies (Sandelowski, 2006; Sandelowski & Barroso, 2002). I chose to use it because I felt that the practical benefits of enabling me to identify areas of focus for

my own study outweighed these potential drawbacks. To ensure credibility I used the original quotes from women as the key information when I was formulating the themes, with the intention that this would keep my analysis as close as possible to women's original stories.

3.5 Conclusion – implications for this thesis

This chapter has demonstrated that despite evidence suggesting that FAS and FASD is more likely with higher levels of alcohol consumption during pregnancy, there is little qualitative research, especially in the UK, which focuses on the perspectives of this population of women. The effects of the current precautionary approach, particularly since the UK-wide guidance changed most recently in 2016, and views about health and social care services, have not been explored with women who drink at more than low levels during pregnancy. This is concerning because women drinking at 'high risk' levels are more likely than others to have a baby with FASD, and may already be marginalised, so it is crucial to attempt to understand how the precautionary approach affects these women, and whether existing services are helpful for them. Without understanding why women drink during pregnancy, and how current services are working from women's perspectives, it may not be possible to provide effective care and support.

Evidence suggests that alcohol consumption is not the only factor that affects a baby's likelihood of being born with FASD (see background chapter), yet most of the existing qualitative research does not explore broader contextual factors such as SES, multiple adversities, or the role of women's partners. This synthesis, as well as previous research with women who use illicit substances during pregnancy, suggests that these factors are likely to be important to women who drink during pregnancy.

This meta-ethnography has highlighted the need for further research including the perspectives of women, especially those who drink at 'high risk' levels during pregnancy. The next chapter will outline how I used these findings to inform my subsequent empirical research study.

Chapter 4 – Methodology

4.1 Introduction

The last chapter synthesised and reviewed research including the accounts of women who drank during pregnancy. It highlighted the need for further research including the perspectives of women, especially those who drink at 'high risk' levels during pregnancy. This chapter outlines how I used these findings to inform my theoretical approach.

Qualitative researchers argue that before deciding on a research question it is essential for the researcher to consider their ontological and epistemological perspectives (Mason, 2002). Ontology refers to theory about the nature of reality, while epistemology refers to theory about the nature of knowledge. This chapter offers an account of my explorations into ontological and epistemological concerns, and the effects these had on my eventual study design. It has five sections: first, ontology, epistemology, and researcher perspective; second, critical realism; third, feminism(s); fourth, understanding 'experience' and 'perspective'; and finally, a pragmatic approach.

4.2 Ontology, epistemology and researcher perspective

Ontology concerns the way in which one views the world and the nature of social reality, for example whether we see the social world as primarily a result of pre-existing structures or the actions of individuals, and whether we believe there is one objective reality or multiple interpretations of reality. This is important when designing a research project because it influences the approach taken by the researcher, the questions that the research asks, and the way in which the data is interpreted; the assumptions we make about the nature of reality are reflected in the outcomes of the research we do (Mason, 2002).

Epistemology concerns the way in which one views the nature of knowledge and evidence, for example whether it is possible or desirable to seek out 'facts'. Questions around the nature of 'truth' and whether it is possible or desirable to 'know' it are epistemological questions. These questions are important because the epistemological approach taken in research affects the type of research that is carried out and the methods that are used (Seale et al., 2007).

Initial attempts to write the research questions for this project were fraught with difficulty. In retrospect, this was at least partly because I was grappling with ontological and epistemological questions which informed everything about the research questions; once I had spent more time exploring theoretical and practical implications of different perspectives, it became easier to write the questions and design the research.

When I started my PhD, I knew I wanted to include the perspectives of women who drink during pregnancy because of the lack of research with women about a topic that affects women, especially those who drink during pregnancy, in a unique way. It seemed unjust to me that women's voices were largely absent in a debate that had been public, judgemental, and influential. At this early stage I was very keen that my theoretical approach should not deny or ignore what I saw as the 'reality' of the world and the social structures that I felt affected lived experience. Although this perspective was to some extent informed by my background reading and literature review (see chapters 2 and 3), it was also something I brought to the research, and predated my PhD. Having completed my undergraduate and postgraduate studies in social sciences with a focus on sociology, I had spent a decade working with children and families in education and social care and was angry about inequality and injustice. I had worked with families who I considered had been damaged by government policy which failed to address structural problems such as poverty, inadequate housing, and lack of educational and employment opportunities, but had been encouraged to see themselves and their choices as responsible for their problems. I therefore came to the research with a strong view that a focus on individual decision making, behaviour, and agency was not enough to inform meaningful responses to social issues, instead only serving to focus blame on the people who held the least power, rather than holding those responsible to account.

At this early stage it felt wrong to take a strongly constructivist approach; I felt that pregnancy existed regardless of how the world felt about it, and that it represented some sort of shared experience among many women, although I recognised that it is experienced differently depending on other aspects of women's lives, and of course that not all women experience it. I also felt that babies were vulnerable because of their size and immaturity, even if we question the social construction of childhood. This perspective, although informed by previous sociological study and my work with families, was also influenced by my situation as a mother; when I started my PhD, my youngest child was less than a year old and this meant that philosophical considerations about the nature of reality were necessarily grounded in the everyday bodily experience of looking after a baby. At this early stage I acknowledged that there were interesting questions to be asked about the way issues such as alcohol dependency, FASD and motherhood were constructed within societies, but was keen to point out that regardless of constructed aspects, these issues were still experienced as real.

Above all, it felt essential to me that the research should be useful as a tool to improve women's lives, and I therefore stubbornly dismissed social constructionist approaches early on and turned to critical realism.

4.3 Critical realism

I was keen to explore theoretical perspectives which explicitly acknowledged the importance of the social structures in which we live, as I did not want to produce a study that reduced maternal alcohol consumption to a behaviour that could be managed through programmes targeted at the individual. I needed to find a way of exploring the structures that affected women's lives while not denying that their experiences as individuals were valid. An exploration of social theory brought me to critical realism, which aims to acknowledge the complex ways in which various elements of the social world interact to shape causality and experience (Mooney, 2016).

Critical realism starts from the premise that there is an objective world, and it is possible to get closer to an understanding of this. It is concerned with three levels of reality – the 'empirical' (what we can see), the 'actual' (what is there, even if we

cannot see it), and the 'real' (causal mechanisms which cause events at empirical level to occur). It acknowledges that there is a difference between what exists and what we are able to observe (Archer et al., 2017).

However, as I continued to read around ontological and epistemological issues, several questions began to trouble me: if there is a real world, whose version of this 'real' world do we accept as real? If it is better to approach a research topic from several different angles (in order to get closer to the 'real' world), does this mean I need to include groups of people other than women who drink as participants – if so, what implications does this have for this group of women, who have not previously been asked their views? In the case of drinking during pregnancy, is it likely to be helpful to make establishing causality the main question? Doesn't the claim that there is one real, objective truth sound a bit simplistic? Is critical realism compatible with feminism?

It took time and several supervision sessions for me to establish that, although critical realism was an attractive prospect as a 'ready- made' theoretical perspective because much had been written about how to apply it practically to empirical research, in this instance my attachment to it was becoming a hindrance. I had developed a preoccupation with establishing causality, and this was stopping me from stepping back and seeing the bigger picture – my focus on causality was leading me to focus on the causes of women *drinking* during pregnancy, rather than allowing me to look beyond this to the broader issues that may be affecting *women* who drink during pregnancy. Ironically, for a perspective whose purpose is '…analyzing social problems and suggesting solutions for social change' (Fletcher, 2017 p182), my attempts to use a critical realist approach to help me formulate the research questions had actually prevented me from being open minded and taking a critical approach to the topic. I still wanted to find a perspective that could acknowledge the reality of the social world, whilst enabling critical questions, and I turned to feminist approaches to explore this further.

4.4 Feminism(s)

When I began exploring feminist theory and research, I found a complex and confusing variety of ways of seeing, describing, and researching the world. Feminist theory that

originated at various times is often referred to as different 'waves' of feminism, but even within these there has often not been consensus about what the term means, what feminism as a movement (although it is not always characterised as a movement) aims to achieve, or the ontological and epistemological basis of feminist knowledge claims (Ramazanoglu and Holland, 2002). This means that it is not possible to characterise feminism as one coherent theoretical or practical approach (Denzin & Lincoln, 2000). Stanley and Wise (2000) argue that a hierarchical relationship has developed between feminist theorists and feminist researchers, perhaps echoing what they call 'malestream' theory (2000, p261), which means that feminist theory writing is often abstract and opaque, necessitating many 'translators' of feminist theory, which often portray various feminist perspectives as conflicting when this is not necessarily the case (Stanley & Wise, 2000, p266). In one key 'translation' of feminist theory, Gannon and Davies (2012) distinguish between critical approaches and postmodern/post-structural approaches: 'Whereas critical feminism is up-front about confronting existing power structures and practices, deconstructive approaches are busy shifting the ground in such a way that what previously seemed normal and natural becomes unthinkable.' (Gannon and Davies, 2012, p68).

I wanted to find a way of 'doing' feminism that enabled me to engage with both approaches. It was a need to maintain a sense of the material world that had led me to critical realism, and although I had found that critical realism did not help me for this project, I still wanted to find a theoretical perspective that would enable me to acknowledge the 'real', rather than taking a strong social constructionist approach. This led me to standpoint feminism.

Standpoint feminist epistemology began to emerge in the 1970s, when feminist scholars argued that science had traditionally seen things from a privileged male perspective, and knowledge had therefore been produced and controlled by the ruling class, reflecting ruling class interpretations of reality, whilst presenting itself as objective, rational and true (Brooks, 2011). Standpoint feminists argue that this male, positivist perspective has led to the perspectives and experiences of women being under-represented in research, so feminists should do research which prioritises the voices of women, giving them 'epistemological privilege' (Brooks 2011, p69). They argue that this is a necessarily political endeavour, and we should be upfront about

this (Gillies et al., 2002). Research should '…draw on what we have learned from women's experiences, to apply that feminist standpoint, toward bettering the condition of women and creating social change.' (Brooks, 2011, p60).

In response to 'mainstream' feminism's overemphasis on women's common experience, intersectionality theory was developed by Black feminists, who observed that by representing white middle class women's experience as a universal women's experience, mainstream feminists ignore the privilege and oppression women experience in relation to each other (Landes, 2003). Intersectional feminists argue that it is crucial to consider the impact of the intersection of gender with socioeconomic status, age, religion, race, and other factors on women's lives (Crenshaw, 1991; Hill Collins and Bilge, 2016; hooks, 1997). In understanding the intersecting nature of various aspects of women's lives, intersectional feminist theory aims to highlight and make visible the systems of oppression, power and inequality affecting women's lives, in order to enable change (Hill Collins, 2002; Hill Collins and Bilge, 2016). This resonated with me because of the potentially disproportionate impact of the current policy approach on marginalised women, despite much research in this area focusing on middle class, white, low level drinkers.

4.5 Understanding 'experience' and 'perspective'

Exploring feminist theory and approaches raises questions about what researchers mean when they use words such as experience, perspective, and viewpoint. The notion of accessing people's experience through research is problematic – it implies that actors always have a motivation, and that this will always be revealed to the researcher, which may not be the case. Silverman asks, '…given the routinized nature of much behaviour, isn't it dangerous to assume that there is a 'point of view' or 'perspective' lying behind every act?' (Silverman, 2013, p130). He argues that researchers should examine the stories people tell, dismissing the idea that these accounts are simply authentic, and should '…treat what they hear as simply a contingent narrative or account and examine the cultural resources that speakers skilfully deploy.' (Silverman, 2013, p135), whilst avoiding collapsing into solipsism and

rendering the research useless in any practical sense. It was important to me to be able to take a more critical approach which treated participants' accounts as created within wider contexts, and I wanted to avoid taking these accounts at 'face value' (see section 5.3.2.7 for further discussion of narrative approaches).

Although I wanted to contextualise participants' accounts, I also wanted to avoid overriding the accounts of my participants with my own assumptions and interpretations. Intersectionality theorists point out that trying to represent the 'voices' of others, particularly those with less power, is problematic and can result in 'colonizing', whereby assumptions and stereotypes about oppressed people are perpetuated by a more privileged group - such as white feminists – speaking on their behalf (hooks, 1997). Although I did not expect issues around race to be central to my research study, I was aware from the background and literature review that the women I hoped to recruit were likely to be marginalised, and the responsibility for ensuring I did not speak over them with my own perspective weighed heavily.

Addressing these issues of representation and 'voice', Wise and Stanley argue for 'Feminist Fractured Foundationalism' (FFF), in which:

> Material reality has to be recognized, but the complexities of interpretation also have to be grappled with in ways that do not position feminist researchers as overriding the understandings of the women and men who are the researched with a priori statements of epistemic privilege. (Wise & Stanley, 2006, p445)

They argue that social structures are experienced as real but are socially constituted, and talk about 'reality, for all practical purposes' (p446). They argue that epistemology always involves a moral element because knowledge claims are made 'against or over' others, and these knowledge claims take place within unequal power relations and social structures. Rather than focusing on producing better 'facts', therefore, Wise and Stanley focus on producing 'moral knowledge' (p447).

Choosing a research topic which prioritises women's perspectives, or asking different questions, is not enough to create 'moral knowledge'; Stanley and Wise argue that the production of moral knowledge involves trying to move beyond 'the current relations of ruling and knowing' (p448) by rejecting and avoiding the objectification of women

which dominant systems of research have been a part of. The production of 'moral knowledge' must use non-exploitative methods, provide enough context to be transparent, and make defensible knowledge claims. The 'knowing subject' (a reflexive researcher), should be the basis of feminist knowledge-claims. This means the researcher should be reflexive, considering their own role as a person who '…interprets and so constructs, not just reflects, research situations and data' (p447), and that the way in which she does this should be accounted for within the research, because the analysis presents the perspective of a particular person (the researcher) at a particular place and time.

Wise and Stanley argue that research participants should not be assumed to be 'immersed in the local and unable to discern the wider relations and structures of ruling' (Wise & Stanley, 2006, p447). They call these 'relations and systems of ruling' the 'extralocal' and argue that people (in this case research participants), not just researchers, interpret and understand these systems and structures on a daily basis (Wise & Stanley, 2006). For this reason, the feminist researcher should not be assumed to be more knowledgeable than participants; she is not '…magically able to check her analyses against the 'really real' ontological reality of the extralocal' (2006; p.12). Unlike some standpoint theorists, they argue that feminists do not necessarily produce better knowledge than others; instead: 'Any knowledge-claims made by FFF will concern *specific* examples and contexts and be grounded in *particular* evidence and interpretations' (Wise & Stanley, 2006, p448). This evidence, and the analytical processes used by the researcher to arrive at particular interpretations, should be clear and accessible to the reader, enabling them to assess the strength of the researcher's argument.

4.6 A pragmatic approach

I drew on standpoint theory, intersectionality theory and feminist fractured foundationalism to aid the design of the research in the following ways:

1. *Challenging dominant assumptions by asking different questions*

As discussed in depth in previous chapters, alcohol consumption during pregnancy is presented through policy and public health approaches as the sole cause of FASD,

although evidence suggests that factors other than drinking are also important. Research about drinking and pregnancy usually focuses only on drinking behaviour (see chapters 2 and 3).

Kleinman (2007), and Crenshaw (1991) argue that feminists should ask questions that challenge dominant assumptions. By framing the research questions around the broader aspects of women's lives, I aimed to challenge dominant assumptions that women alone are responsible for causing FASD. I wanted to decentre the issue of drinking during pregnancy by exploring the social contexts of women's lives, including gender, SES, life histories, and partners.

2. Decentring women versus representing voices that have not been heard

Once I decided to challenge dominant assumptions by asking different questions, I was faced with a dilemma: if I place women at the centre of the research, does this reinforce the assumption that they are solely responsible for the health of their babies? If I truly wanted to decentre women, rather than reinforcing assumptions, was it enough to ask different questions, or should I also be asking different people?

Initially I proposed to overcome this problem by including male partners, policy makers and healthcare practitioners as participants, in order to decentre women. As I read further, however, this decision became increasingly uncomfortable. A key aim of feminist research is to '…seek choices that challenge systems of oppression and privilege' (Kleinman, 2007, p115), and I began to feel that I would be unable to attempt this without prioritising the accounts of women who drink at a 'high risk' level during pregnancy, who are likely to be marginalised, and who appeared to be absent in existing research and policy.

After considering various research designs, I decided to focus on the perspectives of women who drink during pregnancy, making a conscious decision not to include male partners or policymakers as participants, thereby allocating 'epistemological privilege' to women. Wise and Stanley argue that who can be a 'knower' depends on '…where people are situated within the relations of ruling and the operations of power/knowledge in particular contexts or situations.' (Wise and Stanley, 2006, p448). For my study I prioritised women who drink during pregnancy as 'knowers' because they are uniquely affected by the policy and practice in this area, and through their

experience have a certain type of knowledge about the topic that others do not. I argue that this is necessary for this study, due to the lack of research with women who are uniquely affected by the policy framework around drinking during pregnancy.

3. Informed participants

Reading about the problems with accepting participants' accounts as 'factual' or 'authentic' led me to want to acknowledge and embrace the constructed nature of participants' accounts by giving participants the opportunity to take time and space to consider and develop their ideas. This aligns with Wise and Stanley's (2006) contention that research participants should be assumed to be capable of looking beyond their individual experiences to consider wider issues, and intersectionality theorists' caution against speaking over marginalised women.

When I initially began to explore what it meant to be an informed participant, I was drawn to Participatory Action Research, in which participants are involved in the design, fieldwork, analysis and dissemination of the study. Reading about studies that utilised visual methods to include a strong focus on participation, I thought I could undertake research with women, including a visual element, and then hold workshops with groups of participants in order to develop themes and decide what to do next, for example meeting with policy makers, writing a blog or news article, campaigning for equality, or creating a support group. Although this idea was exciting and attractive, there would have been challenges around funding, timescales, and possibly ethical approval. Ultimately, I decided not to plan a study based on PAR methodology, because of the risk that, due to the practical challenges outlined above, I would fail to produce the 'moral knowledge' (Wise & Stanley, 2006) I wanted to produce. It was potentially exploitative to involve women in the lengthy and time-consuming research process without paying them for their time, particularly because many of them would already be doing unpaid caring and knowing that I may not be able to commit to supporting the participants to achieve a practical goal because of the timescales attached to the PhD process. Instead, I settled on a design which I hoped could produce 'moral knowledge' by offering participants time and space to reflect on and develop their own views throughout the research process, without the expectation of ongoing involvement in the project.

4.7 Conclusion

This chapter has offered a reflexive account of my explorations into ontological and epistemological concerns, and explained why I drew on feminist standpoint theory, intersectionality theory and feminist fractured foundationalism to aid the design of the research, which emphasises the production of 'moral knowledge'.

Once I had explored my ontological and epistemological assumptions about the world, and identified the principles that would guide the research, I needed to finalise the research questions and practical methods I would use to gather and analyse the data. The next chapter will introduce and discuss these methods.

Chapter 5 – Methods

5.1 Introduction

The previous chapter outlined the methodological concerns related to this research.

This chapter introduces and discusses the methods I used to gather and analyse the data and offers a reflexive account of the research process.

Despite some practical challenges, I completed semi-structured photo-elicitation interviews and focus groups with women and practioners and analysed these using a narratively informed approach to reflexive thematic analysis. I explored the views and experiences of women who drink (or drank) during pregnancy, and professionals who provide treatment and care for pregnant women drinkers, including how various aspects of women's lives intersect with one another and with alcohol consumption, in order to inform policy and practice in relation to the care of pregnant women who drink alcohol.

For various practical reasons, the research evolved throughout the fieldwork period, so the following chapter provides details of the original plan for the research and an account of how the research happened in practice, including changes to the original protocol and the reasons these changes were made. This aligns with Stanley and Wise's (2006) focus on transparency. This chapter has two main sections: first, the original research plan; and second, the final methods used. This second section encompasses the final research design; data collection; participant characteristics; ethical issues; and data analysis.

5.2 Original research plan

5.2.1 Original Research aim, objectives and questions

Research aim*:* To explore the views and experiences of women who drink (or drank) during pregnancy including how various aspects of women's lives intersect with one

another and with alcohol consumption, in order to inform policy and practice in relation to the care of pregnant women who drink alcohol.

Objectives:

To examine the ways in which alcohol consumption, and factors other than alcohol consumption, feature in women's accounts of pregnancy.

To understand women's views of the effects of the current policy and practice approach to drinking during pregnancy on women who drink/ drank during pregnancy.

To consider implications for policy and practice around alcohol and pregnancy.

Research questions:

- How do pregnant and postnatal women account for their alcohol use, and its effects, during pregnancy?
- In what ways, and to what extent, does Scotland's current policy landscape around alcohol and pregnancy emerge in the accounts of pregnant and postnatal women who drink?
- In what ways, and to what extent, do factors other than alcohol consumption feature in the women's accounts of their pregnancy, and in what ways do they intersect with alcohol consumption?
- How do services, including health and social care services, feature in women's accounts?
- In what ways, and to what extent, do women's contexts and accounts vary between the prenatal, postnatal, and early years' periods?

5.2.2 Original research design

The original research design was a qualitative, exploratory, feminist, longitudinal, photo-elicitation study, using a social model of alcohol consumption (Staddon, 2016) to examine the ways in which women who drink (or drank) during pregnancy account for this. It aimed to explore the social contexts of women's lives, including gender, SES, life histories, and partners, anticipating that these aspects of women's lives would intersect in complex, context-dependent, and fluid ways. I planned to use up to two semi-structured interviews and a photo-elicitation task with women who reported

drinking 7 or more units of alcohol per week throughout pregnancy (see figure 4 for planned study design).

Figure 4: Planned study design with justifications

5.2.3 Original inclusion criteria

Initially I created a set of very specific inclusion criteria. The background and literature review that I had undertaken had led me to decide that this study should include women who drank at 'high risk' levels (World Health Organization, 2000). Previous research suggests that it is likely that some pregnant women under-report their alcohol consumption during pregnancy (Symon et al., 2017), so I took this into account by including women who reported drinking 7 or more UK units of alcohol per week throughout pregnancy, with the aim of including some women who drink at 'high risk' levels during pregnancy. In acknowledgement that some women do not disclose their alcohol consumption during pregnancy, the original inclusion criteria included women

(who report drinking during pregnancy retrospectively) who had given birth and had a child aged 6 or younger. This meant that women who were pregnant when they first heard about the study would still be eligible for inclusion later should they not wish to take part until after their baby is born, and women who did not disclose their drinking until after the baby was born would also be eligible for inclusion.

5.2.4 Planning versus practicality

The original protocol, written in 2017 and approved by the NHS and University ethics committees, was amended several times throughout the fieldwork period in response to early feedback from practitioners and women during a very challenging early recruitment period (see Appendix 6 for list of amendments). These amendments involved significant changes to the research which are outlined below:

1. *Making the study more accessible:*

I anticipated that recruitment would be challenging, and the early recruitment period confirmed this, with just two participants referred and one participating within the first three months. Although discussion with practitioners had led me to believe that these recruitment challenges reflected the low identification of pregnant drinking women by services, I identified some changes I could make at this stage that may increase recruitment.

To make the study more accessible, I submitted an amendment to the NHS Research Ethics Committee (REC) to enable us to offer greater flexibility regarding timing and location of interviews, by offering telephone interviews and home visits, and making the timing of the second interview more flexible – between 1 month and 10 months after the first interview instead of the 6 months initially proposed. I hoped that this would help to overcome issues around travel time and costs, and childcare issues and increase our chances of staying in touch with participants, whilst allowing time for the use of photos and reflection between interviews.

In response to feedback from women and practitioners I shared the study materials on social media, added an email address to the poster and made the Participant Information Sheet (PIS) available online, to make it easier for women to decide whether to participate.

2. Broadening the scope of the study

After the initial recruitment period, in consultation with my supervisors I decided to broaden the scope of the study by including others who would have a view on pregnancy and alcohol, including women who had been pregnant, regardless of whether they drank during pregnancy, and practitioners. This decision was made both as a response to low recruitment during the first three months, and because it had become apparent through engagement with stakeholders and gatekeepers that they held a wealth of contextual information, interest and experience in pregnancy and alcohol which it would be beneficial to be able to explore and analyse in depth.

Broadening the scope of the study in this way created new moral and theoretical challenges and tensions that I needed to carefully consider before implementing changes to the design. I had decided, after much consideration of various approaches, to focus on women's views, giving women epistemological privilege in this study; was I now removing this simply because I was struggling to reach them? This concerned me greatly, because since the outset it had been important to me that this study should have the views of women at its core, and I had seen this as a key way in which to create the 'moral knowledge' proposed by Stanley and Wise (2006). My supervisors helped me to see that the choice was between continuing as planned, and possibly not having any participants and the study therefore not going ahead, or broadening the scope of the study, including a wider range of participants, and being mindful throughout of the group of women who had been unable to participate, and the potential reasons for this; paying close attention to who was *not* included, as well as who was able to participate.

Another way in which I attempted to overcome this new ethical and theoretical challenge was to ensure that I continued to place emphasis on challenging dominant assumptions by asking different questions; I did challenge participants, always asked about broader context, and ensured the conversation didn't just focus on alcohol but also included discussion about inequality, in order to ensure that this study did not simply ignore women who were marginalised, just because they were unable to participate. I also used a reflective journal throughout the fieldwork period to reflect on these challenges (see Appendix 7 for example extract from reflexive journal). This

approach was not ideal, but it was a pragmatic response which enabled me to continue with the research.

5.3 Final methods

5.3.1 Research aims, objectives and questions

Research aim:

To explore the views and experiences of women who drink (or drank) during pregnancy, and professionals who provide treatment and care for pregnant women drinkers, including how various aspects of women's lives intersect with one another and with alcohol consumption, in order to inform policy and practice in relation to the care of pregnant women who drink alcohol.

Research objectives:

To examine the ways in which alcohol consumption, and factors other than alcohol consumption, feature in women's accounts of pregnancy.

To understand women's views of the effects of the current policy and practice approach to drinking during pregnancy on women who drink/ drank during pregnancy.

To understand professionals' views on alcohol consumption during pregnancy and the current policy and practice approach to drinking during pregnancy.

To consider implications for policy and practice around alcohol and pregnancy.

Research questions:

- How do pregnant and postnatal women account for their alcohol use, and its effects, during pregnancy?
- In what ways, and to what extent, does Scotland's current policy landscape around alcohol and pregnancy emerge in the accounts of pregnant and postnatal women who drink?
- In what ways, and to what extent, do factors other than alcohol consumption feature in women's accounts of their pregnancy, and in what ways do they intersect with alcohol consumption?

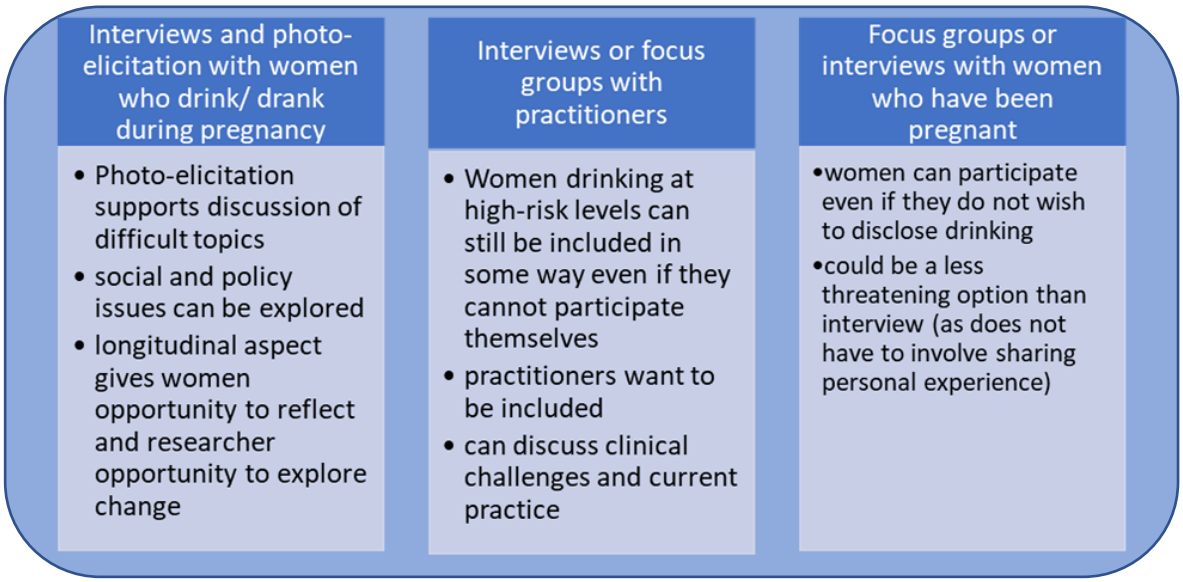
- How do services, including health and social care services, feature in women's accounts?
- In what ways, and to what extent, do women's contexts and accounts vary between the prenatal, postnatal, and early years periods?
- How do professionals account for women's alcohol use during pregnancy?
- How do professionals account for the current policy and practice approach to drinking during pregnancy?

5.3.2 Research design

This study was a qualitative, feminist, photo-elicitation exploration of drinking during pregnancy exploring the accounts of women who drink (or drank) during pregnancy, and professionals who provide treatment and care for pregnant women drinkers, using a social model of alcohol consumption (Staddon, 2016) to examine the ways in which women who drink (or drank) during pregnancy account for this. It aimed to explore the social contexts of women's lives, including gender, SES, life histories, and partners, anticipating that these aspects of women's lives would intersect in complex, context-dependent, and fluid ways.

Women who reported drinking during pregnancy participated in up to two semi-structured interviews including photo-elicitation, while practitioners and women who did not report drinking during pregnancy took part in an interview or focus group. Analysis drew on narrative approaches and reflexive thematic analysis.

Figure 5: Final study design with justifications



5.3.3 Inclusion criteria

5.3.3.1 Inclusion criteria – drinking women

Women who reported drinking at any level throughout pregnancy were eligible for inclusion. Although I wanted to enable the inclusion of women drinking at a 'high risk' level, the challenging initial recruitment period had suggested that a including a requirement for women to report drinking at a specified level was problematic because:

- Women may not always know exactly how much they drank during pregnancy, particularly when they are required to convert this into units of alcohol, making it difficult for women to self-report exactly how much alcohol they drank when they were pregnant (Symon et al., 2017). Three potential participants contacted me in the early recruitment period but could not remember exactly how much they drank whilst pregnant, which reflects the challenges involved in self-reporting.

- It is likely that alcohol consumption is under-reported, and this may be particularly common during pregnancy due to the current policy and social context (see background chapter), which focuses on abstinence during pregnancy. Some women may experience this as judgemental and stigmatising, which may make it less realistic to expect women to give details about how much they drank during pregnancy during an initial screening conversation (Muggli et al., 2015). It may be easier for women to discuss the details of drinking behaviour towards the end of an interview, once they are comfortable and a rapport has been established.

Women across the UK were eligible for inclusion, although in practice only one lived outside of Scotland. Women who drank during a pregnancy within the last 12 years could participate, to reflect the change in Scottish guidelines to an abstinence focus in 2007 (Department of Health and Social Care, 2007). I hoped that this would enable women to reflect on their experiences of drinking during pregnancy within the context of an abstinence approach.

Table 4: Final inclusion and exclusion criteria – drinking women

Inclusion criteria	Exclusion criteria
Women who are: - Pregnant or - Have a child who is 12 or younger	Women whose children are all over the age of 12 years
Women who: - Report drinking alcohol during pregnancy **and** - Report continuing to drink during pregnancy after booking appointment/ advice to stop drinking Note: women can be included in the study if they are drinking and also using other substances	Women who: - Report no alcohol consumption during pregnancy; or - Report cessation of drinking during pregnancy after booking appointment/advice to stop drinking
Capable of giving informed consent	Unable to provide informed written consent
16 years old or over	Younger than 16 years old
Resident in UK	Not resident in UK
Can read and speak English	Non-English speakers who require a translator in order to take part in an interview

5.3.3.2 Inclusion criteria - practitioners

Practitioners were eligible for inclusion if they had worked for a minimum of 6 months with women who report drinking during pregnancy. This enabled a broad range of

professional experience and perspectives to be included. This was a purposive sample including midwives, health visitors, social workers, and staff from drug and alcohol services in Scotland.

5.3.3.3 Inclusion criteria - Women who had been pregnant within the last 12 years:

Women who had been pregnant and given birth within the last 12 years were eligible to participate in a focus group or interview about their views on drinking during pregnancy. There was no requirement for women to disclose whether they drank during pregnancy to participate in this aspect of the research.

5.3.4 Sample size

When I first planned the study, I aimed for 30 participants and sought to maximise the diversity of the sample by including women with a variety of drinking behaviour, SES, service experiences, parity, ages, and relationship statuses to (Patton, 2015).
I soon realised that these plans were impractical due to the difficulties involved in recruitment (see section 5.2.4), so I shifted my goals to focus on ensuring that a range of women were included, and on trying to enable the participation of marginalised women. This was a pragmatic decision which I felt justified in making because previous qualitative researchers have emphasised the critical reflexivity involved in deciding on sample size, and as Braun and Clarke have highlighted, the quality of the data is more important than the quantity (Braun & Clarke, 2016, 2019b). This more reflexive approach to recruitment worked well and I recruited a sample of fourteen women and ten practitioners (see section 5.3.2.5 for participant characteristics).

5.3.5 Recruitment strategy

A different recruitment strategy was used for each of the three groups of participants, according to the type of sample required, to maximise recruitment.

5.3.5.1 Recruitment of women who drink/ drank during pregnancy

I used a broad recruitment strategy, aiming to make women aware of the study both inside and outside of NHS settings. The recruitment of women who drink/ drank during pregnancy took place over a one-year period in the following ways:

1) Through NHS Scotland and partner agency drug and alcohol services (including specialist pregnancy services for women with substance misuse problems); midwifery and obstetric services, child health and community paediatric services in NHS Lothian, Tayside, Greater Glasgow and Clyde, Lanarkshire, Fife, Forth Valley and Borders.

   Women who were recruited through services were identified when they attended routine appointments with a member of their direct care team (e.g., midwife, addiction worker, health visitor). The practitioner introduced and explained the study and gave them the Participant Information Sheet (PIS) to read. If the potential participant expressed an interest in participating, the practitioner asked for verbal permission to pass on the patient's name, address and telephone number to me. I then contacted the potential participant to discuss the study in more detail and answer any questions. Potential participants could also contact an independent person who knew about, but was not directly involved in, the study (see Appendix 8 for Participant Information Sheet). If the potential participant indicated that they would like to take part in the study, I arranged a face-to-face meeting at a convenient time and venue to obtain written informed consent or sent a consent form to be signed and returned if the participant expressed a preference for a telephone interview. I read aloud the PIS and consent form to aid understanding and overcome any literacy barriers. I anticipated that some participants may find it difficult to attend appointments (Schempf & Strobino, 2008; Young, 1994), so in order to keep the process as simple as possible for participants, the first interviews took place immediately after consent had been obtained.

   To maximise recruitment, I tried to visit each team that was able to support recruitment to explain the background and purpose of the study and to meet the staff who would be asking women to participate. I met with 28 teams across NHS Scotland to introduce myself and the study and to answer any questions. Some teams preferred to communicate solely by email, or where it was not possible to schedule a meeting for logistical reasons, but the majority welcomed the opportunity to discuss the study and were supportive of its aims,

although many practitioners were not optimistic about recruitment, stating that women often did not report their drinking or were not known to services. After the meetings I stayed in touch with the teams with regular follow-up telephone calls or emails in order to remind the practitioners about the ongoing recruitment.

2) Third sector organisations in Scotland were invited to help with recruitment, by putting posters up and/ or telling women about the study and asking them whether they would like to be contacted by the researcher (as above). Relevant Scotland-wide third sector organisations were identified throughout the recruitment period by the research team, and key contacts within NHS teams in each geographical area also provided details of relevant local third sector organisations. The list of third sector organisations therefore grew throughout the data collection period as my knowledge of available services increased.

3) Throughout the fieldwork period some specific social work and criminal justice organisations were recommended by key contacts in some areas, so these were also invited to support recruitment for the study.

4) Poster advertisements (see Appendix 9 for poster) were placed in spaces where pregnant women or those with children may be, such as antenatal and child health clinics and addiction recovery hubs, community childcare centres and supermarkets, and online spaces such as facebook and twitter. Potential participants who saw a poster could contact me direct on the study mobile phone or by email and could view the PIS online. I then introduced the study, ensure they meet the inclusion criteria, sent them a PIS and arranged a meeting after a period of at least 24 hours to obtain informed consent.

5.3.5.2 Recruitment of practitioners

Practitioners were recruited over a 9-month period. This was a purposive sample – I had been recruiting women through NHS and other services for 3 months by the time we decided to include practitioners in the fieldwork so had developed a good working knowledge of who to invite to participate.

I sent each potential participant an email inviting them to take part, with the PIS attached. Those who expressed an interest in participating were asked to sign a consent form when they attended for the focus group or interview.

5.3.5.3 Recruitment of women who had been pregnant within the last 12 years

Women who had been pregnant in the last 12 years, regardless of whether they consumed alcohol when they were pregnant, were recruited by poster advertisements and by drawing on personal networks.

Table 5: Recruitment summary

Group	Number of participants	Recruitment methods
Women – report drinking during pregnancy	8	NHS – 4 Poster - 1 Social media – 3
Women – general	6	Social networks – 4 Non-NHS recruitment – 2
Practitioners	10	NHS – 10

5.3.6 Data collection

5.3.6.1 Data collection – drinking women

5.3.6.1.1 Semi-structured interviews with women who drink/ drank during pregnancy

I used semi-structured interviews to interview women who reported drinking during pregnancy, to enable key questions, concepts, and relationships to be explored (Fletcher, 2017), whilst being flexible enough to allow relevant discussion to develop. I did not intend that each interview was conducted in exactly the same way, but that the interviews were seen as social interactions, the content and tone of which depends on the participant and interviewer (Rapley, 2004).

I developed a topic guide (see Appendix 10) which was informed by the findings of the literature reviews. Topics included participants' health and social circumstances and

history (e.g., own childhood, education, work and health history, experiences and views of drinking, pregnancy, and services, the local area, and friends, family, and partners). I also recorded participants' socio-demographic details and involvement with services using a 'Participant details sheet' (see Appendix 11) in order to provide a profile of the sample.

I considered unstructured interviews as an alternative to semi-structured interviews but eventually rejected them as I was concerned that there was too much scope for misinterpretation of the question, and that leaving the interview so open may have been overwhelming for the participants. In addition, the background and literature review I had completed had led me to be interested in exploring a social view of alcohol consumption, with various aspects of life being included in the discussion, which may have been left unexplored if I had simply asked one question about alcohol (I felt that this may lead to participants oversimplifying their answers or focusing solely on alcohol when I was interested in a broader range of topics). Some of the studies in my literature review had used this method to discuss women's drinking (Ford, 2013) and I found that they had not elicited much discussion of the structural factors relating to drinking and wondered whether this was because the single question method had not allowed the researchers to specifically ask participants about them. I wanted to explore these structural factors so needed to choose a method that meant I could ensure they were discussed.

Focus groups were also briefly considered for this group of participants but were rejected, largely due to ethical issues around confidentiality and the sensitivity of the topic, and practicalities – I felt it would be important to be able to be flexible about the place and time of the fieldwork in order to fit in with participants' schedules and thus increase the likelihood of completing the fieldwork.

The eight 'first' interviews lasted between 54 and 104 minutes, with a mean length of 78 minutes.

5.3.6.1.2 Photo elicitation in the first interviews

One of the difficulties with discussing alcohol consumption is that due to the stigma attached to drinking during pregnancy, women might under-report (Muggli et al., 2015). The literature review had suggested that some women who drink during

pregnancy may be marginalised and may have previously experienced intervention from child and family services, and I knew that women may also feel anxious about child protection and other implications of disclosure and may therefore be protective, defensive, or guarded about disclosing their views about drinking during pregnancy. I wanted to overcome these barriers by depersonalising the discussion – looking outwards, to 'other' people or situations, and thought the use of images could help to facilitate this. I therefore built photo elicitation into the topic guide for the first interview; this involves the use of images as stimulus material to elicit discussion about issues that are complex and difficult to explore (Harper, 2002; Margolis and Pauwels, 2011) – for example, the way alcohol consumption during pregnancy is perceived and portrayed.

I selected images portraying the abstinence approach, fathers, mothers, and services and planned to show them to women as prompts during the interview (see Appendix 12 for images). Previous research has found that participants find it easier to talk about some aspects of social context, for example SES, when they are talking about other people rather than themselves (Elliott et al., 2015). The photos were also intended to support women to consider their thoughts about broader aspects of pregnancy, motherhood, and alcohol (Wise and Stanley (2006) call this the 'extra-local'), rather than focusing only on their experiences as individuals (which would implicitly assume that participants were 'immersed in the local'). I hoped that this would help to decentre the research, enabling it to encompass broader sociological and policy issues affecting women.

All the women took part in the photo-elicitation aspect of the first interviews, and the photos opened up discussion about topics that may otherwise have been difficult to get to (for example, what it means to be a good mother, our judgements about other people). In some of the interviews the photo-elicitation worked better than others – some of the participants seemed to find it helpful to have pictures to look at, while others seemed to have come to the interview with something to say and did not reference the pictures very often. With others, the pictures were a good way of providing structure and supporting participants to return to the topic area.

5.3.6.1.3 Photo-elicitation task

Participants were invited to participate in a photo task at the end of the first interview. This task aimed to explore different aspects of their day-to-day lives, and their perspectives on the benefits and drawbacks of drinking during pregnancy (see Appendix 13, photo activity sheet). Participant-led photo elicitation is an established method which is intended to help participants to reflect on their lived experience (Drew et al., 2010; Lapenta, 2011; Tinkler, 2013). To support participants with this, I provided some brief open questions and guidance on the task sheet, but a more structured approach, in which a list of topics is provided (Tinkler 2013) was rejected as this research is largely exploratory and to further guide participants may have affected the topics or issues participants chose to include.

I explained the task and gave the instruction sheet and camera to women who expressed an interest in participating. Studies have found that participants have been keen to participate in photo tasks (Clark & Anderson, 2014), although this method had not previously been used with the population of this study, so I expected that some participants may not wish to participate in this task.

Participants were provided with digital cameras to keep or could choose to take photos on their mobile phones if they preferred (Wilkinson, 2016). I showed participants how to use the digital cameras and explained that any photos they took remained their property and would not be given to the researcher or reproduced in any reports or publications. An early draft of the photo task guide sheet was reviewed by members of the public, including pregnant women and some women who had experience of drug use during pregnancy, and some were concerned about what might happen to the photographs, or that the photos could be used against them. For this reason, I re-wrote the research materials to strongly emphasise that all aspects of the research were optional, and that the photos would always remain the property of the participant.

Completing this type of task involves abstract thought and self-reflection, which some people find difficult (Drew, Duncan and Sawyer 2010). I emphasised that participants could contact me if they had any concerns or required any help with the task. All the participants who had a first interview expressed an interest in this task and took a camera and task sheet. Only one of the women took photos and brought them to the

second interview; the other three who had a second interview had reflected on the questions on the task sheet without taking photos, and both had made notes in preparation.

5.3.6.1.4 A longitudinal element

I decided at an early stage that I wanted to interview each participant more than once, for two reasons. Firstly, to acknowledge that women's views and accounts may change over time and in different contexts (Corden and Millar 2007), including between pregnancy and postnatal periods, and throughout the child's early years. Secondly, to offer participants time and space to reflect on and develop their own views throughout the research process. This is particularly important, as the study encourages participants to consider their drinking in the context of a social model of alcohol consumption (Staddon 2016), which may involve participants 'challenging dominant assumptions' (Kleinman, 2007), which they may not be used to (Staddon 2013), and which may therefore necessitate time and space to reflect (Drew et al., 2010).

There were, however, some practical decisions to be made about the timescales involved in the repeat interviewing. Previous longitudinal studies suggest that interesting research can emerge as participants' accounts can change over time and as research relationships develop and participants have space to reflect (Chandler 2013), but that there may be challenges around the retention of participants between meetings (Corden and Millar, 2007). I was aware that these challenges would likely become more serious the longer the gap between the interviews, but that leaving a longer gap in between may present an opportunity for interesting comparisons between the two time points when it came to the analysis. Eventually I decided to leave the timescales very open, between one and ten months, in order to ensure that retention rates were as high as possible for those who agree to participate in the photo elicitation task and/ or second interview, increasing my chances of staying in touch with participants, whilst allowing sufficient time for the use of photos and reflection between interviews.

I considered including participant validation by showing participants a summary of the first interview and asking them whether there was anything they would change or add, and whether their views, thoughts or feelings had changed, in order to support a shared understanding between researcher and participant (Ramazanoglu and Holland,

2002). Ultimately, I decided against participant validation, due partly to time constraints within and between interviews and partly due to concerns about whether it would be meaningful; was I really willing to change my own understanding of the interview to reflect that of the participant? I wanted to consider aspects of drinking that may challenge dominant narratives and was concerned that a reliance on participant validation may present a barrier to this, particularly as I was unable to base the study on PAR methodology (see section 4.6), which could have enabled the exploration of dominant and alternative narratives with participants.

Beverley Skeggs addressed this theoretical and ethical issue in her feminist ethnographic study of 83 white working-class women in the UK; although this study was not concerned with drinking, it highlighted the lack of alternative discourses available to women in order to explain their situations and experiences. Skeggs' study, which included three years' full-time participant observation, found that many of the difficulties experienced by participants were the result of structural inequalities, but that the only discourse available for the women to discuss their problems was individual pathology and personal responsibility (Skeggs, 1997). Reading around reproductive citizenship had led me to believe that this focus on individual responsibility was likely to be relevant to drinking during pregnancy (see chapter 2).

In her 2001 editorial considering the usefulness of checklists for evaluating qualitative research, Barbour argues that participant validation can lead to researchers abandoning their own analysis and blindly accepting that of participants (Barbour, 2001). Although I could still see the benefits of participant involvement, I decided that taking a reflective approach to the interviews, and being aware of the contingent, changing nature of accounts may be a more responsible approach in this case.

5.3.6.1.5 Second interviews

All participants in the drinking women group were offered a second interview which would be led by participants' descriptions and interpretations of their photographs (see Appendix 14 for topic guide 2). This enabled the participants to have more control over the research agenda (Luttrell & Chalfen, 2010), and was intended to support discussion of sensitive issues by enabling participants to control the level of self-disclosure (Oliffe & Bottorff, 2007). The second interview was intended to explore

aspects of their day-to-day lives since the previous interview, the perceived benefits and drawbacks of drinking during pregnancy, and any changes in perspective or circumstances and context since the first interview. This enabled exploration of the ways in which women's contexts and accounts changed over time (Corden & Millar, 2007), specifically between pre-and post-natal, and early and late postnatal contexts, to make comparisons possible during data analysis, thus helping me to understand the complex, fluid ways in which various aspects of women's lives intersect and relate to their drinking behaviour.

The four second interviews all took place between 4 and 8 weeks after the first interviews and were, as anticipated, shorter than the first interviews, lasting between 26 and 42 minutes.

5.3.6.2 Data collection - women who have been pregnant

In addition to interviews and photo-elicitation with women who reported drinking during pregnancy, one focus group and two interviews were undertaken with women who had been pregnant. These focus groups/ interviews were intended to consider women's views about drinking during pregnancy, including policy and practice approaches, regardless of their own experiences of drinking. It was intended that the data from these groups would improve the comparative potential of the data by including women who did not drink and women who drank at 'low risk' levels.

Focus groups were chosen as the method for this group, because this would enable different views and opinions to be explored in relation to each other (Barbour, 2013). In addition, the issues around confidentiality that had prevented focus groups from being used in the initial planned study were less relevant to this group because the topic guide was more focused on views and opinions than personal experience (see Appendix 15 for topic guide). I undertook one focus group and another two interviews separately (due to a planned focus group turning into two separate interviews due to participants' childcare needs on the day). Six women took part in this part of the research.

There was no requirement to disclose drinking behaviour to take part in a focus group/ interview but in practice women also used the focus groups to discuss their own

drinking, and three of the six women described drinking alcohol during their own pregnancies. This led me to reflect on the wisdom of grouping women according to whether they did or did not drink during pregnancy – I intended to include these focus groups to improve the comparative potential of the data, but in practice there was a lot of overlap between the 'women who drank' group and the 'general women' group.

5.3.6.3 Data collection - practitioners

Practitioners were invited to participate in a focus group because I wanted to encourage discussion and debate within groups. Barbour argues that focus groups 'encourage…questioning discourse', because participants are unlikely to agree about the topic from the outset, so focus groups enable the researcher to examine the ways in which people frame their arguments and reach consensus (Barbour, 2013, p43). I planned to carry out three multidisciplinary focus groups across various geographical locations in Scotland and hoped that this would enable me to compare practice across the geographical areas. This was particularly important as guidance for professionals on supporting women who may be the most at risk, and evidence about the effectiveness of interventions for this group is lacking in Scotland and the UK (Lui et al., 2008; Stade et al., 2009), so it may be the case that drinking during pregnancy is dealt with differently across Scotland. I knew that some of the participants may know each other, which I felt was ethically acceptable because the focus groups would focus on professional opinion rather than personal experience.

The main challenge with carrying out focus groups with practitioners was logistical; finding places and dates that suit a variety of professionals proved challenging, and it became clear early on that a more flexible approach was required. I therefore made another amendment enabling me to speak to staff in focus groups or interviews, which meant that practitioner participants could choose to participate in an individual interview instead of a focus group if they preferred, or if this was logistically necessary. This more flexible approach worked well, and I carried out three focus groups and two interviews with ten practitioners in total. The inclusion of practitioners in the study enabled me to better understand the clinical context in which pregnant women receive care. It also helped me to keep in mind women who drink at 'high risk' levels during pregnancy and who are likely to have experienced multiple adversities and

poverty and marginalisation, and for these reasons and others are probably least likely to be able to participate in the research themselves.

I used a focus group topic guide to inform the discussion (see Appendix 16 for topic guide). Topics included professionals' views on drinking during pregnancy, the practice issues involved in working with pregnant women who drink alcohol, and how women who drink during pregnancy could be helped and supported.

5.3.7 Participant characteristics

The women who participated in the study described their experiences of pregnancy within a very broad range of contexts. In order to illustrate this, I present participant summaries below in the form of tables (see tables 6 and 7) but also include short individual descriptions of the participants.

5.3.7.1 Women who were recruited as drinking during pregnancy:

Eight women who reported drinking during pregnancy participated in first interviews between January and November 2019, and half the women in this group completed a second interview.

Rachel, in her early 30s, was pregnant when I interviewed her. Several of Rachel's children had previously been removed at birth and she was expecting this baby to be taken into care. Rachel described herself as 'a drinker' and said she drank at a very high level before she discovered she was pregnant this time and had drunk throughout some of her previous pregnancies. Rachel had experienced domestic abuse as a child and as an adult and had experienced multiple bereavements including several family members who had died of drug and alcohol related deaths. Rachel said she had felt suicidal in the past, including during previous pregnancies. At the time of the interview Rachel described being in a stable relationship, receiving support from a specialist service for women who are pregnant and have alcohol or drug problems, and maintaining abstinence from alcohol.

Jaime, in her late 30s, had two children, one of whom had been diagnosed with FASD, and the other who lived with the father – Jaime's ex-partner - in a voluntary arrangement. Jaime described drinking alcohol throughout her second pregnancy and using heroin to top-up her methadone as a response to extreme morning sickness.

Jaime described a childhood characterised by extreme violence and poverty, and parental alcohol problems, became homeless as a young teenager, and had experienced anxiety and depression since her teenage years. She was in an abusive relationship when she became pregnant and was single, in receipt of benefits and living in rented council accommodation at the time of the interview.

Cathy, in her late 30s, had three children who all lived with her, and was in receipt of housing benefit and Department for Work and Pensions (DWP) maternity pay. She described chronic stress, anxiety and depression, housing difficulties and homelessness, financial difficulties, witnessing violence as a child, and family members having problematic drug and alcohol use, and reported drinking daily for as long as she can remember, including throughout her most recent pregnancy.

Ellie, in her mid-30s, had two children under the age of five years. She owned her own home with her husband, had a postgraduate degree and was working in a secure, well-paid role. She described a happy childhood and a strong support network of friends and family. She described drinking a glass of wine, a pint of shandy or a cocktail once or twice per week throughout pregnancy, after avoiding alcohol completely during the first trimester.

Karen, in her early 40s, had three children and owned her own home. She was married but not currently living with her husband although he owned another home nearby, they continued to co-parent, and Karen described him as supportive. She described a good support network of friends. She recalled a difficult but financially secure childhood in which her father had left, and Karen had cared for her mother who had physical and mental health problems. Karen had been taking medication for depression and anxiety on and off since she was 16 and described experiencing bulimia for ten years previously in her life. At the time of the interview Karen considered herself to have an alcohol problem, was receiving treatment including medication and counselling, and was abstinent from alcohol. Karen described limiting her drinking to the weekend and drinking no more than three glasses of wine per week throughout her pregnancies.

Niamh, in her mid-30s, had two children and described drinking 1-2 units once or twice per week throughout both her pregnancies. She described a happy childhood and a

strong support network of friends and family, including a supportive husband with whom she owned her own home. Both Niamh and her husband were employed.

Isla, who was in her early 30s, had one child, was not in a relationship, and lived with her child in rented accommodation at the time of the interview. She described becoming pregnant unexpectedly when she was 20 and living with her mum, and looks back on the pregnancy as a calm, happy time. She described drinking at a very low level during pregnancy, drinking 3-4 drinks in total throughout the whole pregnancy. Isla described having good support networks and a supportive partner when she was pregnant.

Maddy, in her late 30s, had two children and she and her husband were employed, financially secure and owned their own home. Maddy described a strong support network and a happy childhood. She described drinking one or two glasses of wine per week throughout both of her pregnancies.

5.3.7.2 Participants who were recruited regardless of drinking during pregnancy

Dawn, in her late 20s, had three children who lived with her and was in a relationship with the father of two of her children. They owned their own home and Dawn was not working at the time of the interview but reported no financial difficulties. Dawn described experiencing social work involvement as a child. Dawn described abstaining from alcohol throughout her pregnancies.

Charlie, in her mid-20s, had one child and lived with her partner and child in rented accommodation. She described a happy childhood and a strong support network including a supportive partner. Both Charlie and her partner were employed, and Charlie reported no financial difficulties. Charlie reported not drinking any alcohol after realising she was pregnant (she had had two drinks prior to this).

Kate, in her mid-30s, was married with two children and they owned their home. Both Kate and her husband were employed, and Kate reported no financial worries or health difficulties. Kate reported abstaining from alcohol completely throughout both of her pregnancies and when she was planning to become pregnant and described herself as a weekend binge drinker before she was pregnant.

Sophia, in her late 30s, was married with two children and they owned their home. Both Sophia and her husband were employed, and Sophia reported no financial worries or health difficulties. Sophia reported drinking wine at a very low level and always with food, and continued to do this occasionally throughout her pregnancies.

Eilidh, in her late 20s, was married with one child and they owned their home and were both employed. Eilidh reported no financial worries or health difficulties. Eilidh described abstaining from drinking whilst trying to become pregnant and during the first and second trimesters but drinking at a low level throughout the third trimester.

Alison, in her mid-30s, was married with two children and they owned their home. Alison was not working at the time of the interview, but her husband was employed, and Alison reported no financial worries or health difficulties. Alison, who had been pregnant four times and had two miscarriages including a late miscarriage, described abstaining from drinking alcohol on discovery of pregnancy until after 16 weeks of pregnancy, and then drinking at a low level throughout.

5.3.7.3 Participant summary - practitioners

A total of 10 practitioners from specialist drug and alcohol services across five health boards in Scotland participated. Practitioners had a range of job titles, so in order to ensure anonymity when reporting the findings, I grouped them into three broader categories according to specialism, including: maternity/child health (five participants); addictions (two participants); and social work (three participants).

Table 6: Practitioner participants

Pseudonym	*Practitioner category*	*Focus group or interview*
Alex	Addictions	Focus group
Anna	Maternity/child health	Focus group
Caroline	Maternity/ child health	Focus group
Irene	Maternity/ child health	Focus group
Jane	Maternity/ child health	Interview
Jean	Social Work	Focus group
Julie	Maternity/ child health	Focus group
Lynne	Social Work	Focus group
Sam	Addictions	Focus group
Val	Social work	Interview

Table 7: Summary of participants - women

Pseudonym	*Recruited due to drinking during pregnancy*	*Drank during pregnancy*	*Specialist drug/alcohol services during pregnancy*	*SES*	*Focus group or interview*	*Second interview*
Alison	No	Yes	No	High	Focus group	No
Cathy	Yes	Yes	Yes	Low	Interview	No
Charlie	No	No	No	Low	Interview	No
Dawn	No	No	No	Low	Interview	No
Eilidh	No	Yes	No	High	Focus group	No
Ellie	Yes	Yes	No	High	Interview	Yes
Isla	Yes	Yes	No	Low	Interview	Yes
Jaime	Yes	Yes	Yes	Low	Interview	No
Karen	Yes	Yes	No	High	Interview	No
Kate	No	No	No	High	Focus group	No
Maddy	Yes	Yes	No	High	Interview	Yes
Niamh	Yes	Yes	No	High	Interview	Yes
Rachel	Yes	Yes	Yes	Low	Interview	No
Sophia	No	Yes	No	High	Focus group	No

5.3.8 Ethical issues

The study gained a favourable ethical opinion from the NHS South East Scotland Research Ethics Committee No.1, and the Edinburgh Napier University School of Health and Social Care Research Integrity Ethical Approvals Committee before recruitment and throughout the fieldwork when I made amendments (see section 5.2.4). NHS Research and Development Office approval was also obtained from the participating health boards. The ethical considerations discussed during the REC process are explored below.

5.3.8.1 Informed consent

Participant information sheets were provided before the study and were read to all potential participants to overcome literacy barriers. Throughout the research I made it clear to participants that they could withdraw from the study at any time or opt to participate in some aspects but not others (for example, women may not wish to take part in the photo task but may consent to a second interview). Participants chose a variety of levels of participation, with some opting to participate in all three parts of the research (first interview, photo task and second interview), some having a second interview but not doing the photo task, and others preferring only one interview.

When seeking informed consent, I considered questions developed in line with good practice (NHS, 2000) when assessing capacity to consent, and if at any point I was in any doubt that a participant could provide informed consent, I would not have sought written consent and the interview would not have taken place.

5.3.8.2 Confidentiality and child/ adult protection

I obtained an NHS research passport to conduct this study, which meant that I was required to adhere to interagency child protection and adult protection procedures, including the need to share information regarding concerns around adult or child protection if risk of significant harm was identified or suspected. I knew that I could not guarantee confidentiality because of the possibility that respondents may disclose child or adult protection issues. I explained this to potential participants so that they understood the circumstances in which confidentiality would not be maintained, giving examples to help illustrate what was meant by the terms ‘child protection/ adult protection issues’ and ‘significant risk of harm’. A plan was in place to discuss and agree any actions in response to any adult or child protection concerns with my

supervisors as they arose and if necessary, I or my supervisor would have involved relevant services in cases where the immediate safety or wellbeing of a participant or a child was at risk.

There could be potential ethical implications around confidentiality when discussing alcohol and pregnancy in a focus group setting, because it was not possible to guarantee that all participants would respect the confidentiality of fellow participants. For this reason, women in focus groups were not asked about whether they drank during pregnancy, but about their general views and opinions on the topic. My experience as a mother suggested, however, that women may choose to discuss their own experiences of drinking during pregnancy, so at the beginning of the focus group participants were reminded about the need to respect the confidentiality of other participants. The PIS and consent form also explained the boundaries of confidentiality in a focus group setting. In the women's focus group all the women talked about their own drinking, including during pregnancy, and I was confident that they chose to do this and did not do so due to perceived pressure or expectations.

5.3.8.3 Handling sensitive topics

Fieldwork included the discussion of sensitive topics including alcohol consumption and potentially other drug use, pregnancy, relationships, adversities, and experiences of services including child protection involvement. It was possible that participants may become upset or emotional during or after the interviews.

I had a plan in place for this eventuality; if participants become upset during the interviews, I would pause the interview and ask the participant if they would like to continue or not and it would be made clear that the interview could be stopped or postponed if they preferred. However, I felt it important that emotion should not be assumed to be necessarily negative; and will form part of the data (McCormack, 2004). However, the wellbeing of participants was the primary concern, and if continued involvement in the project could place the participant at risk, this would be discussed with the participant. A protocol was in place in case further support was required; I would take appropriate steps to help the participant arrange further support (after obtaining consent from the participant), for example by contacting a friend or support worker of the participant or making an appointment with the GP. If emergency help or

support were required, I would contact my supervisor and agree an immediate support plan for the participant, for example a referral to emergency psychiatric services.

In practice, participants did occasionally become upset, but when I offered to pause or stop the interview they always chose to continue. Jaime, for example, told me before I turned the recorder on that she found it difficult to talk about her drinking, but that she felt it was important to share her point of view. Rachel became angry at points when describing her experiences with the child protection system; this did not require a pause because she very clearly wanted to tell me about her experiences and me asking her whether she wanted to pause or stop at this point may have given her the impression that her expression of her feelings was in some way wrong or unacceptable to me, and I felt it very important not to give her this impression, particularly when one of the things making her angry was her lack of 'voice' within the system.

I anticipated that some of the participants may be experiencing adversity and difficulty. This made it crucial that wherever possible, the research ended on a positive note, and that there was an opportunity to say goodbye and thank participants and to signpost them to ongoing advice and support should they require this. A debriefing information sheet (see Appendix 17) was given to all participants to keep at the end of each interview.

5.3.8.4 Researcher safety

I followed the University and NHS lone working policies and had a fieldwork safety protocol, so my supervisor always knew where I was. I texted or called the designated supervisor before and after each participant interview. I followed the Social Research Association's Code of Practice for the safety of social researchers (Social Research Association, 2001), which includes safety protocols for issues such as the assessment of risk, interview precautions, strategies for handling risk situations (e.g., people who are aggressive or drunk), as well as debriefing after fieldwork.

5.3.8.5 Data management

I created and followed a data management plan for the study to ensure the security of personal and research data (see Appendix 18).

5.3.8.6 Power and exploitation

Consideration of issues around power and exploitation are considered key by many feminist researchers including Wise and Stanley (2006), for whom ensuring non-exploitative research is a key aspect of creating 'moral knowledge'. In her reflections on her own research methodology, Parr describes using '…feminist inspired research practices' in order to '…ensure that my research was ethically responsible' (Parr, 2015, p197). I attempted to do this throughout the planning of the study in the following ways:

1. *Being respectful and non-exploitative*

In their focus groups with 27 women who use drugs and had previously been involved in research studies, Bell and Salmon found that women felt 'dehumanized' by their participation in research. They described feeling like 'guinea pigs' and focused on the importance of researchers explaining why they were doing the research, what would happen with the results, and treating participants with respect (ways of doing this included not repeating the same question over and over, not trying to sway participants towards saying certain things, and not being condescending) (Bell & Salmon, 2011).

It has been argued that it is not appropriate to give drug users money, often based on the assumption that this is enabling their drug use (Anderson & Dubois, 2007). Conversely, participants in Bell and Salmon's focus groups were clear that they felt it was disrespectful to decide what they should spend their money on when others who were not considered to be drug users were not expected to account for their spending, and that being paid for their time made them feel valued and respected. Good practice guidance on this topic now states that participants should receive out of pocket expenses (Health Research Authority, 2014; INVOLVE, 2012), and in line with this, participants received a £20 voucher (of their choice) to cover expenses for each interview they completed, to cover expenses such as travel, childcare, phone calls and subsistence. The provision of expenses payments seemed natural and obvious to me, but it created some concern at the University REC. The problem regarded the choice of gift card, which presented administrative problem and, for some, a moral problem, as they did not want 'alcoholic' women to be given gift vouchers which could be spent on alcohol. I found this argument paternalistic and classist; the shops which offer greatest

value for money (for example on baby clothes) are generally supermarkets, which also sell alcohol, so if we followed this guidance, the £20 gift vouchers would stretch nowhere near as far for the participants. The supervision team were required to provide further evidence to advocate for the use of this approach, and the use of a choice of gift card was eventually approved.

2. *Power and the research relationship*

Ann Oakley cautioned against 'objectifying your sister' in her discussion of the problems with interviewing women about personal issues (Oakley, 1981). She overcame this by answering all questions as fully as necessary and by offering participants support with childcare and household tasks while interviewing them. I could not do this because my research needed to be approved by the NHS REC, and I felt it highly unlikely that they would approve this. I expected, however, that participants may ask me personal questions, and I decided early on that I would answer these as honestly as possible, without disclosing too much personal information, to minimize the power imbalance in the research relationship. Answering questions does not, however, negate the power dynamics that accompany a research study (Ramazanoglu and Holland, 2002). To redress the balance to some extent, I explained to participants throughout the study that their help was being sought as they were experts in this field; they had knowledge that I did not have. I made it clear to women throughout every meeting that they could choose whether to answer all my questions, how far they wished to participate in the research, whether to show me any photos they took, and when they wanted to have breaks during interviews.

I was surprised how few questions I was asked – some participants asked if I had children and one participant asked me about breastfeeding, but nobody asked whether I drank alcohol. The women who asked me questions about my life all had high SES and possibly would have asked them anyway, so it may be that my attempts to balance the power dynamic were ultimately unsuccessful, or that the women who did not ask questions were so used to a deeply skewed power dynamic that they simply accepted it.

5.3.9 Data analysis

It was important that the analysis aligned with the theoretical position of the study, so I explored a range of options and considered different ways of conducting the analysis

before settling on a narratively informed approach to reflexive thematic analysis. This enabled me to use reflexive thematic analysis (Braun & Clarke, 2019a) as a practical method of analysis, whilst remaining aware of the socially situated nature of participants' accounts.

5.3.9.1 Narrative analysis

Narrative analysis enables researchers to explore the ways in which participants tell their stories, and how they use narrative frameworks or dominant narratives, which connects participants' individual accounts with their cultural contexts. Rather than accepting participants' accounts as representative of fact or truth, researchers can use narrative analysis to consider how research participants are constrained by the narrative frameworks that exist in the time and place they are telling their stories (Fleetwood, 2014; Woodiwiss et al., 2017). It is important to acknowledge and explore these frameworks because if only some narratives become accepted as truth this can make it difficult to challenge these narratives and offer alternative explanations, which has the effect of dismissing or silencing alternative narratives, which in turn has practical implications for the way researchers, members of the public, and policy makers understand and therefore respond to situations. This is exemplified in Langley's research with young women who had experienced partner violence, which found that they utilised dominant narratives around romance that justified, romanticised, and legitimised their partners' violence. This helped the women to make sense of what happened, but Langley argues that it also damaged them, as it enabled them to normalise, and therefore accept the violence, while at the same time blaming themselves for not leaving the relationship (Langley, 2017).

Loseke argues that paying attention to 'socially circulating stories' is a crucial step in understanding how individual stories reflect and reproduce wider narratives (Loseke, 2013). Loseke's research explores why some stories are more persuasive than others; those that are based on systems of meaning that are widely circulating and deeply held are more persuasive than others, while those stories built on contested 'codes' (units of meaning) are less convincing and will therefore have a smaller audience. Having explored existing research and policy about drinking during pregnancy during the background and literature review, I thought it was possible to identify certain dominant stories based on deeply held meanings (babies as vulnerable and in need of

protection, women as choosing to drink, women as responsible for keeping babies safe, what makes a good mother), and that little space was available for alternative explanations. It was therefore important that this research allowed space for these alternative explanations and did not simply accept participants' accounts as the only possible explanation.

Recognising dominant narratives can make it possible to challenge dominant assumptions. The dominant narratives that are available often reflect the position of those where power is concentrated (Stanley & Wise, 2006; Wise & Stanley, 2006; Woodiwiss et al., 2017). This can prevent those who do not 'fit' this narrative – those with less power - from '…emerging in their [own] stories as subjects with their own needs.' (Lockwood et al., 2017, p209). Instead of creating research projects that simply accept participants' accounts unquestioningly, they argue that feminists should ask: 'Are there better stories that could be told to explain and improve the lives of the women in our research?' (Woodiwiss, 2017, p33-34), and that '… the opportunity and the challenge for feminist narrative research is to enable the telling and hearing of those 'better stories'' (Lockwood et al., 2017, p211).

Practical approaches to narrative analysis vary widely, ranging from a focus on language structure to a focus on the function of stories (Kim, 2016). Language-based approaches, for example Riessman (Riessman, 1993) did not seem a good fit for this study because I wanted to take a more flexible approach which would allow me to analyse the data thematically while also treating the data as contextual and related to broader stories.

Although some narrative researchers and feminists including Wise and Stanley (2006) caution against 'fracturing' data by taking it out of context, in later work, Riessman argues that narratively informed thematic analysis works by '…identifying common thematic elements across research participants… while also preserving narrative features' (Riessman, 2007, p74), pointing out that this type of analysis focuses more on 'the told' than 'the telling'. This aligned with my wish to ensure that specific aspects of women's lives were considered in the research, in order to make the research practically useful, which was also reflected in my semi-structured approach to the data collection (see section 5.3.2.4). This meant that participants had not told their stories uninterrupted; they were responding to the questions I asked them, so it would have

felt disingenuous to claim to take a more 'purist' approach to narrative analysis because the methods I had chosen did not reflect this. Throughout the analysis I continually returned to the interview transcripts to read the data in its original context rather than relying only on the coded data. This helped me to retain a sense of participants' stories and to ensure that the themes made sense in relation to the transcripts.

Taking this type of narrative approach also enabled me to remain mindful of women who drank at a 'high risk' level, even though (and perhaps because) there were fewer of them; previous research (Broadhurst & Mason, 2017; Kenny et al., 2015; Morriss, 2018) suggests that the women who have been most harmed by the current child protection policy and practice approach may go 'under the radar' after pregnancy, so I knew it was especially important to make the best possible use of the accounts women in this situation had shared with me. I therefore made sure to carefully examine the differences and similarities in themes but also stories and storytelling in each participant's account, in the potential differences in women's accounts and practitioners' accounts, and the accounts of women who had been involved with specialist services.

5.3.9.2 Reflexive thematic analysis

Narrative approaches attracted me because they treat data as accounts which are situated within the broader context of society. I wanted to find an approach to analysis which could retain this sense of 'situatedness' but also enable practical comparisons and recommendations to be made about the topic. Thematic analysis has often been described as an unsophisticated or uncritical form of data analysis, in which data is simply grouped into categories with similar data, and the dataset is summarised; little analysis takes place (Braun & Clarke, 2019a). Braun and Clarke argue that this is based on a misunderstanding of what thematic analysis is; a practical method of analysis which researchers can tailor to their own theoretical approach.

Central to Braun and Clarke's (2019) reflexive thematic analysis is that the theoretical commitments and values of the researcher are always a key part of analysis and should be made explicit, and be reflected upon, throughout the analytical process (Braun & Clarke, 2019a). Some qualitative analysis texts talk of themes 'emerging' from the data

(Braun & Clarke, Accessed 2020). Having reflected on the process of generating themes while undertaking early drafts of the literature review, I had begun to question this idea, as I had noticed that the themes that 'emerged' from the literature were similar to the themes I was interested in; I felt that I was unwittingly giving more importance to some ideas than others. Further reading crystallised these ideas; Paley analysed the interpretations and analysis of several research studies and concluded that '…each analyst will find in the data a reflection of themselves' (Paley, 2016, p162), and that it is important to examine our ideas and expectations about a topic before embarking on analysis. Wise and Stanley argue that this analytical subjectivity is impossible to overcome; research always presents the perspective of the researcher, and so we should make this subjectivity explicit in our analysis, rendering it visible to those who read and critique our research (Wise & Stanley, 2006). For this reason, I tried to record each stage of the coding and theming process as it happened, and to be as transparent as possible in the way I coded the data. In order to avoid making claims about themes 'emerging' from the data as if the data contained the 'truth' waiting to be found, I have attempted to be explicit about my starting positions and how these relate to the knowledge claims I make.

5.3.9.3 Analysis in practice

When conducting the analysis I followed the six phases identified by Braun and Clarke (2006). These phases involve: first, becoming familiar with the data; second, generating codes; third, creating themes; fourth, reviewing these themes; fifth, defining and naming the themes; and sixth, reporting the analysis. I discuss each of these phases below.

5.3.9.3.1 Phase 1 – transcribing and field notes

All the interview audio recordings were transcribed either by me or a transcription company with a data agreement with the university. I then fully anonymised them. I took field notes as soon as possible after each interview or focus group and used these notes in addition to the transcripts. This enabled non-verbal communication and inflection to be considered when analysing the data. Analytic summaries of the coded transcripts were discussed in supervision sessions with the research team.

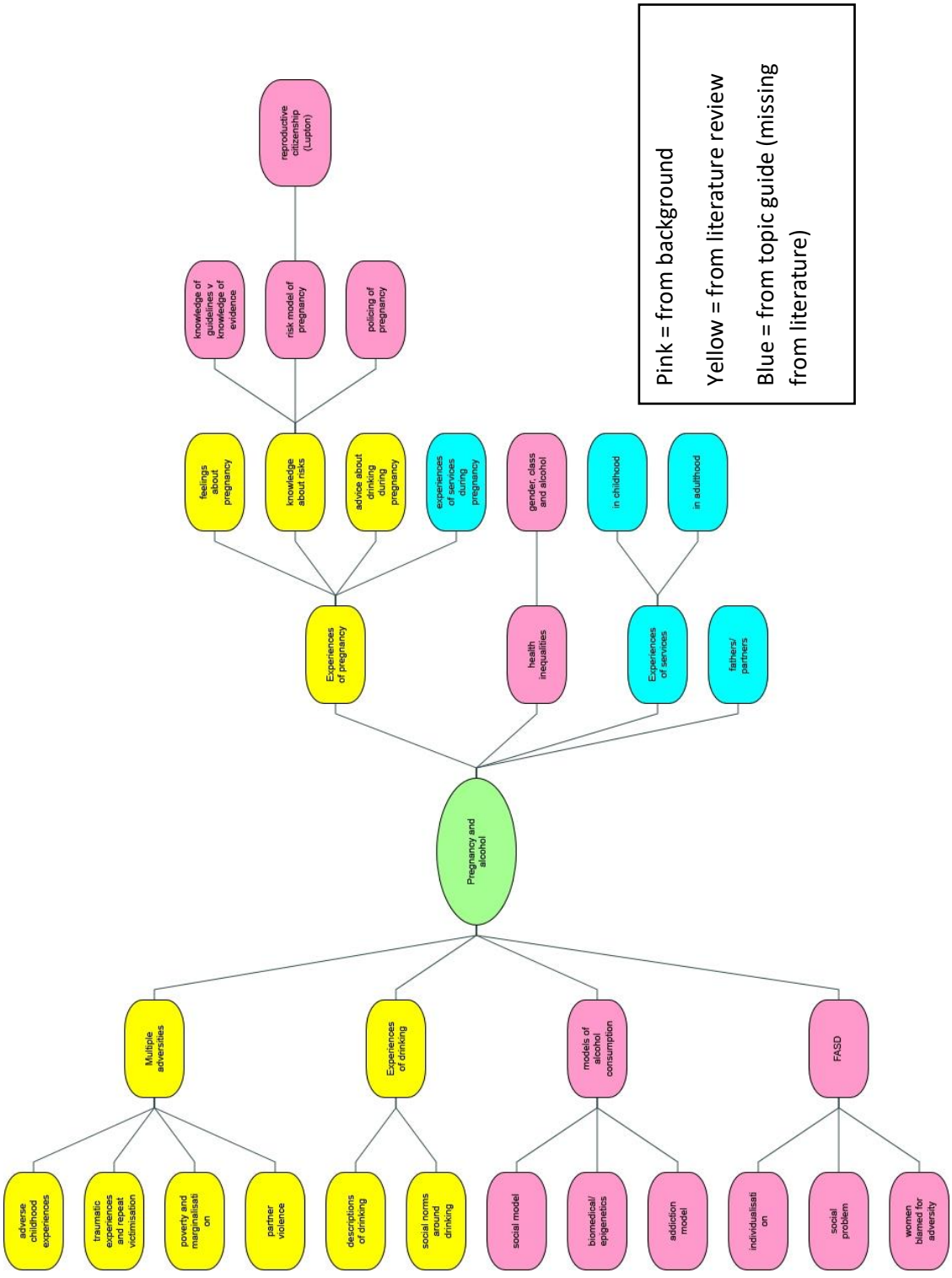
5.3.9.3.2 Phase 2 – developing an initial coding frame

I began the analysis by making a provisional coding frame based on issues identified in the background and literature review I had conducted, as well as some additional issues that I had included in the interview topic guides because they were not addressed in previous research (see figure 6 for provisional coding frame).

I used the provisional coding frame flexibly as the data was analysed, merging deductive and inductive approaches (Fletcher, 2017). I took this approach in order to ensure that the study included some of the issues that I thought were key but had not always been included in previous research (for example women's views about alcohol treatment services, the role of fathers) but also allowed space for participants to shape the data. I expected that the number of codes would increase throughout the analysis as issues that I had not anticipated arose from the interviews/ participants. As anticipated, the process of 'doing' the coding was time consuming and sometimes messy.

The number of codes I generated as I began phase 2 of Braun and Clarke's RTA quickly grew, and each new data item (interview or focus group) prompted new codes; when I finished coding the first interview (Rachel), I had used 26 codes (including some new and some unused from provisional coding frame). This was because things came up in the interviews that I had not included in the provisional coding frame. For example, when Rachel was talking ideas around the importance of place kept coming up – how her experience of drinking, for example, was different between the place she grew up and the place she now lived. This kept coming up in different ways during the interview, so I coded it as 'importance of place' because it did not fit with the pre-existing codes but seemed to be something different and potentially important. After coding the first four interviews (plus one second interview) there were 55 codes (compared to 31 in the initial coding frame), and some of the codes were very broad, for example 'descriptions of drinking' started as a sub-code of 'drinking during pregnancy' but ended up containing all women's descriptions of drinking, before during and after pregnancy. In this way it acted as a sort of holding code until I had time/ space to look at all the descriptions again (both within the code and within the context of each individual transcript) and see how best to organise data that included descriptions of drinking.

Figure 6: Provisional coding frame



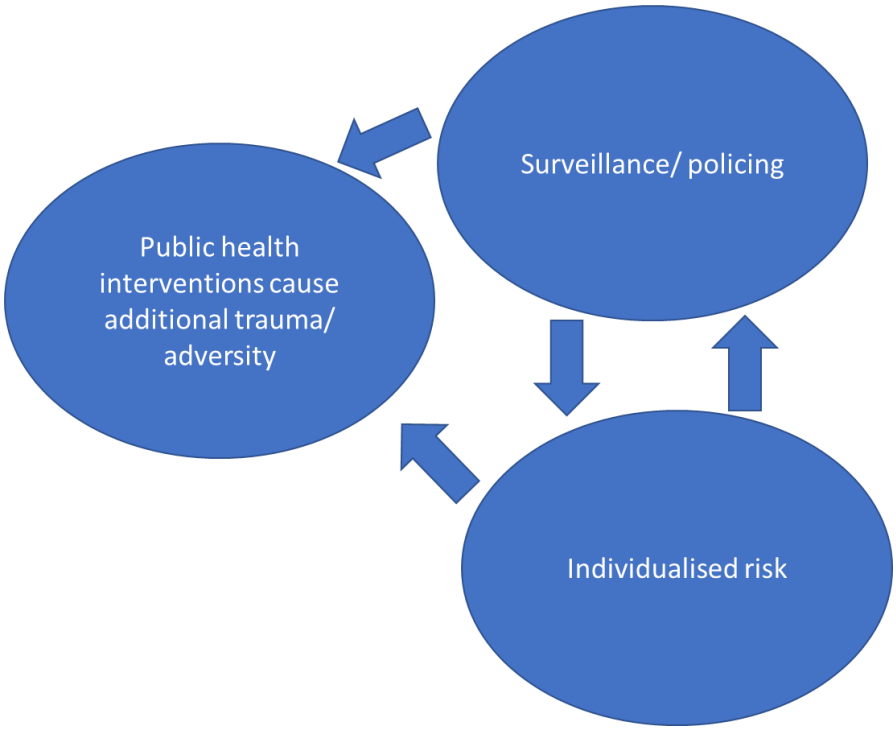
As I coded each interview and the number of codes in the coding frame increased, I returned to earlier data items to recode them in the light of the new codes. As the number of data items grew this approach became unwieldy; due to the constantly shifting nature of the codes it became hugely time consuming to return to all previous data items each time new codes were generated, so instead I continued to code each data item, adding to the coding frame as I did so, then once all the data items were coded I returned to the first item and recoded it using the more comprehensive coding frame, until all the data items had been coded using the final coding frame. This was also an opportunity to check the consistency of my coding and ensure that everything was coded as intended; I did this by reading through the collated codes, but also re-reading each transcript, including coding, from start to finish.

Once this process was complete there were 127 codes (see Appendix 19 for list of codes).

5.3.9.3.3 Phase 3 – developing analytic themes

Once I was confident that I had coded the data as intended, I used the codes as 'building blocks' to create 'candidate themes'; potential themes that include interesting data and concepts. I had uploaded the anonymised transcripts to NVivo and coded them within NVivo, so it was easy to collate all the data in each code together using this software. Some of the codes were repetitive or referred to different aspects of the same issue (for example 'baby as overriding mother' and 'foetus as a person or mother versus foetus') so I collated these into the same theme, keeping all the data that may be relevant to each candidate theme together at this stage so that I did not miss any potential aspects of each theme. Most of the data extracts were coded into more than one code, which meant that some of the data extracts spanned candidate themes, and I did not try to undo this repetition at this stage because I wanted to be able to see what the candidate themes looked like, how they fit together, and to keep it as flexible as possible to avoid getting stuck in or wedded to the candidate themes which could make it harder to progress with the analysis and reach a better understanding/ interpretation of the data.

Figure 7: Initial thematic map of candidate themes

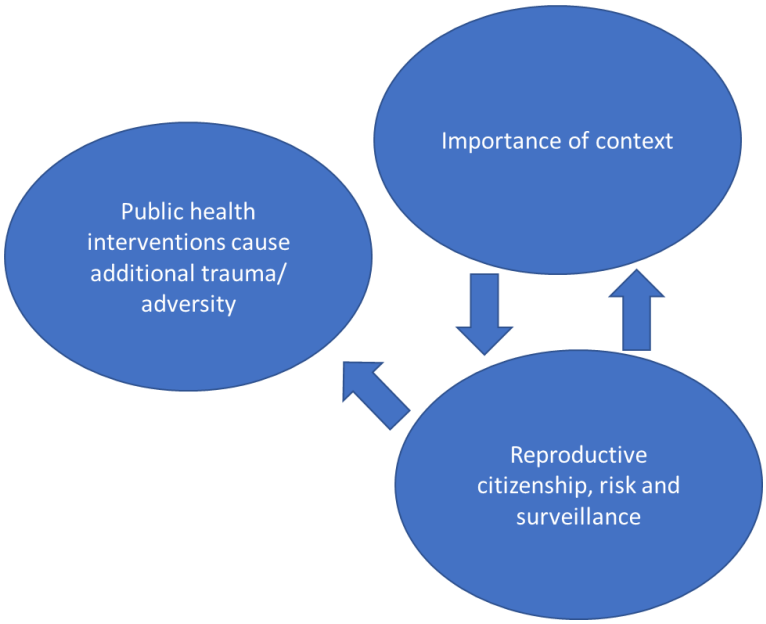


5.3.9.3.4 Phase 4 – testing themes

Braun and Clarke recommend 'testing out' candidate themes by mapping them out and considering them in relation to the research questions, to explore whether they answer them; each other, to see whether they tell a compelling story and to check for overlaps between themes; and the data, to check that they are not missing any key aspects of the story (Braun et al., 2019). When I tested out the candidate themes by returning to the entire dataset – both the coded data and the interview transcripts - I realised that a key aspect of the data which was not adequately reflected in the candidate themes was the importance of the wider context of women's lives and their drinking. In addition, I was not confident that the themes could answer the research questions without explicitly including this aspect of the data.

After a long-winded period of writing and re-writing potential thesis chapters around individualisation and surveillance, I also realised that they were proving difficult to write because there was a lot of overlap between them, and after further thought and discussion I decided that they would fit better if they were combined into one theme. I created another thematic map to reflect these changes (see figure 8) and repeated the process of testing it out.

Figure 8: Second thematic map of candidate themes



I was now more comfortable that the themes captured the interesting and important aspects of the data, and they related to the research questions in ways that the original themes were unable to; for example, the context theme directly related to several of the research questions.

5.3.9.3.5 Phases 5 and 6 – finalising themes and writing up

When I read through the content of each theme again, I felt that they were not all sufficiently 'internally coherent' – the 'reproductive citizenship, risk and surveillance' theme was more like a domain summary; the 'central organising concept' or 'essence' of the theme was unclear (Braun & Clarke, Accessed 2020). I undertook a more detailed mapping of the candidate themes (see figure 9) to help me to identify and foreground the central organising concept in each theme, which highlighted significant areas of overlap between the 'reproductive citizenship, risk and surveillance' and 'impact of UK policy and practice approach' themes and enabled me to better understand how to represent the relationships between the themes and make each one internally coherent.

After the mapping, I returned again to the coded data which had formed the basis of the 'reproductive citizenship, risk and surveillance' candidate theme and realised that because this theme had arisen from my combining of two previous candidate themes, I had not adequately highlighted the central organising concept, which was about

accounts suggesting that it was women's responsibility to keep babies safe and holding women accountable when they were unable to do this. When I reorganised the data to reflect this change, the two previously overlapping themes became more separate, and each was more internally coherent.

As I continued to write the findings chapters and refined the names of some of the themes and sub-themes to better capture their meanings (see figure 10 for final thematic map), I became aware that the three themes were analytically distinct: although my approach had remained consistent throughout the analytic process, the degree of focus on narrative varied across the themes. The 'contexts and complexities' theme focuses on the ways in which drinking and contexts intersected in the accounts of women and practitioners, and is more focused on demonstrating these substantive findings than on analysing participants' narratives. The second theme, 'mother blaming', highlights the dominant narratives reflected in the accounts, and the third, 'powerlessness and marginalisation' explores the impact of these narratives on women, particularly those who are marginalised. This analytic variation across the themes – and therefore the findings chapters – was necessary to answer the research questions, to do justice to the complexity of the data, and to enable its use in future practice and research.

Figure 9: Thematic mapping to identify overlap between themes

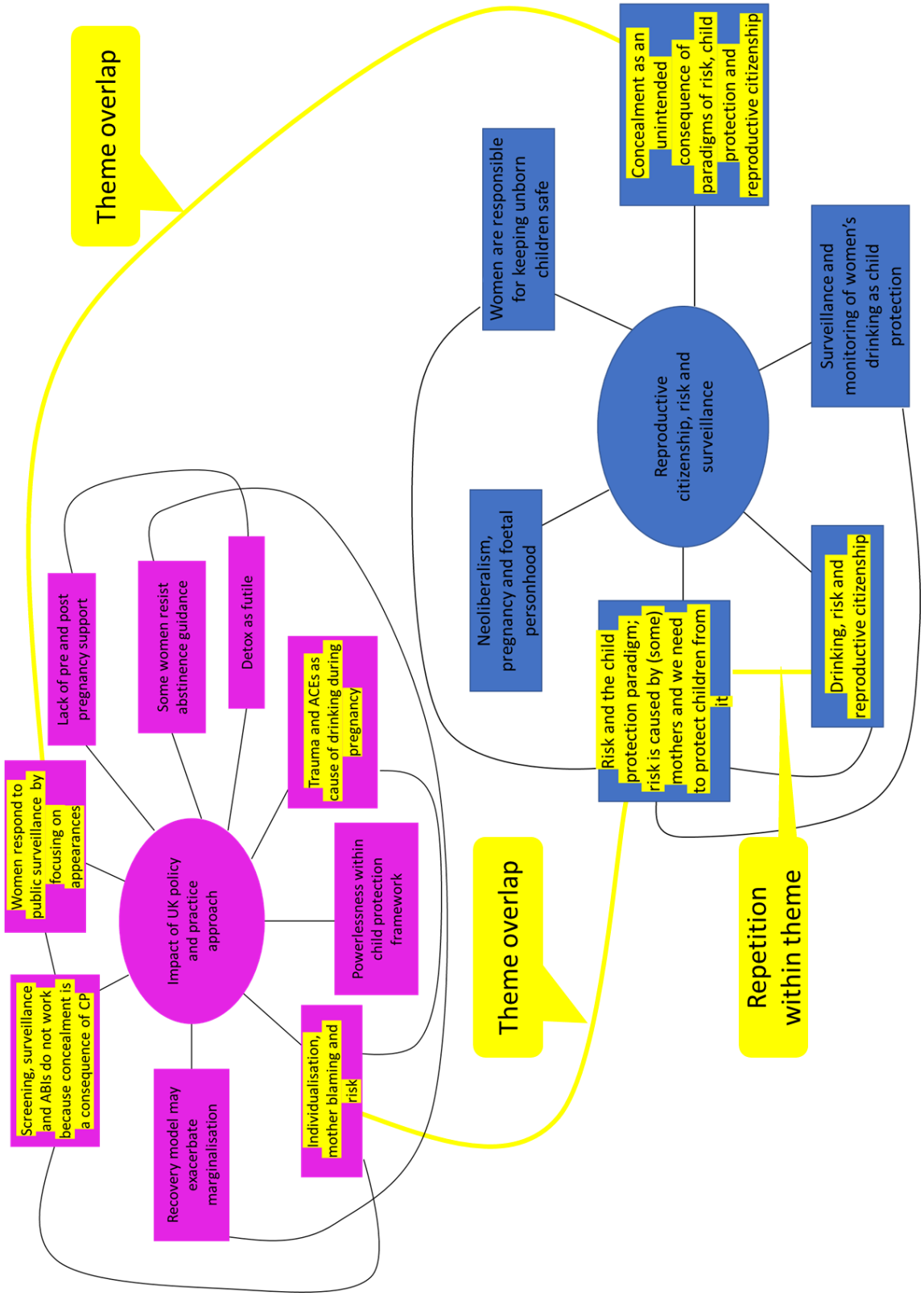
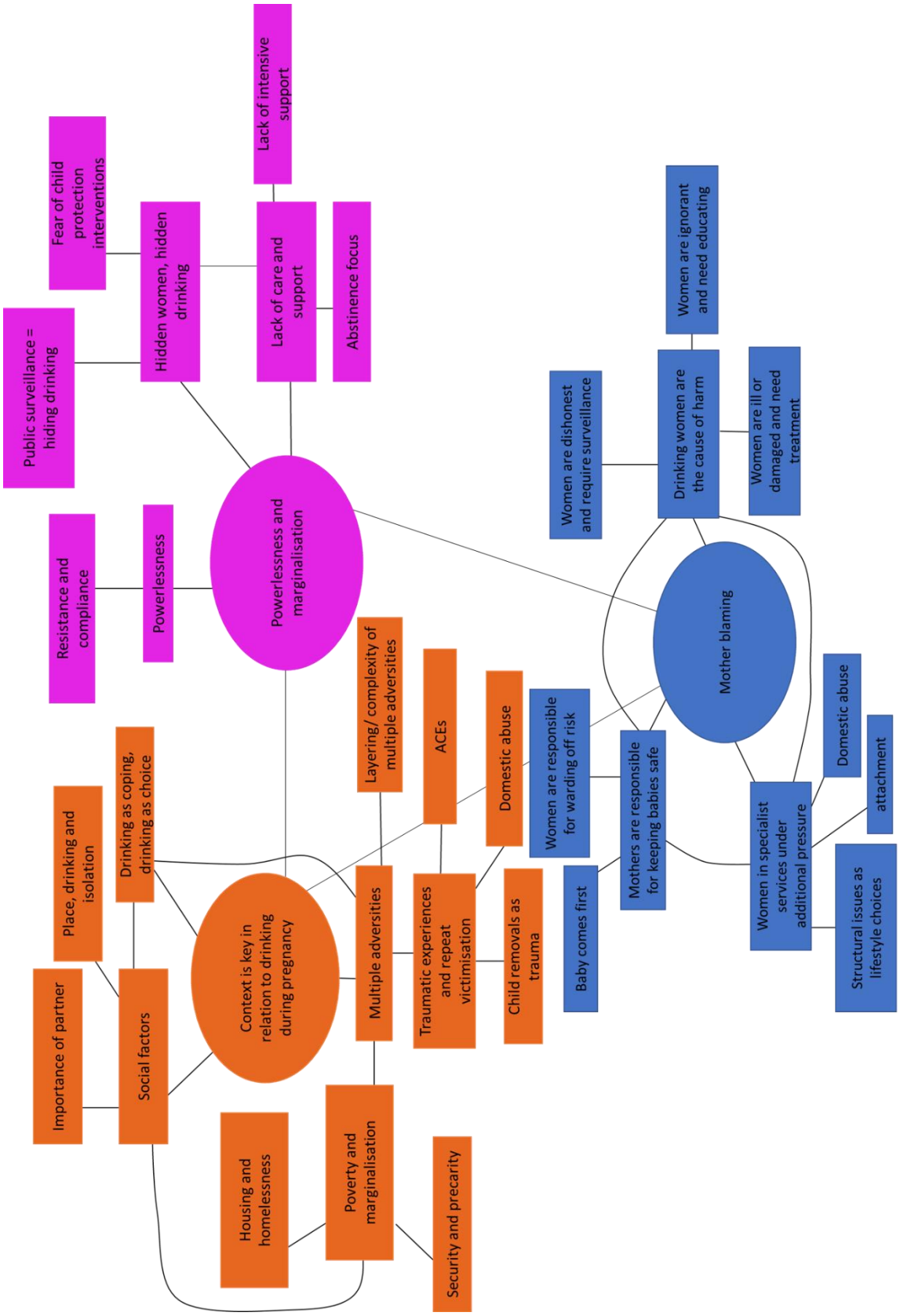


Figure 10: Final thematic map



5.4 Conclusion

This chapter has provided a reflexive account of the research methodoloy and methods employed in this thesis, including the ethical and practical challenges of doing research aiming to centre the accounts of a marginalised group. It has highlighted the differences between the original research plan and the actual research, in order to make my thinking and decision-making transparent.

Despite the challenges involved in recruiting participants, it was possible to complete a combination of semi-structured interviews and focus groups with women and practioners, and to analyse these using a narratively informed approach to reflexive thematic analysis. This resulted in the development of three main themes: contexts and complexities; mother blaming; and powerlessness and marginalisation. The following three chapters report on each of these themes in turn.

Chapter 6 – Contexts and complexities

6.1 Introduction

One of the central tenets of my study is that women's drinking, including drinking that happens during pregnancy, is connected to the rest of their lives. Women are pregnant in the context of the rest of their lives, and women drink in the context of the rest of their lives; neither pregnancy nor drinking occur in a vacuum, so it is crucial to consider the contexts in which women drink during pregnancy. Similarly, Patsy Staddon argues that women's drinking intersects with other aspects of their lives and should be viewed in its wider context, including consideration of the ways in which alcohol consumption may help people to deal with structural problems such as inequality (Staddon, 2013, 2016). Previous studies of women's alcohol use in pregnancy have largely neglected these contexts (see chapter 3), so I ensured a focus on these was built into the design of my study.

This chapter explores the interconnected contextual factors such as trauma, poverty, and social factors that women and practitioners described as important in relation to drinking during pregnancy. The women who had been involved with specialist services during pregnancy had all been affected by multiple interconnected adversities and marginalisation, and their accounts usually framed drinking as a way of coping with these, which contrasted with the accounts of other women, who mainly framed drinking as a choice.

There are four sections in this chapter: first, traumatic experiences and repeat victimisation; second, poverty and homelessness; third, social factors; and fourth, contexts, coping and choice.

6.2 Traumatic experiences and repeat victimisation

Many of the women recounted traumatic events such as bereavement or violence, although they did not usually use the term 'trauma'. The women who had accessed specialist services, however, described multiple, repeated trauma, and the multiplicity and repetition of the adversities they experienced contrasted with the discrete traumatic events described by other women. Rachel, Jaime, and Cathy described childhoods and adulthoods involving multiple traumatic experiences, including violence, isolation, mental health problems, and loss through bereavement or separation, often repeatedly. They described multiple traumatic events from many sources throughout their lives; they had all witnessed extreme and repetitive violence as children, experienced several bereavements in a short space of time, and Rachel and Jaime had both been victims of domestic abuse. Rachel had also had several children removed from her care, and Jaime and Cathy had experienced homelessness. Similarly, practitioners described the pregnant women they worked with as having experienced repeated, ongoing, complex trauma, and this seemed akin to the accounts Rachel and Jaime gave of the trauma they had experienced:

> '… quite a lot of my women, as I call them, are, the trauma issues they have are either related back to childhood, or they have been involved in some kind of abusive relationship, in their early teens, kind of adulthood. And there's a high proportion of women out there, who are so unlucky to have, you know, really quite complex trauma, it's just been one event, after another event, after another event. And they are the most difficult to work with.'
>
> (Val, Social Work Practitioner)

This conceptualisation of trauma as an 'event' or series of events, but also 'trauma issues' and 'complex trauma' as something that an individual either has or does not have reflects a medical understanding of trauma as events that happen to somebody, causing psychological problems which make women and situations 'difficult' (see section 7.4.3 for further discussion) (Khantzian, 2017). In recent years there has been a move towards 'trauma informed' models of working which aim to understand the

impact of trauma and structure services accordingly, and this approach was evident in practitioners' accounts, as they always acknowledged the trauma women had experienced.

Practitioners described domestic abuse as something experienced by many of the women who used their services. This is unsurprising, as previous research suggests that it is common for women who attend specialist substance use services to report experiencing abuse (Humphreys et al., 2005). Jaime and Rachel, both of whom accessed specialist services during pregnancy, described experiencing repeat victimisation throughout their lives, including during pregnancy. The domestic abuse they described was repeated, long term, controlling and violent. Jaime described how her partner when she was pregnant, in addition to physically abusing her, ensured that she did not have the opportunity to speak to practitioners alone, which had an impact on the maternity care she received, and on her ability to leave him:

> 'I was never left on my own to talk to anybody, he was always there with me to make sure that I wasn't saying anything that I shouldn't be saying and things like that but… they were all done at his dad's house, ehm, at that time that's where I was living with him, I was kind of in a small box bedroom and that's where I'd spend my life was in that bedroom.' (Jaime)

Rachel described a similar situation in which she was unable to tell practitioners about the abuse she faced. Rachel explicitly connected her alcohol consumption with the abuse, describing her alcohol consumption as a way of coping with the abuse she experienced. Previous research with women who attend services because they drink problematically suggests that women sometimes drink as a way of coping with domestic abuse, although many women do not attend treatment services, so the extent of this link is unknown (Galvani & Toft, 2015). Although practitioners highlighted the high incidence of domestic abuse among women using their services, they did not usually explicitly frame it as connected to women's reasons for drinking; it was more often framed as a risk factor for the baby which women must control (see section 7.3.2) than an aspect of women's lives that may contribute to their reasons for drinking.

6.2.1 Child removals as trauma

Although practitioners' accounts reflected their awareness of trauma-informed approaches, their accounts simultaneously implied that the current system for women who drink during pregnancy was unable to provide a trauma-informed response in practice because of a lack of intensive services (see section 8.4), the timescales involved, and the possibility of exacerbating women's trauma by enforcing child protection interventions. The practitioners in my study acknowledged the impact of child removals on women, and some of the practitioners explicitly acknowledged the trauma caused to women by the removal of their children, and usually explained this as an amplification of or addition to pre-existing trauma.

> '… the type of patients we would see are… very challenging because this group particularly are heavily…I would say very traumatised and all…the…trauma from past history but also previous pregnancies as well and removal and all those things are thrown in and can be very challenging.'
>
> (Alex, Addictions Practitioner)

Alex acknowledged the impact of child removals and the complexity of the trauma women in specialist services had often experienced, emphasising this complexity by repeating the word 'challenging'.

For Rachel, who had experienced multiple child removals and was facing another when she gave birth to her next baby, the impact of having her children removed was key throughout the interview. Child removals – a state sanctioned trauma – were framed as key events that has caused her problems, and a crucial part of the repeated victimisation she had experienced throughout her life.

> 'But if I had my kids and I had a better life I wouldn't be what I am today, I'd be so happy, having them all in your care, and to have that, like that life you've always wanted, so honestly I wouldn't be like this today, like just getting that chance.' (Rachel)

Rachel kept returning to the impact of child removals throughout her interview, stating that her life would be completely different if she had retained custody of her children, that previous child removals had not taken into account the impact of the trauma she

had experienced, and that services had been focused on the children at her expense. It was clear throughout the interview that the repeated removal of her children had been a major recurring trauma on top of the other multiple traumas she had experienced. Previous research with women who have had their children removed suggests that child removals have a profound and permanent impact on women's lives (Kenny et al., 2015; Morriss, 2018). It is unclear how services for women who drink during pregnancy, which take place within a child protection paradigm (Featherstone, 2019), can be expected to take a trauma-informed approach when child removals are such a key aspect of the trauma women experience.

6.3 Poverty and homelessness

Unlike discussions about trauma, conversations about poverty usually happened only when I started them. This may reflect the dominant framing of drinking during pregnancy as an individual psychological, rather than social and policy, issue, so that participants were not expecting to discuss the structural determinants of health during the fieldwork. When these conversations did take place, practitioners highlighted the impact of poverty on women's lives, saying that most of the women using their services had low SES and that poverty had become more extreme in recent years. Practitioners said that many of the women using their services experienced poverty and made it clear that the austerity policies of the UK government had made this situation worse, with the families they support experiencing more extreme poverty in recent years. Throughout the fieldwork it was clear to me that practitioners understood the far-reaching impact of poverty on people who were already marginalised, but they had no remit, budget, or tools to address this; they were in an untenable position in which it was impossible to adequately support women without also addressing this much wider issue:

> 'And then sometimes, when we have the clinics, we put out brownies…although we're not meant to…but we put, you know, treats. Just for them to come in and just get a wee, you know, a wee treat.'
>
> (Val, Social Work Practitioner)

Many practitioners described trying to mitigate this poverty, for example by handing out food vouchers and using their services' welfare funds, and some talked about 'bending the rules' to help women who needed food but did not want to be referred to the service. Several practitioners described providing high-calorie food at community groups to ensure women were able to eat and offering cakes and biscuits in clinics.

There was a palpable sense of hopelessness from practitioners as conversations about poverty developed; they acknowledged that punitive Government policies such as welfare sanctions, for example benefits such as Jobseekers Allowance being frozen due to a missed appointment, were harmful to women and families, and that change needed to happen at a policy level:

> 'You know, it's like, would we work…yeah, we're working in a way that we get our … salary, you know, and…yeah. But in that case, you have to wait and then sanctions, you know, and for the reasons that people are being sanctioned, I suppose it is very challenging. And it just feeds into the expectations from society and really if change needs to happen, it has to be at that level.'
>
> (Sam, Addictions Practitioner)

While practitioners were more explicit than women about the impact of poverty, they did not usually make explicit connections between poverty and drinking, instead leaning on narratives that prioritised links between trauma and ACEs and drinking (see section 7.4.3).

Practitioners commonly talked about poverty and inequality, while women did not usually describe it in these terms. Although poverty had affected the lives of some of the participants - the women who had been in specialist services (Rachel, Jaime, Cathy) had low SES and were experiencing or had experienced poverty and marginalisation – they usually focused on symptoms of poverty such as homelessness.

6.3.1 Housing and homelessness

Women and practitioners said housing was crucial. Women who had experienced homelessness (Jaime, Cathy) were very clear that this was one of the biggest influences on their lives when they were pregnant. Their accounts of housing and homelessness underlined the impact of poverty on women's lives, including their

parenting and their drinking. Cathy, who became homeless during her pregnancy, linked her experiences of homelessness and financial stress to her drinking. Cathy described a range of stressful factors that she was dealing with during pregnancy, and highlighted financial worries and homelessness as the most stressful of these, explaining that her daily drinking in the evening helped her to cope:

> '… my landlord serving a homeless...a letter to get her property back, so it [drinking] was my release kind of thing. It was my release; it was like my thing and selfish or not it did help me. I see it as if it helped me in a way. I know it'll maybe not have helped the baby but, in a way, it helped me to deal with everyday pressure if you can understand.' (Cathy)

Cathy's account highlighted the central importance of practical issues such as housing and financial support. These issues also permeated Jaime's account. Jaime had become homeless as a child and experienced insecure housing as an adult. When she was pregnant, she lived with her abusive partner in his father's house and had nowhere else to go. She could not ask for help because of her fear of her baby being removed from her care so the only place she could flee from her partner was to her sister's house, and she ended up drinking when she went there because her sister was alcohol dependent (see section 6.4.1). This left Jaime with few practical options – she could stay with her abuser or seek help from services. When the social worker and housing officer secured her a local authority house when her baby was born it changed her life:

> 'Aye [yes], I was so lucky getting that house. But it's not alw – coming out of homeless into somewhere like that you just never hear it ken [you know] what I mean you're usually quite in a, not a very desirable place. I think they really worked hard though to make sure I was in a place where I was gonna make the best go I could… cos I abandoned the house before, fleeing domestic violence and stuff, so I think they just wanted to give me the best chance with Connor, aye [yes], they done good there eh!... even as far as coming out of homeless, you only get 2 days to get into a house with absolutely nothing… So between her and this housing officer they got me carpets, they got me a settee suite, all second hand stuff or borrowed stuff. But it was enough to get me and my son into the house, aye [yes] so, I dinnae ken [don't know] where I would've been,

> cos I dinnae ken [don't know] how I would've done it in 2 days with absolutely nothing, newborn baby' (Jaime)

Jaime had continued to live in this house with her son for several years, and she emphasised throughout the interview the impact being safe and settled had had on their lives, both because of the links they had built up within the local community, and the house itself, which suited their needs and made it easier for Jaime to look after her son:

> 'I'm in a really quiet area, ehm, front and back door, massive back garden for my son, especially with the way he is, ehm, he's not got really stranger danger or road sense or, ken [you know] he would just run out, so having this big enclosed back garden where I can put the swings and the trampoline and, aye [yes]… and just have the back door open in my kitchen, or outside with him, we've got a wee dug, runs up and down with him all day every day… Aye [yes], he's such an outdoor person, he loves being outdoors, ehm, sometimes my anxiety gets in the road of taking him out places and that, so just having that back garden there I can have everything outside for him… there's erm, one or two that've got kids that'll come over to the back garden and play with Connor, and erm, obviously because were local to the nursery there he knows them from nursery and that too…' (Jaime)

Jaime and Cathy's accounts highlighted the crucial importance of housing quality and availability on all other aspects of their lives, including drinking and escaping domestic abuse. Practitioners across all the health boards acknowledged that housing was often a problem for the women who used their services, although the nature and extent of this problem varied by geographical area. Although practitioners often initially stated that pregnant women did not experience homelessness, as our conversations progressed it became clear that homelessness affected many pregnant women, because housing services were so stretched that even though pregnant women were prioritised, adequate accommodation could still sometimes not be provided. Some practitioners described situations in which women were pregnant and sleeping on the streets:

> '… in this day and age, there should be no pregnant women on the streets… Because if that's the case, the women are normally put up in, like, a B&B for the night, or anything like that. There have been some cases where people have been told to go away, given a sleeping bag, and then come back the next day.' (Val, Social Work Practitioner)

More commonly, practitioners talked about the challenges presented to women by temporary accommodation and the practical problems, as well as loneliness and marginalisation, this caused. Practitioners described women being offered accommodation which was far away from their friends and family, in areas which were difficult and expensive to reach by public transport, and which would sometimes necessitate their older children moving schools, or require the women to change buses several times to get their children to school. Temporary accommodation was problematic for women because of the lack of connection with the community that this facilitated. Some of the practitioners described how the isolation caused by temporary accommodation compounded the other adversities women faced; aside from the financial implications of travelling long distances on public transport, the anxiety and depression experienced by many of the women using these services was described by practitioners as compounded by moving around constantly.

> 'And you're expecting people to…they've got poor enough, you know, relationships with their families as it is, but you're then taking them away to a different area. I mean, for us, that's fine, we drive. But they don't have much money to travel and, you know, leaving them…and they're already…you know, have got usually anxiety disorders of some kind. Putting them somewhere completely by themselves, they don't know anybody.'
>
> (Anna, Maternity/Child Health Practitioner)

In addition, some practitioners stated that housing issues affected decisions about child removals, with local authorities' rules about minimum standards for children's accommodation, for example babies not living in hostels, indirectly affecting some women's ability to take their babies home with them. Similarly, if they were only offered a hostel in which to live during pregnancy, they could not realistically be expected to meet the criteria set by practitioners and services to retain the custody of their own children, for example having suitable accommodation, and 'gatekeeping'

(see section 7.3 for further discussion of the expectations placed on pregnant women in specialist services).

> Caroline: 'We have a lot of women in hostels and things…'
>
> Julie: 'I suppose it is difficult, they do usually get into a temporary flat at some time before they go into labour…'
>
> Caroline: 'So erm, the baby's, in that situation usually in care isn't it and that's what quite often we've had a couple of parents who've had to go back to hostels, not for very long, having delivered their baby – baby's in care and they've still not got their own tenancy, I mean it's really bad…'
>
> Annie: 'And in terms of… women who have been in a hostel … is the housing connected to the decision to take the baby into care?'
>
> Julie: 'erm…'
>
> Caroline: 'I suppose it's a factor'
>
> Julie: 'It's a factor, it's definitely a factor. It's often not their own fault, they've not, you know they can't say you've not got a house, you're not having your baby home, but there would need to be a safe place for the baby so yes the decision would … have we got situations where women are doing really well in a hostel? (pause) I can't think of an example of that… the situation that created them to be in the hostel, you know, and that, and they're around other drug dealers, and its, they're not the most pleasant places to be, and that's just putting an understatement on it… so housing do consider that I guess and priority don't they and… yeah… its unusual, that's probably an unusual setting when baby's in care and mum's, parents are still in a hostel but it has happened, but I would say that again that's not the most normal scenario…'
>
> (Julie and Caroline, Maternity/Child Health Practitioners)

Although practitioners emphasised that it was unusual for women to be homeless by the end of their pregnancies, I was struck by the uncertainty and lack of control with which some women were expected to live during pregnancy. Practitioners described situations in which women did not know whether they would be able to take their

babies home or whether they would have anywhere to live. I found this disturbing as I thought back to my own pregnancies and considered how this level of uncertainty would have felt, and how I would have coped in this situation. Practitioners described women having to move house but having no choice about where they were moving to, and being judged while doing it, with an increased likelihood of going into labour before the house was ready, and with little support from family and friends, while heavily pregnant. This seemed extreme to me; the odds seem to be stacked against women succeeding. Some practitioners acknowledged this, hinting that services often require women to survive, and even thrive, in situations that are made almost impossible by factors they cannot control. This extended to talking more generally about poor housing and areas where some of the women lived, which practitioners found difficult to be in:

> 'You know that going in to a…because we're in a community, going to certain areas, going in to the flats, you actually feel yourself, like, oh…I'm having to go, I'm having to get in to the lift. I mean, we obviously work by ourselves quite a lot but even I, like, get in to a lift and I'm thinking…that, kind of, like…you know, you do get a bit like, oh I wonder who else is going to get in to the lift with me, things like that. So that's you and you don't even live there. You know, that's how you feel. Imagine, like, going there every single day…You have to go there every single day. No wonder, you know, they're so…their mood's so poor.'
>
> (Anna, Maternity/ Child Health Practitioner)

Despite acknowledging the difficulties involved in some women's living situations, and although practitioners sometimes drew links between 'depressing' areas or housing and 'poor mood' and 'motivation', they stopped short of linking it to drinking.

The descriptions from Jaime, Cathy and practitioners illustrated the impact of homelessness and precarious housing on pregnant women, and this was emphasised further by its stark contrast with the accounts of women who had not experienced homelessness or poverty, who described situations characterised by stability and security. The women who had no financial or housing problems emphasised the importance of feeling settled during pregnancy. When I asked Niamh what the good

things in her life were when she was pregnant, her house was the first thing she mentioned:

> ‘We’d been married for about a year and half [when I became pregnant] and had a nice little house. I mean that was, you know, virtually unheard of in [area]. Most of my colleagues, most people lived in a flat, for one thing but we had a tiny house with a tiny garden and a cat. And had a healthy pregnancy.’
>
> (Niamh)

Similarly, Karen emphasised the importance of living in a big house in what she appeared to perceive as an area made for families:

> ‘We live on a modern estate, so a lot of their friends live on the same estate, it’s suburbia, you know? It’s kind of middle-class suburbia, you know everybody’s the sort of same and it’s a new build and… it suits our needs, you know we’ve got a front and back garden, driveway, we’ve got space, and it’s what you need when you have a young family.’ (Karen)

Although Isla’s situation contrasted with Karen’s, because she was living with her mum when she became pregnant while Karen emphasised the need for ‘space’, they both focused on the importance of security. Isla described living with her mum during pregnancy as a positive situation; she had lived with her mum and her gran since she was born, and throughout both her interviews she described the positive relationships she had with the two women.

> ‘I was still staying with my mum and I never really had any worries; it was quite carefree and I was excited because I was having a baby.’ (Isla)

Although they were in different situations, Isla, Niamh and Karen all described being in secure, reliable situations which meant they did not have to worry about their finances and housing. This contrasted strongly with the accounts of Jaime and Cathy, and the women described by practitioners, who described chronic anxiety compounded by their precarious housing and financial situations.

6.4 Social factors

Women talked about their friends and families', and partners' drinking, and many of the participants described their own drinking being affected by the drinking of others, although this was much more of an issue for women whose lives and relationships were more intertwined with alcohol and who risked losing relationships and being lonely if they stopped drinking.

6.4.1 Place, drinking and isolation

Many of the women said that whether their friends and family drank alcohol affected their own drinking, before, during and after pregnancy. The women who were most surrounded by people who drank, and in which drinking was a central activity (Rachel and Jaime) were most vulnerable to isolation and lack of support if they stopped drinking. Jaime and Rachel, who described family and friendship groups in which drinking was a central activity, appeared to be more affected by friends' and family's drinking than the other women did. Jaime, who described herself as having several addictions including alcohol, associated her sister with drinking and during pregnancy would drink with her sister whenever she left her partner:

> '… whenever I left my partner I'd go to my sisters, ehm, my sisters got an addiction as well, I suppose I was finding it hard with the alcohol being in the house and around me a lot, so aye [yes], there was a few times I ended up picking up a drink when I was, when I found it too hard…' (Jaime)

Jaime's account of going to her sister's house when she left her partner contrasted with Karen's account of starting a home detox – Karen owned her own home and had a supportive partner, a secure job and a support network of friends to help her with the detox and post-detox period. Jaime lived in her abusive partner's dad's house and had nowhere else to go when she had to leave her partner except her sister's house. In comparison with Karen, Jaime's SES provided an additional challenge when trying to stop drinking: she had no home and no access to safety except at her sister's house, where alcohol was a prominent feature of her sister's life.

Similarly to Jaime, Rachel, who described herself as dependent on alcohol, appeared to connect drinking with particular people and particular places. She described her Mum,

brother, and Dad as dependent drinkers, her mum 'died of alcohol', and brother 'died of drugs and alcohol'; and she described finding it harder not to drink when she went back to visit the town where she grew up. These accounts underline the importance of place, and are reminiscent of Niamh Shortt's contention that those living in areas of deprivation are more bounded, and less likely to experience areas and spaces outside of the places they live, and therefore may be more affected by the drinking (and other 'environmental bads') that are present there (Shortt, 2016).

For Jaime and Rachel, stopping drinking was isolating. They both described attempting to avoid friends or family and places where they were more likely to drink. Rachel, who was pregnant and abstinent at the time of the interview, described avoiding the area where she grew up because all her friends there drank, and family encouraged her to drink:

> 'It's when I'm in, over in [area], that's when I tend to hit the bottle… and when I'm at my sister's house, it's like they want to see me drink, they want to see me not be happy…' (Rachel)

Similarly, Jaime, who was also abstinent at the time of the interview, although she was no longer pregnant, described being careful about when she visited her sister, who she described as an important part of her life, because of concerns that she may start drinking again if her sister was drinking. The loneliness caused by not being able to see their friends or family because of their drinking appeared to compound the isolation Jaime and Rachel experienced. It is also possible that this isolation exacerbated the impact of the domestic abuse they had both experienced, because stopping drinking required them to cut off many of the important relationships in their lives.

Isolation was a problem also identified by practitioners, who also described the women that used their services as often coming from families and friendship groups in which substance use including alcohol was the focus of relationships. Practitioners discussed how they routinely expected pregnant women to stop seeing friends or family who may encourage their drinking, although they could see that this could exacerbate isolation:

> 'I've got a twenty-four year old pregnant woman at the moment who is literally starting from scratch – she's had to just say goodbye to every single person in

her life apart from two members of her family because that's what she had to do to move away from... She doesn't have anyone left in her left really because they're all drug users.' (Lynne, Social Work Practitioner)

The isolation described by practitioners and Jaime and Rachel contrasted with other participants in the study, who described their decisions about whether to drink during pregnancy having little bearing on their relationships with friends and family. This may be because alcohol was not so central to their friends and families' lives, and there was more variety in their lives; they were less bounded, participating in various activities such as working, travelling, and childcare. For women who described drinking at a low level, friends' and family's drinking was less important. Charlie, for example, who described herself as a low-level drinker before becoming pregnant, went on holiday to Ibiza when she was 12 weeks pregnant and did not drink although everybody else was drinking, and this did not affect her friendships because drinking was not the main or sole activity.

Even women who abstained or drank at a low level, however, described struggling to navigate their friendships when pregnant, and drinking was part of this. Isla, who was one of the first in her friendship group to become pregnant, described the impact that not drinking had on her social life during pregnancy, because drinking had been a key social activity before she became pregnant:

'… we didn't go out and not drink, that just didn't happen… it was mostly… me being pregnant and not going out and, you know, there being a lot of alcohol and I'd be like, oh, yeah, I don't want to kind of be around it, kind of thing…' (Isla)

Charlie and Isla's accounts of not drinking during pregnancy highlighted the choices that were available to them; Charlie was able to not drink but still go to Ibiza and dance; Isla was able to choose not to go out and to stay at home with her supportive family. These accounts contrasted strongly with those of Jaime and Rachel, and with the women described by practitioners, whose choices were severely limited by their pre-existing isolation and precarity, and further limited by their attempts to cut down their drinking. The isolation experienced by women who tried to stop drinking was highlighted in the meta-ethnography, with women in some of the studies saying they

felt they would be excluded from their social networks if they stopped drinking, and other studies finding that women relied on their drinking friends out of necessity, because no alternative support was available (Badry, 2008; Zabotka, 2012). The isolation of some of the women in my study concurred with this, with the women who were most surrounded by people who drank, and in which drinking was a central activity (Rachel and Jaime) being most vulnerable to isolation and lack of support if they stopped drinking.

6.4.2 Importance of partner to experiences of pregnancy and drinking

All the women were clear that their partner affected their experiences of pregnancy and being a parent; some women described their partners as helpful and supportive, whilst others described their partners as a hindrance during pregnancy. Some of the women were able to compare experiences of being pregnant with different partners – Dawn, who did not drink during pregnancy, reflected on her experience of being pregnant and having a baby with two different partners, saying that her experience was different with different partners, one of whom was more helpful and supportive than the other. Jaime also compared two different partners and said the experience of having a child had been completely different because of them; her daughter's father was reliable and helpful, while her son's father was abusive and violent. Similarly, Rachel emphasised the impact of an unsupportive partner when talking about her previous partner, who was abusive and controlling, making pregnancy harder to cope with. This contrasted with women whose pregnancies occurred in the context of supportive relationships, who emphasised how it made the experience easier and less stressful.

Women's partners also influenced their drinking during pregnancy; women described drinking or abstaining with their partners. Some of the women who reported drinking at a low level or abstaining said they found it easier not to drink if their partners were not drinking because they had previously enjoyed drinking together as a couple, and they associated drinking with fun and relaxation. Alison, who drank at a low level during the later stages of pregnancy, found that it was easier not to drink if her partner did not drink in front of her:

> ‘Like even at home if my husband came back and had a drink, I would… want to do it too. So I found it easier when he didn’t drink with me. So then we’d just be at home, both not drinking and it wouldn’t be a thing. But if it’s in front of me, then I want it.’ (Alison)

Although Alison pointed out here that if her partner was drinking she would want to drink, her account also emphasised the relative unimportance of alcohol in their lives; if they did not drink it would not have major consequences for their relationship – it ‘wouldn’t be a thing’. This contrasted with Rachel’s account, which centred drinking or not drinking as a key aspect of her relationships and her life. During her interview Rachel described two contrasting pregnancies: one in which she drank heavily in response to the abuse perpetrated by her partner; and her current pregnancy, in which her partner encouraged and supported her to abstain. Rachel described her new partner as a key reason for her ability to abstain during her current pregnancy:

> ‘I met, ehm, [partner], my partner, got Isla with him, my little daughter, 3, and [partner] used to be an alcoholic, and because I’m with him, it’s actually got me like away from it, cos he helped me get away from it’ (Rachel)

Rachel’s account suggested that in contrast with Alison, drinking was not just an activity which Rachel and her partner could take or leave; it was part of her partner’s identity (he ‘used to be an alcoholic’), and drinking was something she needed his help to ‘get away from’ because drinking had previously been such a central aspect of her life.

Karen, who described herself as alcohol dependent, also spoke about her partner’s role in her ability to cut down her drinking during her three pregnancies. She described only drinking at weekends and limiting her alcohol intake to a maximum of two or three glasses of wine per weekend, suggesting that her partner took a lead role in this decision by imposing drinking rules for her to adhere to:

> ‘… Davie and I had had various conversations about you drink too much, I’m really worried about it and… he was like I’m going to limit your weekend drinking or you know, no drinking during the week, and we only drink at weekends…’ (Karen)

The impact of women's partners on their drinking, however, was not simple; Karen cutting down her drinking, for example, was not wholly attributable to her partner. Instead, she also reflected on times throughout her life when her drinking had fluctuated in response to difficult circumstances, for example drinking extremely heavily as a teenager when she was trying to cope with her relationship with her mother, and later when her children grew older and developed complex health problems and she was stressed at work. In contrast with this, she described a relatively stable and happy period in her life when she first became pregnant; the wider context in which Karen was drinking was important too, not just her partner:

> 'I felt very much alone, growing up alone, dealing with my mum on my own, having, feeling like I had no support network at all, so kind of by the time I was 16, 17 I was… pretty much left to my own devices really, in a sense of … life's been pretty shit, so… you turn to things you think will make you happy.'
>
> (Karen)

Practitioners' views on the importance of partners' drinking concurred with women's accounts that partners' drinking behaviour can affect women's drinking during pregnancy. Many of the practitioners also highlighted the strain that stopping drinking can put on women's relationships if drinking had previously been an activity that women did with their partners:

> Anna: 'One person falls off the wagon, then they both fall off the wagon. That's just the way it…and it comes hand in hand. It's just not possible for two that are dependent to be together…'
>
> Irene: 'And …that can …become a problem for your relationship. If they're both drinkers together or they're drug using and drinking together, when they become sober/detoxed, actually they might not like their relationship. They might not like the other person they're living with.'
>
> (Anna and Irene, Maternity/Child Health Practitioners)

Although my findings concur with previous research that pregnant women's drinking may be affected by their partners' drinking (see literature review), women's and practitioners' accounts suggest that partner drinking is one of many factors affecting

pregnant drinking women and has different meanings for women depending on other aspects of their contexts.

6.5 Contexts, coping and choice

Women and practitioners described contextual factors such as trauma, poverty and social factors as important in relation to drinking during pregnancy. These factors were interconnected, for example SES affected women's ability to move away from traumatic situations such as domestic abuse, and determined where they were able to live, and where women lived affected how isolated or connected they felt.

All the women described adversity of some kind but the women who were engaged with specialist services described multiple intersecting adversities and repeat victimisation, mediated by structural inequalities, which affected every part of their lives including their drinking. Jaime, Rachel, and Cathy, who had been involved in specialist services during pregnancy, all described experiencing multiple extreme adversities throughout their lives; all three described challenging childhoods including many ACEs, and Jaime and Cathy both explicitly discussed poverty and homelessness, while Rachel's experience of loss through child removals, and feeling rejected throughout her life, including by services, had resulted in extreme isolation. Jaime and Rachel both described experiencing long term domestic abuse.

When given the opportunity to do so, practitioners acknowledged the complexity of the lives of the women who used their services, including the many adversities they had usually experienced. Sometimes practitioners included structural adversities such as poverty when they discussed the complexity of women's lives, but often they focused more on individual experiences such as trauma (see section 7.4.3):

> '… our group of women tend to have quite similar life experiences, they tend to come from poverty and they come from complex families and quite often have had a history of maybe domestic violence and they might be victims of domestic violence, so they're not a typical, run of the mill person that walks through the door for midwives. I suppose in a way that can skew it slightly, can't it, because people with addictions, there are a lot of tick boxes that go

with people with addictions and it's not one glove fits all but there's always common themes amongst the women that we work with.'

(Lynne, Social Work Practitioner)

Despite this lack of explicit acknowledgment of the role of structural factors such as poverty in women's experiences of drinking during pregnancy, it appeared to be a crucial aspect of the complex contexts affecting women. Of the eight women who were recruited as drinking during pregnancy, the three who were involved with specialist services all had low SES. This is unsurprising, as practitioners also indicated that most of the women who used their services had low SES, and those living in deprived areas are more likely to experience child protection interventions and receive treatment for alcohol problems (see sections 2.2.2 and 2.5.4). Although Isla had low SES she did not describe experiencing multiple adversities – and Karen, who had experienced ACEs and trauma, but had always had high SES, had not come to the attention of specialist services during pregnancy and described managing to cut her drinking down in preparation for pregnancy.

Previous research suggests that drinking can be a response to living within systems of oppression, and that women whose drinking becomes defined as problematic have often experienced multiple adversities including gender-based violence such as domestic abuse, poverty, and powerlessness (Galvani & Toft, 2015; Staddon, 2012; Williams, 2005). My findings support this research, suggesting that Jaime, Rachel and Cathy, and many of the women practitioners described, had been marginalised by the multiple intersecting contexts – including structural adversities - they had experienced.

When women talked about their reasons for drinking, they gave multiple and varied reasons which were usually related to their wider contexts. Even when women described drinking or abstaining as a choice they made in isolation, it was possible to see how this related to other aspects of their lives. I identified two main narratives in women's descriptions of their reasons for drinking: drinking as coping and drinking as choice. Sometimes women drew on both narratives to explain their drinking, but usually they focused mainly on one.

6.5.1 Drinking as coping

Jaime, Rachel and Cathy, who had experienced multiple adversities, were involved in specialist services, had low SES, and described drinking at a relatively high level (daily drinking or binge drinking) framed drinking as mainly about coping. Cathy explicitly described drinking as coping; she and her three children had been evicted from their home and were facing homelessness (see section 6.3.1), and Cathy was working part time but did not qualify for maternity pay when she unexpectedly fell pregnant. She repeatedly stated throughout the interview that drinking helped her to cope with the challenges she faced which were beyond her control:

> '…but I can safely say – and I keep saying about the alcohol – if I never had to get alcohol through my pregnancy I don't know if I would be where I am today because it helped me cope with a lot. It wasn't an act of selfishness for me, it was an act to...trying to get through the day...' (Cathy)

Cathy's explicit acknowledgement that drinking 'helped' her to cope with living with the financial precarity caused by structural inequality is reminiscent of Staddon's (2012) research with women who had experienced alcohol 'problems', concluding that social injustice, rather than drinking itself, was the problem.

Rachel also described drinking as helpful at various times throughout her life to help her cope with multiple adversities, including during previous pregnancies following the death of her mother when Rachel experienced physical and mental abuse from a series of partners. She stated that drinking helped her to cope with these contexts:

> 'Basically I wanted to kill myself, and to go away, I'd just had enough, like I was rock bottom… Like rock bottom, everything that's happened to me and all that pain, I actually stopped eating and that… I actually feel a lot better compared to how I was before… I think I was just going through all that pain with my mum and that, it's all gone, like it's all gone now, it's like I feel a lot better, and I think the drink's probably helped it… I think it helped with the grieving… But at the same time it made me worse, but when I was grieving and drinking I wasn't as bad.' (Rachel)

Jaime, who was abused by her partner during her pregnancy with her son, had experienced multiple adversities, and was on a methadone prescription, also described drinking as a coping mechanism, during pregnancy and at other times in her life. Jaime's narrative around alcohol was focused on addiction as a way of coping; she described herself as addicted to opiates, and when her methadone prescription stopped working because of her serious morning sickness, she switched back to heroin. When she was with her sister, who drank, she tended to drink; when she was with her partner, who used opiates, she tended to use opiates – she appeared to see the addiction itself as the coping mechanism, rather than a specific substance:

> '…I ended up picking up a drink when I was, when I found it too hard… Just my way of coping again with everything that was going on… I think it was more of a coping mechanism, ehmm I think all my addictions have been a coping mechanism, and aye [yes], when I'm not around alcohol or staying away from alcohol I manage to do fine but if it's in front of me and I'm going through a stressful time or somethings happened then aye [yes].' (Jaime)

Throughout the interviews with women who primarily used the 'drinking as coping' narrative, they sometimes seemed uncomfortable describing themselves as drinking to cope with wider contexts, and were careful to demonstrate that they took individual responsibility for their actions. They did this by sometimes referring to their drinking as a choice, and sometimes demonstrating that they blamed themselves for their drinking. For example, when Jaime described the diagnosis of her son with FASD, although she had been able during other parts of the interview to consider how her drinking related to other aspects of her life, she still described guilt and individual responsibility, and kept coming back to these ideas throughout the interview:

> '… that's when I said well, I used alcohol and it was the paediatrician that says well, this is a condition, this is what this is, I think that your son might have this. And the guilt that you feel is immense.' (Jaime)

Although Cathy's circumstances were different to Jaime's – Cathy's child was still a baby and did not have a diagnosis of FASD – the tension between describing drinking as coping and still taking individual responsibility was still evident. Cathy described her

drinking as coping but continually emphasised the guilt she felt about doing it; she drank to cope but still held herself individually responsible for doing so:

> 'But it's a vicious circle because you drink and then the guilt comes back down and you think what damage have I done to this baby? And then you start feeling bad about yourself for drinking alcohol and then the next thing you want to do is go and drink more alcohol and forget kind of thing.'
>
> (Cathy)

At points during the interview Cathy insisted that drinking was always a choice, therefore taking personal responsibility for it. In doing so, Cathy framed her drinking as simultaneously a choice *and* a coping mechanism:

> '… I think as an individual you've always got a choice; you can take it or leave it and for myself I would always take it. I enjoy having a glass of wine for it does help me cope. It makes me forget – like not forget – but it takes like the heaviness away if you know what I mean.' (Cathy)

The conflict between drinking and coping and drinking as choice was also evident in Rachel's interview. Throughout the interview it was clear that Rachel had been hurt, let down and rejected repeatedly by family and services, and drinking had been a way of coping with this. Rachel simultaneously appeared to be aware, however, that she was expected to take individual responsibility for her drinking and make changes to her life if she wanted to keep her baby; it seemed to me that she had been drinking to cope with adversities caused by other people and the state, but was forced to take individual responsibility:

> 'I sit and sort of think to myself, now, I'm like, well why? What have I done? You know, 30 years, what have I done, what have I got? Nothing, cos I lost it all through drink.' (Rachel)

Staddon argues that the dominance of biomedical discourses to explain drinking can make it hard for women, particularly marginalised women, to talk about the social issues, and particularly the structural inequalities, that are related to their drinking (Staddon, 2016), because they do not want to appear to be seeking an 'excuse' for drinking. The accounts of Jaime, Rachel and Cathy support Staddon's argument; even

when they described their drinking as a way of coping, they always also emphasised the blame and individual responsibility they felt.

6.5.2 Drinking as choice

Niamh, Ellie and Maddy, who did not describe experiencing adversities, had had minimal interaction with services, described having good support networks and had high SES, described drinking as a choice. They also described drinking at a low level throughout pregnancy (occasional drinking, and one or two drinks per session). All three women described the pleasure they got from drinking as the main reason they did not want to stop drinking altogether during pregnancy. They emphasised being aware of the risks of drinking during pregnancy (see 'mother blaming' theme for more information) but making a choice to drink anyway.

The concept of responsible drinking was a key part of the drinking as choice narrative – women who strongly emphasised their drinking as a choice were careful to explain that they drank at low levels and took a range of precautionary measures to ensure it did not harm their babies:

> 'I think it felt good in that I knew… I was following the guidelines. And it just, in my head it seemed to make sense that it wouldn't do any harm because, well how could it? It was low percentage, it was like, it was never more than 12 per cent. It was never more than, I mean I measured it out with a jug.'
>
> (Niamh)

Sometimes women who mainly framed their drinking as a choice also referred to it as a coping mechanism - for example Ellie described drinking as stress relief - but they still primarily framed their drinking during pregnancy as their own choice:

> '…my policy for myself was that I'm certainly not going to be getting drunk, but if I fancy the odd drink, if the odd drink, kind of, makes life a bit easier and reduces my stress levels, then I'm not going to worry too much about it.'
>
> (Ellie)

Even when women primarily framed drinking as a choice, it was still connected to other aspects of their lives – it served a purpose, for example to enable women to retain a sense of autonomy or a connection with their lives before they were pregnant,

or as a way of relaxing or relieving stress. Whether women were drinking primarily as coping or drinking primarily as choice, their drinking was always connected to the wider contexts of their lives:

> '… you still feel the same in terms of wanting some sort of relaxation at the end of a working week. It would normally be on a Friday that I would have a drink with my husband and, of course, like I said before he didn't stop drinking. His life, he still needed a couple of beers on a Friday night and we used that time to kind of download how our weeks have been, well, mainly his but, yes, you know, just kind of relax a bit.' (Maddy)

My findings suggest that although women who drink during pregnancy do so for varying reasons, these reasons always connect to other aspects of their lives, so these aspects should not be ignored. It therefore makes sense to take a social approach to drinking during pregnancy (see section 9.3.1 for a social model of drinking during pregnancy).

6.6 Conclusion

This chapter has highlighted the interrelated contextual factors that surround and affect drinking during pregnancy. The women who had been involved with specialist services during pregnancy had all been affected by multiple interconnected adversities and marginalisation. Women's descriptions of their reasons for drinking, although varied, centred around two main concepts: drinking as coping, and drinking as choice. Concepts of autonomy, independence and freedom characterised the accounts of women who framed their drinking as a choice, which contrasted with the powerlessness and adversity which characterised the accounts of women who mainly described drinking as coping. The contexts in which women drink during pregnancy are complex, multi-layered, and varied. It is possible, however, to see how women's experience of social factors, multiple adversities and structural and political contexts affect women's reasons for drinking.

This chapter has explored the complex contexts relating to women's reasons for and experiences of drinking during pregnancy. The next chapter will demonstrate how despite this complexity, women's and practitioners' accounts still reproduced

dominant narratives about individual responsibility, reproductive citizenship, and child protection.

Chapter 7 - Mother blaming

7.1 Introduction

The previous chapter highlighted the complex, multi-layered, and varied contexts affecting women's drinking during pregnancy. Whilst concepts of autonomy, independence and freedom characterised the accounts of women who framed their drinking as a choice, participants who had been involved with specialist services during pregnancy had all experienced multiple interconnected adversities and marginalisation and described drinking to cope with these.

This chapter will demonstrate how despite the powerlessness and adversity which characterised the accounts of women who described drinking to cope, women's and practitioners' accounts still reproduced dominant narratives about individual responsibility, reproductive citizenship, and child protection. These accounts emphasised women's responsibility to keep their babies safe and positioned women's behaviour as the cause of risk and harm. Even when women and practitioners used narratives which avoided explicitly blaming women, they still situated mothers as the cause of harm and therefore the appropriate focus of responses and interventions. This emphasis on women's individual responsibility required them to control risks that were beyond their control, contributing to a climate of mother blaming, and justifying and reinforcing the UK's largely individual level, rather than structural, responses to drinking during pregnancy.

There are three sections in this chapter: first, keeping babies safe; second, women in specialist services are under additional pressure; and third, women who drink cause harm.

7.2 Keeping babies safe

7.2.1 Mothers are held responsible for the safety of their babies

Practitioners and women both framed women as responsible for the safety of their babies, with many of the women explicitly positioning themselves as individually responsible for warding off risk and keeping their babies safe during pregnancy. Kate described how she saw it as her responsibility to ensure the safety of the baby when she was pregnant:

> 'I had complete fear of risk, absolutely… so I stayed away from like if somebody was smoking on the road, I would cross the road so I wouldn't be near them … And putting that blame and guilt on me, because only I could carry our baby and look after our baby and keep it safe. So I just eliminated all risks.'
>
> (Kate)

Kate explicitly stated that pregnant women were solely responsible for the safety of their babies ('only I could… keep it safe'). Implicit in her account was that mothers could and should 'eliminate all risks' during pregnancy, which is reminiscent of Ruhl's contention that pregnant women adopt the risk model of society, in which they must avoid all risk (Ruhl, 1999). Women described in detail the advice they had been given about how to behave during pregnancy, various risks to their foetuses, and how to ward off risk. They described taking steps to minimise risks to their babies, perhaps using the interview as a space in which to demonstrate that they were enacting reproductive citizenship by learning how to avoid risk and then doing so (see section 2.5.3).

Even when women were not explicit about their responsibility for risk, it was implicit in women's accounts that they considered themselves responsible for the health of their foetuses, and that when things went wrong it was the mother's fault. Women described blaming themselves for various aspects of pregnancy and motherhood including not being conscious during childbirth, not breastfeeding, feeling stressed, not sleeping enough, and their children's health conditions. In taking all the blame for these situations they enacted reproductive citizenship (Lupton, 2012; Salmon, 2011);

even when there was no way that they could have caused these risks and harms, they held themselves responsible. This responsibility for warding off risk appeared to cause them stress and worry, particularly if they could not adhere to it. Sometimes women described weighing up potential risks to the foetus against any benefit themselves, for example Ellie talked about suffering with severe migraines and trying to avoid taking pain medication:

> 'I'm on medication for my migraines. But as soon as I got pregnant, I knew that I had to come off my medication… I was getting quite bad migraines for the first three/four months with both pregnancies… And couldn't really do anything about it. And everyone said, oh yeah, well you can take a paracetamol, but firstly paracetamol doesn't really work but also even taking paracetamol, I, sort of, felt guilty. I, sort of, felt like I shouldn't be because the advice is, sort of, 'oh well, you know, you can take it if you really need it but you probably shouldn't.' So that was quite difficult.' (Ellie)

Ellie's example illustrated the challenges women face when expected to avoid all risk to the baby; Ellie was expected to live with the pain of migraines, although this was not explicitly stated by practitioners, because the advice was that she 'probably shouldn't', turning the provision of pain relief into an individual decision that she would be held accountable for, creating guilt and discomfort. The expectation that women are expected to prioritise any potential risk to the baby over their own pain and discomfort was a key feature of Ellie's interview, and I thought Ellie used the interview to question the risk model of pregnancy by highlighting the tensions it causes for women.

Practitioners also reproduced the dominant narrative that women were responsible for keeping their babies safe – keeping the baby safe was almost always framed as a woman's responsibility, with fathers, other family members, and wider communities rarely mentioned as either threats or protective factors. In practitioners' accounts women were portrayed as responsible for keeping children (including 'unborn children') safe by controlling their situations to minimise risk.

> '… it's about talking to [women] about not drinking for the rest of the pregnancy and looking after themselves as well as they can so make sure they're sleeping well, they're reducing their stress levels, they're eating well,

they're attending all their appointments, erm because all of these will have a positive impact on the health on the babies as well.'

(Julie, Maternity/Child Health Practitioner)

Although Julie's account of advising women how to keep their unborn baby safe may seem straightforward, it is what is missing from the quote that is interesting. Women should 'reduce their stress levels', for example, but it is unclear how they can be expected to do this when stress levels are intricately connected to wider contextual factors such as relationships, work status, their partner, and SES. Similarly, 'eating well' is not straightforward and is not equally achievable by everybody; for example, women residing in temporary accommodation may not have access to kitchens in which to prepare fresh food or have the money to buy and store it. Despite these and other structural factors being understood by practitioners (see chapter 6), they still responsibilised pregnant women for keeping babies safe and healthy.

This focus on mothers' individual responsibility to protect babies reproduces dominant narratives about babies as innocent and in need of protection, and mothers as ultimately responsible for children, which are well known and therefore highly believable narratives involving 'common sense' western understandings of motherhood and babyhood. It would be harder for practitioners to tell stories in their interviews prioritising the needs of women, or women's wellbeing being a precursor to children's wellbeing, or inequality being a cause of risk and harm to babies and women; these are arguably contested codes that do not have the same persuasive potential (Loseke, 2013). These stories also would not necessarily fit with the policy and practice currently available for women who drink during pregnancy, which rely on individual rather than structural interventions, so it would be very difficult for practitioners to explicitly tell these stories without acknowledging that they are unable to respond appropriately to women's needs (although some practitioners did sometimes subtly suggest this – see section 8.4).

7.2.2 Baby comes first

Throughout the fieldwork practitioners and women emphasised the importance of the needs and interests of children and babies. Practitioners focused on child protection and the safety and wellbeing of children, including unborn children, as their primary

responsibility. Some of the practitioners' roles were explicitly tied to children, and others were ostensibly about women, but all the practitioners highlighted that child protection was paramount, reflecting the child protection paradigm in which Scotland and the UK currently operates.

> 'Remember, we work for social work so… our primary focus is always the children and it's always about building evidence to support. So we look at risk factors and we look at positives and we look at negatives.'
>
> (Lynne, Social Work Practitioner)

Lynne explicitly framed her role as focused on children and building evidence to enable decision-making rather than supporting families. This positioned the purpose of the practitioner within a child protection framework as primarily to protect the child, and to gather evidence to enable this. The focus on risk to the baby was evident throughout practitioners' accounts, even though they were sympathetic and respectful about the pregnant women they worked with, and even when they defined themselves as women's workers. This suggests that either practitioners in the study prioritised child protection in line with the UK's child protection paradigm (see section 2.5.4), or they knew they were expected to do so and therefore demonstrated it to me in their interviews. This focus on the protection of babies was implicitly acknowledged by many of the women, and was overtly raised by some of the higher SES women, who explicitly objected to being made to feel like human incubators:

> 'I was a confident, independent, intelligent, tax paying member of society able to make my own decisions. As soon as you become pregnant, you no longer are that thing and you just…you're just a baby carrying vessel that needs to be instructed on how best to care for that or how best to protect that baby's interests.' (Ellie)

Ellie's quote explicitly addressed what many of the other women alluded to during the interviews; during pregnancy, the woman is reduced to a carrier for a baby rather a whole independent individual, 'you're just a baby carrying vessel', and being pregnant is expected to take precedence over all other aspects of the mother's life, with her purpose to 'protect that baby's interests'. Ellie implied that the current approach to pregnancy necessitated a loss of independence for pregnant women, because formerly

autonomous, independent women ('I was… able to make my own decisions') were expected to submit to the advice (or 'be instructed') about how to live all aspects of life during pregnancy. The impact of this positioning as simply a baby carrier for some of the women was that they felt disempowered and unimportant. At various times throughout their interviews, several of the women alluded to feeling as if health professionals did not care about them, and that they felt disempowered by this focus on the baby, both before and after birth:

> '…but I think sometimes midwives are there for the baby so they don't care. Sometimes I get the feeling that they don't care about you, like you're the shell, you're carrying the baby. As long as that baby's safe then that's it.'
>
> (Dawn)

Dawn's repeated contention that midwives only 'care about' pregnant women to the extent that they are necessary to the safety of the baby ('as long as that baby's safe then that's it') highlighted her awareness of the dominant narrative that unborn babies take precedence over their mothers when it comes to care during pregnancy, and was an implied criticism of this dominant narrative.

In contrast with Ellie and Dawn's overt resistance to being positioned as a 'shell', the three women in the study who had used specialist services during pregnancy did not criticise this focus on the baby; instead they tended to reproduce the narrative that they should prioritise the needs of their unborn baby above all else. It is possible that this was because they were more compelled to demonstrate that they were 'good mothers', because of the intense scrutiny they were under compared to the other women, or that they were less able to voice any explicit critique of these ideas in the interview. Although all three – Rachel, Jaime, and Cathy - acknowledged the problems with the 'baby comes first' narrative, this was usually implicit rather than explicit. Rachel, for example, emphasised that 'baby comes first' throughout her interview, but went on later in the interview to critique her experience of social work interventions, and part of her critique was that social workers were 'all about the baby'. Her account of trying to access services while not pregnant reflected this focus on pregnancy and babies; practitioners and women both suggested that many of the specialist services which were available to women during pregnancy were not available before or after

pregnancy; some services were available for a limited amount of time after the birth of the baby, but were usually dependent on whether the woman retained or regained custody of her child. This reflects the focus of the current policy approach being focused on the baby rather than the mother or the mother-baby dyad. Despite the women who had experienced specialist services not explicitly criticising the 'baby comes first' narrative, it became clear throughout the research that women in specialist services were affected in specific ways by this narrative and the accompanying expectation that women were responsible for keeping their babies safe.

7.3 Women in specialist services are under additional pressure

Whilst women with higher SES who were mainly middle class and had partners and jobs were expected to ward off risks by controlling their bodies, women who were involved in specialist services were expected to minimise risks which they had little control over, in addition to the risks related to their own bodies. These less controllable risks included having a support network; being financially secure and having a safe home environment; and attaching to the baby in an acceptable way. For women in specialist services, all these broader risks became part of the risks they were expected, and under pressure, to control, which had the impact of framing structural issues as lifestyle choices and responsibilising women for factors beyond their control.

7.3.1 Attachment is a mother's responsibility

Practitioners' accounts reproduced dominant narratives about attachment, suggesting that attachment was natural and normal, that mothers were responsible for 'attaching' to their babies, and not acknowledging the importance of context to women's experiences of attachment. Practitioners often talked about the importance of childhood, and the impact of ACEs on the women who used their services. Although this was not usually framed as directly caused by women's drinking, 'problems' with attachment appeared to be seen as a common issue for the women who were engaged with their services. Some practitioners framed women's own experiences of being parented as predictive of their parenting capabilities, often without acknowledging the structural and contextual factors that affect people's ability to care

for children. This aligned with the findings around ACEs in my meta-ethnography, in which studies that placed emphasis on ACEs tended to have a psychological or individual focus (for example Zabotka, 2012), at the expense of other possible factors including possible broader, structural explanations.

> '… am I able to protect this baby – with their own parenting. You expect people to be able to parent who have had good parenting and they struggle so what about people who have had poor parenting.'
>
> (Jean, Social Work Practitioner)

The assumption that women who did not receive 'good parenting' would not be able to protect their babies reflects the current UK policy focus on parenting as the crucial aspect of children's lives. These assumptions responsibilise parents, and particularly mothers, for their children's wellbeing, whilst ignoring the wider social contexts such as austerity policies and lack of appropriate housing in which family relationships take place. It is deterministic, assuming that women who experienced adversity as children would be less likely to be able to 'parent' their children. This has worrying potential implications for practice with families who have experienced previous statutory intervention.

Practitioners required pregnant women to prepare for the birth of a baby emotionally and practically, in specific ways, including buying baby paraphernalia and emotionally attaching to the foetus. They positioned this attachment as natural and normal, and therefore problematic and in need of correction if women did not experience it:

> 'I suppose, where the baby's not seen it's very easy to distance yourself, isn't it, and we work with an awful lot of mothers who have real difficult attachments to the unborn baby. I've worked with mums where there's no attachment to the unborn baby and that can either correct itself when the baby's born or just kind of continue on through.'
>
> (Lynne, Social Work Practitioner)

This social work practitioner positioned attachment as the mother's responsibility by stating that women who have 'difficult attachments' to their babies were distancing themselves, implying that women can choose whether to attach to their unborn babies

and that if there is 'no attachment' this is because the mother has chosen this. This perspective was also implicit when another social work practitioner argued that 'shock tactics' were necessary for women who did not attach to their unborn babies. Both practitioners portrayed attachment during pregnancy as natural and normal; it was a 'natural bond' and it was 'shocking' when women did not have it, suggesting that when it did not happen (or at least when it was not visible to practitioners) women were abnormal and not good enough mothers:

> 'This is going to sound really, really, there is some women out there who do not have that natural bond, that… aye [yes]. And it's kind of weird working with them, and I will use shock tactics for them. And I know that sounds really bad, but nothing seems to work with these women, and they will continue to drink throughout pregnancy, and they will deliver early.'
>
> (Val, Social Work Practitioner)

Despite practitioners' apparent confidence that they could recognise maternal-foetal attachment (and its absence), and their representations of it as indisputable fact, prenatal attachment is a contested concept (see section 2.5.3). Although practitioners at other times in their interviews acknowledged the multiple adversities, stress and poverty faced by the women who used their services, they did not acknowledge that 'attachment' took place within, and could be affected by, these contexts; instead, women were held responsible for the perceived lack of attachment and it was held against them if practitioners perceived it to be lacking. The two practitioners' quotes above also imply that a lack of 'attachment' prenatally was likely to indicate problems later – women would 'deliver early', the lack of attachment may 'continue on through' once the baby is born.

Practitioners' determinism about children's early years is reflective of the UK's current policy focus on the early years (including pregnancy) as a crucial time for children's brain development – a claim not as well evidenced as policymakers have suggested - and the focus on parenting as the key determinant in children's outcomes in later years (Featherstone et al., 2014; Lee et al., 2014; White, 2017), and was also reflected by some of the women. Several times throughout her interview Rachel mentioned using baby books and google and was keen to demonstrate her knowledge about

foetal development. Reflecting on the physical and emotional abuse she experienced during a previous pregnancy, she seemed sure that this abuse was the cause of the baby's tremors:

> 'Um, Nancy, she had tremors when she was a baby, shaking, cos of the, what I was going through… Yeah and I didn't know that, 'til I got like the baby books, the ready steady book? And I'm constantly reading that now, aye [yes] every time I read I go oh my god I can't believe a baby actually can tell when things is happening, you know they can hear you, they know what's going on…'
>
> (Rachel)

Although infant tremors are common and could have been affected by anything, or could have been completely normal, Rachel responsibilised herself for them because her reading about foetal development suggested that everything women experience during pregnancy affects the foetus because they 'know what's going on'. This reflects the dominant narrative around the early years, and particularly pregnancy, being a crucial period for brain development (see section 2.5) (Lee et al., 2014).

7.3.2 Keeping babies safe from domestic abuse

The reproduction of the dominant narrative of women being able to and responsible for keeping their babies safe was also evident when women and practitioners discussed domestic abuse. Jaime and Rachel both described experiencing domestic abuse throughout pregnancy and both talked as if it had been their personal responsibility to protect their babies from this abuse (Jaime said 'I need to keep my son safe'), or as if it was their fault for 'letting' it happen. Rachel described the mental and physical abuse she experienced during a previous pregnancy as if she was responsible for it, or as if it was a character flaw or weakness of hers which she had since managed to overcome:

> 'Really hard… now I wouldn't stand, like I don't stand up for it now, I'd get them told, no cos it's made me stronger, before it used to get me to go to drink, and now it doesn't…' (Rachel)

Rachel portrayed domestic abuse as something which she enabled by allowing it, which she would no longer allow (' I wouldn't stand… for it now). She also positions

herself as responsible for her response to the abuse; she is responsible both for not allowing the abuse to happen in the first place, and for ensuring that she does not '… go to drink' in response to it. This narrative reflects the broader responsibilisation of women for keeping their unborn babies safe; women are responsible for keeping their babies safe and blamed when they cannot do so.

Women who described experiencing domestic abuse as children (Jaime, Rachel, Karen, Cathy) also represented this as their mothers' fault, rather than apportioning blame to either their fathers as individuals, or to gender roles and oppression more broadly. When describing her childhood, for example, Jaime focused on her mum not being able to keep Jaime and her siblings safe from their dad's violence, positioning her mother as the person who should have protected her children, implicitly suggesting that women are responsible for keeping children safe from men:

> '… I was 11, when my mum moved from [area] to [area], into a women's aid refuge, and that's, was her break, that's when she finally got away fae [from] him… I used to have my mum up on a pedestal all the time, and it took me a long time to realise that ken [know] she never really kept us safe, she kinda should've maybe done something earlier so we didn't have all these bad memories …' (Jaime)

In this quote, and throughout her interview, Jaime placed little emphasis on the actions of her father or his responsibility to not abuse his family; the responsibility was placed with her mother, who should have protected them from him but 'never really kept us safe'. Jaime did not represent her mother as a victim of, or at risk from, her father's abuse; it was the children who were at risk and should have been kept safe.

Practitioners also implicitly suggested that women were responsible for protecting children (including unborn children) from abuse, although this was more subtle. When practitioners talked about the domestic abuse experienced by the women who used their services, they explicitly held the perpetrator of the abuse responsible, but still when it came to the safety of the baby or unborn baby they emphasised the woman's responsibility to end the abuse.

> ‘But she’s just this one person in amongst everything else. Services can tell people and support people and give them other supports and signposts, but if the female doesn’t remove from that situation then we can’t force people, we can’t say to people you need to go to Women’s Aid or you need to remove… if someone’s in a situation where the child is there then it’s easier for us, or Children & Families, to say I’m going for a Child Protection Order [CPO] – that child’s in an unsafe place and there’s immediate risk to that child. But I’ve never known it to be done for someone who’s pregnant… I’ve never known of a CPO when the child’s not physically there.’
>
> (Jean, Social Work Practitioner)

The above quote exemplified the positioning of women as responsible for children’s safety by focusing on the mother’s need to ‘remove’ herself from the abusive situation. This subtly positioned women as responsible for their ongoing abuse, implying that they were free to choose whether to leave their abusive partner. Children, in contrast, were positioned as straightforward victims in need of protection (that child’s in an unsafe place and there’s immediate risk to that child’). This contrast was striking because it further emphasised the positioning of women as individually responsible for their circumstances, and therefore to blame for the ‘immediate risk’ faced by their children.

Practitioners described several women who had been victimised, often multiple times, and experienced multiple adversities, and who were acknowledged by practitioners to be vulnerable, being expected to leave their abusive partners or ‘remove’ from the situation during pregnancy in order to protect the baby. Similarly, women were expected to ‘gatekeep’ by protecting the baby from people who may pose a risk. Both of these expectations are problematic because they responsibilise women for male violence by expecting women who have experienced ongoing, repeated violence to be able to protect themselves and their baby from this and punishing women when they cannot ‘remove’ or ‘gatekeep’ by removing their children. The women being described by practitioners appeared to me to be at risk and in need of support and care, but instead of positioning the mother and baby as at risk in an abusive situation, practitioners’ accounts positioned the baby as at risk and the woman as failing in her

duty to protect the baby. This is an example of Lupton's 'discourse of risk' (Lupton, 2013 p94), in which the unborn baby, not the mother, is positioned as at risk, and it reproduces dominant narratives around mother-blaming, in which mothers are blamed and held accountable for harm inflicted by others (Carlton et al., 2013). My findings around mother blaming accord with a wide body of research about victim blaming which highlights the structural factors contributing to the existence of, and societal responses to, poverty and inequality (Horton, 2005; Tyler, 2013) and violence (Christie, 1986; Randall, 2010; Suarez & Gadalla, 2010).

7.3.3 Structural issues as lifestyle choices

The focus almost solely on the baby in complex situations in which women are also at risk, and the subsequent removal of women's children, consolidates women's marginalisation by causing additional trauma. It contributes to the construction of the mother as the primary threat to the baby and reduces women's situations during pregnancy to lifestyle choices rather than the result of multiple, complex, intersecting factors (see chapter 6). Sometimes accounts were explicit about this and at other times it was more implicit. The social care practitioner below, for example, described women whose children were subsequently removed who would have made 'amazing mums', explicitly stating that they were unable to because of what she termed their 'lifestyle'; difficulties faced by the women were framed as 'lifestyle' issues which would not be appropriate for a baby (rather than adversity women were expected to cope with, or needs that services could (and in the past would) have helped to fulfil:

> 'Because when I'm looking at mum with her baby, I'm looking for the wee connections, the wee attachments, is she noticing the wee things the baby's communicating to her. And half the time, they are, you know… But they just don't get the chance, because obviously, of their lifestyle. So, yes, it's very sad, because I do believe that a lot of mums, if they had the chance, and the support, they could be amazing mums, and they could have amazing children. So, but that's it.' (Val, Social Work Practitioner)

This narrative of women making lifestyle choices responsibilises women for the situations they are in, which perpetuates the individualisation of risk and feeds into the expectation of women that they should 'do' reproductive citizenship and adhere to the

accepted middle-class standard of parenting. By framing the reasons women have their babies removed as due to 'lifestyle', practitioners - in line with policy - pathologise mothers, reproducing narratives around choice and women's individual responsibility to adhere to the middle-class ideal of a good mother, while silencing other potential understandings of challenges in family life as responses to poverty and inequality (Bell et al., 2009; Hyslop & Keddell, 2018; Salmon, 2011). This enables and reproduces a system in which it is justifiable and acceptable to forcibly remove children from their mothers (Featherstone et al., 2019; Morriss, 2018; White, 2017).

Although it reproduced dominant narratives around choice and individualism, Val's account simultaneously alluded to other possibilities. She argued that 'if they had the chance, and the support, they could be amazing mums', implying that there could be another way of responding to these women that may enable them not to be further marginalised by the removal of their children. Later in her interview Val went on to explore the lack of meaningful outreach and support services available for women who drink (see section 8.4), and in combination with the resignation that accompanied her description of women's 'lifestyle' issues here ('so, but that's it.'), I understood that she was deeply critical of the current policy and practice approach but was compelled to continue working within it because there was no alternative system.

Practitioners' accounts suggested that women in specialist services were expected to change their lives during pregnancy to eliminate all risk, including the things that were outside of their control, despite the fact that these women were arguably the least able to control these aspects because of their lack of power and material resources:

> Annie: 'Are those things that she needs to do, are they mainly around substance use or are there other…'
>
> Julie: '… other things, so it could be you know just things like you know attending all your appointments …obviously yeah about their substance use but also have they got a, you know what's their housing like, is there a safe home environment, are they able to gatekeep, erm, how are they preparing for the baby, have they bought things, are they thinking about things, have they got benefits in place, you know all these things, like what's their relationship like,

> erm, how's their family support, have they got people who could support them after they have the baby…' (Julie, Maternity/Child Health Practitioner)

Many of the items on Julie's list were beyond the control of any individual person, for example housing type and availability differs widely according to local authority area (see context chapter); and whether there is a 'safe home environment' involves the behaviour of other people living there, not just the mother. For women experiencing poverty, homelessness, and domestic violence, as many of the women attending specialist services are, it is unreasonable to expect them to take control of complex, potentially dangerous situations when they do not have the material means to do so. The current policy and practice focus on the potential risks caused by women's bodies and behaviours during pregnancy perpetuates the individualisation of risk to women, which leads to mother-blaming because it implies that it is solely women's responsibility to keep their babies safe which positions women as to blame when they cannot keep their babies safe.

7.4 Women who drink cause harm

Practitioners positioned all drinking during pregnancy as a source of risk and harm to the unborn baby. Although some practitioners acknowledged that the research around the impact of low levels of drinking was inconclusive, they always emphasised the importance of abstinence and none of the practitioners' accounts questioned whether FASD was caused solely by women's drinking, instead assuming that the increasing numbers of children being identified as having FASD indicated that many women were drinking during pregnancy:

> '…there's a great sea of babies out there, you know, more and more being picked up through the paediatricians, with alcohol problems, that we have never known about during pregnancy.'
>
> (Jane, Maternity/Child Health Practitioner)

Jane's observation that more and more children are being 'picked up' through paediatricians in Scotland may be accurate but is at least in part due to changes in the way it is defined and approached by clinicians (see section 2.6). Her assertion that there is a 'great sea' of babies out there may reflect what Armstrong (2008) describes

as the democratization of FAS, in which what was once seen as an uncommon birth condition affecting the babies of women who drank at a very high level during pregnancy has become broadened out, or 'democratized', to include anyone who drinks anything at all during pregnancy (Armstrong, 2008). The assumption that all drinking during pregnancy is potentially harmful to the foetus, and that FASD is caused solely by women's drinking, reflects UK discourse around pregnancy, and fails to take account of the broader factors which affect maternal and infant health, but crucially it also affects the way that practitioners frame potential responses to drinking during pregnancy.

Various narratives were evident in practitioners' accounts of women's drinking during pregnancy, with women's drinking framed as due either to ignorance, illness, or dishonesty, and requiring interventions from services to keep babies safe from their mothers' drinking. Although these narratives may have been used as a way of avoiding mother-blaming, they still centred the mother as the cause of the risk and harm. This constructed the mother as the focus of the problem and therefore positioned individual responses rather than structural change as the solution.

7.4.1 Women are ignorant and need educating

Practitioners' accounts often implied that women were unaware of the risks involved in drinking during pregnancy, and unaware of abstinence recommendations. This narrative was often used to explain lower levels of drinking:

> 'And many women who probably are not even binge drinking, they are just socially having a drink, are not really realising the full implication that that can have on their baby.' (Irene, Maternity/Child Health Practitioner)

Irene asserts that women drink because they do not understand the risks of drinking during pregnancy, an assumption that was often implicit in practitioners' accounts. In doing so she problematises all drinking during pregnancy as potentially harmful, reflecting the abstinence framework and the precautionary principle, and suggesting that if women were better educated about the risks, they would not drink at all. This notion of unrecognised threat and harm reflects the policy and public discourse around FASD, with FASD literature often focusing on awareness raising, implying that

women are currently unaware of the risks posed by drinking during pregnancy (SIGN, 2019; Scottish Government, 2013). Practitioners' accounts aligned with this, often assuming that women were unaware of the risks and needed educating, and presenting education as a key part of their role as practitioners:

> 'I would say that erm my role mainly being a midwife has been to make them aware of what the current guidelines are as regards alcohol and what our advice would be, and that is no alcohol no risk, and why we're saying that, so explaining what effects alcohol can have on the developing unborn baby, erm, what they might see in their baby with regards to the physical effects but also talking about the long-term developmental effects as well, erm, and as that child develops and then goes into school what potentially they might see…'
>
> (Julie, Maternity/Child Health Practitioner)

In asserting that women drank because they did not know what the risks of doing so were, practitioners simultaneously constructed women as the source of the threat to their foetuses, and as ignorant of the risks. Practitioners' focus on women's lack of knowledge contributed to the reproduction of individualising narratives, framing women's ignorance of the risks of drinking as the source of threat to unborn babies. This implicitly constructed the solution as awareness-raising or education (usually focused on women), so that these women could make better choices – but drinking is not simply a matter of choice (see 'context' chapter for further discussion). Although practitioners acknowledged throughout the fieldwork that the women they worked with were overwhelmingly very vulnerable and had usually faced multiple adversities and poverty throughout their lives, they still often implied that women's ignorance about the impact of drinking during pregnancy, rather than the challenging situations women face, was the key problem. The quote below exemplifies the assumption by many of the practitioners that a lack of clarity in the guidance about drinking during pregnancy was a major problem contributing to drinking during pregnancy, and that a clear abstinence-focused message would reduce women's drinking during pregnancy:

> 'My view on alcohol in pregnancy is just, don't drink, just don't drink…there's so much conflicting information out there, about drinking in pregnancy, far too

much conflicting information. It just has to be, everybody needs to get together and come up with one thing, and that's it.'

(Val, Social Work Practitioner)

Although the guidance around drinking and pregnancy has varied from place to place throughout its history and has recently changed in Scotland and then the rest of the UK (see section 2.7.1), to present this as a major issue in relation to FASD is problematic because it focuses on low level drinking and whether guidance should promote abstinence or low level drinking. For women drinking at a high level during pregnancy, and who were largely drinking to cope with complex contexts (see section 6.5), more consistent advice about abstinence is unlikely to have made any difference to their drinking, and the continued focus of policy and practice on low level drinking may distract from the more complex and difficult area of adequately and meaningfully supporting women drinking at a higher level during pregnancy.

Furthermore, practitioners' assumptions that women were ignorant about the risks of drinking contrasted with women's accounts of drinking during pregnancy, which suggested they were knowledgeable about guidance regarding drinking during pregnancy. All the women except Jaime stated in their interviews that they knew the advice was not to drink at all during pregnancy; women's accounts suggested they were well informed but drank anyway, for a variety of reasons that were intertwined with their contexts and experiences (see chapter 6). Even Jaime, who stated during her interview that she would not have drank during pregnancy if she had understood the risks, also described cutting down and stopping drinking during pregnancy, suggesting that she knew she was expected not to drink during pregnancy. Most of the women were aware of the recent change in guidelines regarding drinking during pregnancy:

'…when I was pregnant with [first child] er, the guidelines on the NHS website were… essentially it was 1-2 units a week is ok… and then what I noticed with [second child], when I went back onto the NHS was they basically just said no, outright no, you really shouldn't be drinking at all because we just don't know, lockdown, boom. Eliminate risk. Risk elimination society …'

(Maddy)

In this account Maddy demonstrated an understanding of the precautionary principle as a way to eliminate risk in when a safe limit is unknown ('we just don't know'); the evidence had not changed in between her two pregnancies, but the advice had. Maddy, like the other women, did not drink because she was unaware of the risks, but because drinking during pregnancy takes place in the context of women's lives and cannot be reduced to a solitary health behaviour that is unconnected to other aspects of women's lives. On the contrary women's accounts suggested that they knew the risks and employed risk-management strategies specifically related to alcohol. Some of the women described stopping drinking completely as soon as they realised they were pregnant (or before) and remaining abstinent throughout the pregnancy (Kate, Charlie, Dawn, Rachel), while others described cutting down their alcohol intake (Karen, Jaime, Maddy) or drinking less at various stages of pregnancy (Eilidh, Alison, Ellie) and eating food with alcohol (Cathy). Although these strategies varied widely, they all demonstrated an awareness that drinking could be risky:

> 'But when I drank, I always made sure I had something to eat and stuff like that. I wouldn't go like hungry because in my mind if I ate something it was better for the baby kind of thing, so I could have the wine as long as I had something to eat kind of thing.' (Cathy)

Cathy, who described drinking caffeinated wine daily throughout her pregnancy, stressed that she had made her best efforts to protect her baby by drinking at only certain times of the day, always eating enough food, and trying to avoid stress (which she said alcohol helped her with). In doing so she positioned drinking during pregnancy as a rational choice that she had made and was therefore responsible for (see section 6.5.2 for further discussion on the positioning of drinking as a choice). This rationalisation contributes to and furthers the responsibilisation of women for the health of their foetuses, because positioning drinking as a choice makes women responsible when they 'choose' to drink. Telling me about these strategies in the interview served the purpose of making it clear during the interview that women had thought about how to keep their babies safe and minimise risk. I interpreted this as women demonstrating their reproductive citizenship in an area in which they knew they had broken some of the reproductive 'rules' by drinking during pregnancy.

7.4.2 Women are dishonest and require surveillance

Practitioners' accounts often implied that women were dishonest about whether and how much they drank, and FASD estimates and police reports of alcohol related incidents were sometimes referred to as evidence of this dishonesty. Although women participants also said they under-reported their drinking during pregnancy (see section 8.2.1), practitioners' contention that women are both ignorant of the risks and guidance, and simultaneously dishonest about their drinking, is illogical; if women were ignorant of the guidance and risks around drinking during pregnancy, they would not need to be dishonest about drinking because they would not be aware they 'should not be' drinking.

The framing of all drinking as potentially harmful, women as the source of harm, and mothers as dishonest, meant that for women accessing specialist services, surveillance was standard. Practitioners (all of whom were from specialist services) spoke as if it was obvious that women in their services should experience a high level of monitoring and surveillance and appeared to view surveillance as a way of minimising risk to children (unborn and born). Women were the cause of the risk, so practitioners were responsible for minimising the threat women posed to their unborn babies; women were 'chaotic' and 'high tariff'; they had 'high-risk' pregnancies; women were described as if they were inherently threatening to their babies, who needed protecting from them by services:

> Caroline: 'The kind of chaotic women that don't engage well in pregnancy would probably be the biggest concern… what I document if they're chaotic and they've not engaged is their alcohol consumption is unknown because we actually don't know what they've been doing… because the engagement's been so poor so they're kind of high tariff well really high tariff but the really chaotic women that we don't see much of that you maybe see twice during pregnancy, they maybe show up at the hospital for one scan, they make a couple of appointments but they don't show up, you know, they're not engaging, they don't, we can't find them a lot of the time, really high-risk pregnancies.'
>
> Julie: you just don't know what's going on'
>
> (Caroline and Julie, Maternity/Child Health Practitioners)

Practitioners' discussions of risk and threat positioned women's compliance with surveillance as an important factor which could protect children, and non-engagement with surveillance as risky. 'Chaotic women that don't engage well' were framed as the most worrying women of all, because they made it impossible for practitioners to assess the level of risk posed by the mother to the baby. To be unable to control, or at least monitor, 'what they've [women known to specialist services] been doing' was positioned as risky and problematic. This reflects the intersection of the risk paradigm around pregnancy (Ruhl, 1999) in which women should avoid all risk, and the child protection paradigm (Lonne et al., 2009), in which families are monitored for their ability to keep their children safe, creating a situation in which practitioners are expected to know what women are doing at all times.

Practitioners explained that working with women who drink alcohol rather than using other substances could be challenging because there was no substitute medication, so there were fewer opportunities to monitor women's behaviour. They described treatment options for women who drink during pregnancy as very limited, because drugs such as naltrexone and disulfiram that are often used for treating alcohol dependence cannot be used during pregnancy. This distinguishes alcohol from other substance use during pregnancy, which is often managed with an Opioid Substitution Therapy (OST) prescription, which would usually require women to pick up their OST daily.

> Alex: 'Do you think that's why maybe drug…opioid dependency in pregnancy is easier, because you can give substitution? Whereas alcohol, you can't give the substitution…'
>
> Sam: 'They're very different models and you get a lot of control with someone's movement and behaviour with a methadone prescription…you can find them and contact them and…'
>
> Anna: '…and you can also keep…you've got somebody to, kind of, keep an eye if they're going to the pharmacy.'
>
> Irene: 'You've got a professional five or six days a week who are actually…'
>
> Anna: 'Or seven.'
>
> (Addictions and Maternity/Child Health Practitioners)

Here practitioners emphasised the lack of opportunities to monitor pregnant drinking women; the lack of available medication was framed less as a medical problem and more as a lack of control, suggesting that OST may be used as a way for women to stay in touch with services during pregnancy. This incentive does not exist for drinking women, so this method of control is unavailable to practitioners. This 'problem' of not being able to know what women were doing in all aspects of their lives at all times came up with many of the practitioners. The need to monitor women, to know where they were, who they were with, and all aspects of their lives, came up repeatedly in interviews and focus groups with practitioners.

When practitioners discussed surveillance and monitoring, they implied that the ideal situation – and the expectation on them as professionals – would be that they *ought to know* what was going on with the women/mother every moment of every day – and if they didn't, they had to be 'really assertive', 'track people down', build 'evidence', try and get 'reports from the police' and other family members. This suggests that the imperative for women to 'do' reproductive citizenship also affects professionals, who have to monitor whether women are 'doing' reproductive citizenship correctly; like the women themselves, they have to prove themselves competent. This focus on surveillance, imposed both by and on practitioners, had the effect of reinforcing the positioning of mothers' drinking as the cause of risk to babies, and distracted attention from other potential responses to drinking during pregnancy:

> 'What I try and introduce as well, with this girl, as well is what I've said is that I will do an arranged and unarranged appointments but I'll also breathalyse and that's not about trying to catch her out – but in some ways it is – but it's also to support her as well. Sometimes people will say if I know there's a chance that someone's going to breathalyse me then if I think of using it might deter me. Others they won't and they'll just try and avoid you – oh, sorry, I forgot you were coming today. But we start to quickly pick up on those kinds of patterns so it's trying to put in supports. The other hand of that is if that individual keeps all her appointments, planned and unplanned and she's breathalysed and it's zero and they're not having any reports from the police and they've got family members saying that she's keeping to her routine as well then that's the evidence as well.' (Jean, Social Work Practitioner)

Jean cited breathalysing as a surveillance strategy which also came up in other conversations with practitioners, who appeared to view breathalysing as an unproblematic technique to monitor pregnant women using their services. She asserted that breathalysing was not just about 'catching her out' but supporting women too; and this was supported by some of the women (Jaime, Karen), who described their negative tests to me as evidence of their commitment to their recovery and to their child-centredness. Practitioners who did not use breathalyser tests – because they did not have the budget to buy them – described attempting to lean close enough to women during home visits to smell their breath.

7.4.3 Women are ill or damaged and need treatment

Another narrative used by both women and practitioners was that women who drank during pregnancy were ill - addicted or mentally ill - or damaged through trauma and ACEs. This narrative was more commonly used to explain 'high risk' drinking than lower levels of drinking and appeared to me to be an attempt to avoid mother-blaming. Practitioners' accounts often implied that addiction was an illness which exempted women from blame and enabled practitioners to be compassionate:

> 'I think the other thing is not to be… if it is a real addiction… it's really hard to see someone do this to themselves and potentially their baby, but you know, it's important to have compassion…'
>
> (Jane, Maternity/Child Health Practitioner)

This practitioner distinguished between a 'real addiction' and (presumably) other types of drinking which do not indicate 'real' dependence. This distinction relies on a biomedical understanding of addiction, implying that it is an illness and can therefore be treated medically. Her account suggested that conceptualising addiction as an illness enabled her to maintain compassion ('If it is a real addiction… it's important to have compassion'), thereby avoiding (or attempting to avoid) mother-blaming. Other practitioners framed alcohol dependence as a response to trauma or ACEs, which appeared to serve a similar purpose in practitioners' accounts; if women drink because of past events that have happened to them, their drinking is not their fault.

> '… pregnancy for a lot of the women that we work with triggers previous traumas from themselves. So if they've had childhood sexual abuse and things like that when they get pregnant a lot of their anxieties or memories and flashbacks of that come back and their coping strategies have been alcohol and in some cases alcohol and drugs.'
>
> (Jean, Social Work Practitioner)

Trauma and ACEs were framed by practitioners and sometimes women as a key barrier to recovery as well as a reason for drinking, implying that women drank to cope with or mask the trauma they had experienced – this reproduced self-medicating theories of addiction (see section 2.3); in the social work practitioner's account above, trauma is something that can be 'triggered' and drinking is a psychological 'coping strategy' that women use to suppress the trauma they have experienced.

Women also commonly used the self-medication theory of addiction to explain their drinking. When reflecting on their drinking, some of the women framed it as a response to trauma, particularly childhood trauma and their parents' drinking. Jaime, Rachel, and Cathy all recounted in detail some of the traumatic experiences from their childhood during the interviews, and explicitly connected these experiences to their later drinking. I would suggest that in some cases these accounts were being provided in the context of the interview, in order to make it clear to me – the interviewer – that they were 'good people' whose problematic drinking could be explained by the adversities they had experienced. As such, these adversities offered an acceptable explanation – or justification - for their drinking, which they knew was unacceptable and problematised (see background for further discussion of the problematisation of women's drinking).

> 'Ehm, like I say all my family, sisters and brothers, we've got an aye [yes] we've all had a heroin addiction, we've all had an alcohol addiction, I think it because what we seen growing up, that's what we knew… I think… we were all homeless by the time I was 16…' (Jaime)

Jaime, like all the participants who were involved with specialist services during pregnancy, described multiple experiences of trauma and abuse occurring in the context of complex, overlapping and multifaceted multiple adversities (see chapter 6),

but when she tried to explain the reason for her and her siblings' substance dependence, she focused on the traumatic incidents in her childhood rather than the structural aspects of the adversity she has faced, such as homelessness. Certain types of explanations are more acceptable than others in various cultural contexts (Scott & Lyman, 1968), and addiction as a mechanism for coping with trauma is currently a well-known and believable explanation, so it is possible that Jaime's account focused on the individual trauma she had experienced, rather than the less well understood structural aspects of her life, because this was the most visible explanation to her, but also perhaps the one which she thought would be the most acceptable to me.

Even when practitioners appeared to attempt to centre structural aspects of women's lives as a way of avoiding mother-blaming, they still often fell back on the illness/ damage narrative. In response to a question about the impact of poverty and as part of a broader discussion about the impact of austerity, one practitioner stated:

> 'And I think as we were just talking about there, about, like, Universal Credit [sanctions] and things like that, all it takes is one tiny, tiny, tiny little thing like that, when you've already got complex issues including addiction, to completely and utterly spiral you out of control. And that's it. One tiny little thing, having no money, because your priority has actually never been food and electricity. Your priority has been drugs and alcohol. So that's not going to…that's not changed. You're just…now just have no money all…at all. So then you then have to go and get money from somewhere, you know, so your health is deteriorating 'cause you've got even less money for food and electricity…'
>
> (Anna, Maternity/Child Health Practitioner)

Although she started by describing the impact of Universal Credit on the women she worked with, this practitioner ended up subtly positioning women's addiction as the cause of the problems here – she began by talking about structural problems (universal credit) and ended up blaming individual behaviour ('prioritising' drugs and alcohol). This moved the conversation away from consideration of the impact of social policy on women's lives towards blaming women's individual addictions for their untenable situations. This implicitly constructed addiction as the cause of women's problems

rather than a symptom of the adversity they faced. This was common throughout practitioner accounts; even those who explicitly acknowledged the impact of poverty and gender framed women who were struggling the most as having mental health or trauma issues, or being 'chaotic', which individualised the problem.

This individualisation reinforces and justifies the importance of focusing on 'treating' addiction rather than fighting for broader societal and political change. Although it was clear that many of the practitioners understood the structural inequalities and poverty faced by the women they worked with (see chapter 6), there was nothing they could usefully do with this knowledge because it was beyond the scope of the services they worked for. With no way to impact these broader and more complex issues they often fell back on mental health or trauma services – which they also highlighted as lacking - as a solution. This unintentionally retained the focus on the mother as the source of the problem and may justify the continued lack of broader social support services for women in these situations.

7.5 Conclusion

This chapter has shown that women's and practitioners' accounts reproduced dominant narratives about individual responsibility, reproductive citizenship, and child protection. Although practitioners and women took steps to be sympathetic and respectful, understood the complex contexts related to drinking, and sought out narratives which avoided explicitly blaming women, they still situated mothers as the cause of harm and therefore the appropriate focus of responses and interventions.

This emphasis on women's individual responsibility affected all the women but placed women involved with specialist services under additional pressure by requiring them to control risks that were beyond their control.

The next chapter will consider the ways in which women's powerlessness and marginalisation is exacerbated by a policy framework which renders services unable to offer intensive support for women's complex contexts.

Chapter 8 - Powerlessness and marginalisation

8.1 Introduction

The previous chapter explored how women's and practitioners' accounts positioned women as the cause of risk and harm to babies, reflecting and reproducing the mother-blaming narratives that shape the UK's approach to drinking during pregnancy.

This chapter will consider the ways in which women's powerlessness and marginalisation is exacerbated by these mother-blaming narratives. Situating mothers – and particularly their drinking – as the cause of harm to babies orientates the UK's practice towards abstinence and child protection and away from family support. My findings suggest that women respond by hiding their drinking, which may exacerbate the marginalisation of women who are already marginalised. Although women were generally ostensibly positive about the specialist services they were in contact with, their accounts were characterised by powerlessness and compliance, which highlighted their ongoing marginalisation within a policy framework which is unable to offer intensive support for women's complex contexts.

This chapter has three sections: first, hidden women, hidden drinking; second, powerlessness; and third, marginalisation.

8.2 Hidden women, hidden drinking

In Scotland, pregnant women's alcohol consumption is screened as standard, and women are given an ABI if considered appropriate (see section 2.7.4). Despite this screening, women and practitioners agreed that drinking during pregnancy was under-reported. Practitioners across the health boards stated that the extent of drinking during pregnancy was largely unknown to services, suggesting that screening may be ineffective. My difficulties with recruiting women participants may also reflect the ineffectiveness of screening (see methods chapter for more detail on recruitment);

most health boards involved in the study struggled to identify women who were drinking during pregnancy. Generic practitioners often assumed the specialist drug and alcohol services would be able to identify drinking pregnant women, and specialist services often could not identify, or were unable to contact, pregnant or previously pregnant drinkers. This suggests that while all women are screened during pregnancy, services are unlikely to be aware of women's drinking. This raises questions about the effectiveness and impact of screening and suggests that drinking during pregnancy may be largely hidden.

8.2.1 Fear of Child Protection interventions leads to under-reporting of drinking

Throughout the study both women and practitioners suggested that the hidden nature of drinking during pregnancy was in part a consequence of the UK's current policy and practice approach to child protection, which foregrounds surveillance at the expense of intensive family support. Practitioners said that women under-reported their alcohol consumption, and midwives described sometimes giving ABIs to women even when they did not meet the criteria to do so, if they suspected under-reporting. Practitioners acknowledged that fear of additional or child protection interventions may be a reason for under-reporting:

> '' [If I tell the midwife] she's only going to tell somebody else and then they might come visit me' and, you know, that seems…that's quite a scary prospect. So I think you have to remember that, that the women are probably thinking, 'Oh the midwife, she…she's about the baby, and this might harm the baby, so I'm just not going to bother telling her'.'
>
> (Anna, Maternity/Child Health Practitioner)

Anna acknowledged, as did many of the practitioners, that the threat of triggering further interventions put women off reporting their alcohol consumption ('… that's quite a scary prospect'). This inferred that disclosure led to other interventions which were unwanted and unwelcome; women could not seek support because of their fear of the repercussions; they knew that the focus of any state response would be on child protection, which could eventually lead to child removals. Simultaneously, practitioners were aware that women were scared and therefore may not disclose

their drinking, which lead them to increase their surveillance of women they suspected of drinking.

All the women were aware of the state's power to remove children from their families and appeared to share a fear of child removals to some extent, regardless of SES and drinking status. Many of the women described how this child protection focus influenced their decisions to disclose (or, more commonly, not disclose) their alcohol consumption. Maddy, who had high SES and reported drinking at a low-level during pregnancy, did not disclose her drinking to the midwife and cited fear of additional interventions as her reason:

> '…first time pregnancy, you're just new to this, you don't know if someone's going to try and grab your child out the womb the minute they pop out because you, if you did admit that you actually had a couple of glasses, obviously not but, you don't know where the line is within that…'
>
> (Maddy)

Although Maddy's account was partly tongue-in-cheek, it highlighted an understanding of statutory intervention and child removals as arbitrary and unpredictable, an understanding that pervaded many of the women's accounts. Charlie, Maddy and Dawn all alluded to this unpredictability when they described 'not knowing where the line is' (Maddy), worries about being misunderstood about 'not coping' (Charlie) and cleaning their children and homes when practitioners were visiting 'just in case' (Dawn). Their accounts implied that it was not possible to predict what might prompt additional intervention, or whether state responses would be proportionate or fair, so they pre-empted it by being guarded when presenting themselves to practitioners.

Although all the women were aware of the child protection focus of services, women who had experienced child protection procedures (Jaime, Rachel, Dawn) appeared to be more acutely aware of their potential impact. They were particularly attuned to the risk of child removals and described being extra vigilant about what they disclosed to practitioners. Dawn, who had first-hand experience of being involved with social work as a child, described her decision to manage the image she presented to health professionals to avoid further intervention:

> ‘So I just told them that I never drank and they didn’t ask questions after that… I’m so paranoid with social workers like I was brought up on social workers so I know once you’ve got them, they stick like glue. So I’m a bit like, oh. I’m one of those like freaks that I’m a bit like ‘will that cause social workers to come?’ or ‘my bairn’s dirty so I better clean them just in case’. I was scared of that so I thought I’ll just stop everything and then nobody can complain about anything.’
>
> (Dawn)

Dawn, who described herself in her interview as a ‘weekend drinker’ who drank regularly with her friends before she became pregnant, here recalled presenting herself as a non-drinker to the midwife in order to avoid further questions or interventions (‘I’ll just stop everything and then nobody can complain about anything’); having been involved with social services as a child, her main concern was to avoid them as an adult (‘will that cause social workers to come?), which meant being careful about what she told them. Implicit in Dawn’s account was that additional intervention is necessarily negative and should be avoided. It also alluded to the disproportionate involvement of social workers with some families while others remained under the radar. Compared with Maddy’s light-hearted reflections on the risk of child removals, Dawn’s considerations were more concrete, describing practical work to avoid drawing the attention of additional interventions. This may be because she had first-hand experience of these interventions so knew more about what they entailed and therefore made more effort to avoid them, but could also be because she perceived herself to be more likely than others to attract attention from social work because of her class status and her family’s previous engagement with them.

The consequences of this concealment for Maddy and Dawn may have been negligible, but for women who drink at higher levels the consequences of being unable to disclose drinking are potentially very serious. Jaime, whose sibling had had a child removed from their care, recalled not telling practitioners the extent of her drinking for fear that her baby would be removed. Needing to conceal her drinking from practitioners had serious consequences for Jaime because it meant that when she attempted to cut down and eventually stop drinking, she had to do it alone without monitoring from healthcare practitioners. This could have posed a serious risk to her and her baby but was a necessary consequence of the child protection paradigm, in which she risked

having her baby removed if she disclosed her alcohol consumption. Jaime was reflective throughout her interview about the impact of the child protection focus of services on women, and in particular the impact of the fear of child removals:

> 'Especially if you've heard bad stories and that, kinda somebody you know's had kids removed… I mean, one of my siblings had a child removed, back in their care now, but so I think aye [yes], when you've seen kinda what goes on around you that can make it scary too… for it to happen ken [know] in your family you really do want to just keep quiet about everything, you don't want to open up about anything at all… I don't even think to be honest that after I found out I was pregnant I told them the extent of my drinking, I said I'd been drinking but I never told them the extent of the drinking cos I was that scared. I was worried that they were gonna think she'll not be able to stop or ken [know] whatever.' (Jaime)

Crucially, Jaime's account suggested that her fears about child protection interventions, and particularly child removals, meant that she was unable to ask for help to stop drinking during pregnancy ('I never told them the extent of the drinking cos I was that scared'); the child protection paradigm itself put Jaime and her baby at risk by forcing her to detox alone, without support from practitioners. Jaime judged that detoxing alone was a way to keep herself and her baby safe, which I saw as a rational response to the situation in which she found herself. Jaime's experiences of poverty, homelessness, domestic abuse, and opiate and anti-depressant prescriptions were likely to have seen her labelled 'vulnerable' during pregnancy, leading to additional interventions. Jaime may already have been considered as potentially unable to keep her baby safe, despite the adversities she was experiencing not being her fault, so any further disclosure or attempt to seek support for her drinking would potentially have marked her out as requiring child protection measures. Ironically, the child protection system forced her to take a risk (detoxing alone) to minimise the risk of her baby being taken away.

Jaime's account of detoxing alone was shocking because it implied that she was scared enough of statutory intervention and possible child removals to take the risk of detoxing without professional support. There was, however, also a palpable absence

throughout this research; women who were unable to participate because they were unknown to services or for whom participation may have felt too risky. Practitioners indicated that women who had been involved with specialist services during pregnancy and were no longer pregnant were often no longer contactable by these services, and throughout the recruitment period, two women were referred to the study but lost contact with services before we could meet; in both cases their children had been removed and the women were no longer known to services. There were no referrals to the study from paediatricians even though I specifically sought to recruit from them in each of the 7 areas, and only one referral from child health services; informal discussions with practitioners suggest that this may partly be because they do not always keep track of women once they leave maternity services, particularly if their babies are removed. Previous research has highlighted that women whose children are removed are often no longer eligible to receive support from services, because they are no longer responsible for a child, and they are therefore left alone to deal with the trauma caused by child removals, thus exacerbating the exclusion they already face (Broadhurst & Mason, 2017; Kenny et al., 2015; Morriss, 2018). Although it is impossible to know why these women did not participate, or what they would have said if they did, it is likely that those who did not participate were even more marginalised and powerless than those who were able to participate. If women who need help (for example Jaime, but also potentially those who were unable to participate) actively avoid it, this raises serious questions about the acceptability and accessibility of public services and how this may exacerbate existing inequalities.

8.2.2 Public surveillance leads to hiding

A consequence of the focus on women as the source of risk and harm to babies is that women experience public surveillance and judgement throughout pregnancy, which women described as contributing to the need to conceal their drinking. Women described feeling watched when they were pregnant, with people offering advice and opinions about many aspects of how they should behave and feeling disapproved of even when they were following government advice, reflecting the expectations of reproductive citizenship explored by previous research (Lupton, 2012; Salmon, 2011). Experiencing surveillance (although they did not use this word) during pregnancy from friends, family, acquaintances, and strangers was commonplace. Niamh described

being advised by friends and strangers not to exercise during pregnancy, which conflicted with government advice and made it impossible to avoid feeling disapproved of:

> 'As soon as you become pregnant, they have an opinion about how you look, what you're doing, you know, if you're exercising. Like, I was on the treadmill in the gym, and waddling very slowly, with my first, because I wanted to keep active… But some people were like, you know, what are you doing, that can't be good for the baby. And it actually enabled me to have the stamina to give birth, without any sort of interventions. So, it's very hard, it's a very, very difficult line to walk, I think.'
>
> (Niamh)

Niamh suggested that pregnancy involved being watched constantly, and having to make decisions which are publicly judged, and that this surveillance and judgement necessitated a careful balancing act, a 'difficult line to walk'. Many of the women alluded to the discomfort caused by this public surveillance, although they acknowledged that it was not intended to be unhelpful or unkind. Women described surveillance in all aspects of life during pregnancy – they described being watched at work for their fitness to continue working, feeling watched while in public pregnant and with their older children, and while with family and friends.

Drinking or not drinking alcohol took place within the context of this surveillance – women knew they were being scrutinised, anticipated it, and knew that drinking during pregnancy was disapproved of. They described a range of experiences of surveillance regarding drinking, ranging from 'knowing' that they were being judged (Maddy, Ellie) to people shouting at them for drinking (Isla). Many of the women described changing their drinking behaviour in public in anticipation of and response to the surveillance and judgement of others; taking steps to appear to not be pregnant, or to appear to not be drinking alcohol, in order to avoid this judgement. This was the case for women with high and low SES, and women who reported drinking at a low level and women who reported drinking at a higher level. Women did not describe cutting down their alcohol intake behaviour as a result of this policing; their focus was ensuring they were not *seen* drinking when pregnant. Ellie, for example, continued to

drink alcohol throughout pregnancy, but did not drink non-alcoholic beer in public places because it looked too much like an alcoholic drink:

> 'I missed having a pint when I was watching the rugby. But they had this non-alcoholic beer on tap, so I would get a pint. And over the course of a rugby game, I might get through three or four pints of this stuff…I ended up stopping doing it 'cause I just felt so judged. Because I knew it was non-alcoholic but everyone around me just saw this heavily pregnant woman with a pint.'
>
> (Ellie)

Ellie's example highlighted the impact of public surveillance, which was about appearance rather than risk; she stopped drinking a non-alcoholic drink because she 'felt so judged' but continued to drink alcohol at home; the surveillance did not reduce the risk to the baby. Many of the other women also described public surveillance leading to changes in how they portrayed themselves or their drinking, rather than changing the drinking itself. Women described making attempts to hide their drinking (for example by drinking mainly at home or drinking alcoholic drinks that could pass for non-alcoholic drinks), or their pregnancy (by wearing baggy clothes or sitting down); nobody described cutting down their alcohol consumption because of surveillance or judgement. This finding supports previous research around stigmatisation, for example around obesity, which argues that far from improving health, a focus on appearances draws attention away from the structural determinants of health and increases the blame and stigma individuals experience (Williams & Annandale, 2020).

This focus on appearances and the importance of concealing unacceptable behaviour during pregnancy was further illustrated when women looked at pictures of pregnant women during interviews (see figure 11). Although many of the women disliked the first picture, Jaime, Rachel, and Cathy, who had all been involved with specialist drug and alcohol services during pregnancy, had the strongest reactions. They all took steps to distance themselves from the woman in the picture, making clear during the interview that they did not approve of her and would not do what she was doing, and they all focused on her perceived lack of effort to conceal her drinking during pregnancy, rather than the drinking itself.

Figure 11: Pictures of pregnant women drinking

(Pictures from Shutterstock)

Cathy argued that the woman in the picture should attempt to conceal either her drinking or her pregnancy; she was not making the effort to adequately conceal her drinking during pregnancy, which was unacceptable:

> 'Well, see the [first] one, and this might contradict what I'm saying, but see if that was me, I wouldn't be walking about with my belly out like that… you're going to get heavily judged by people if you're wandering about like that. Like you're putting it in people's faces, I'm pregnant but I've got this fag and this bottle.'
>
> (Cathy)

Cathy was keen throughout the interview to emphasise that she was not like this woman; she always either drank at home or wore baggy clothes to hide her pregnant body; she didn't 'put in in people's faces'. Jaime and Rachel also made it clear that they did not drink in public once they were visibly pregnant and were very careful to make it clear that they were different to the woman in the picture; they 'wouldnae [would not] like to be seen like that' (Jaime) because 'it looks like she doesn't care' (Rachel). This focus on the woman's lack of concealment enabled Jaime, Rachel and Cathy to contrast themselves with her so that they could avoid the stigma of public drinking during pregnancy; they successfully hid their drinking, thus conforming to how pregnant women should appear. This focus on appearances is a logical response to public surveillance, which focuses on the superficial. The public surveillance described by women, including the judgements they made about other women, functioned to

ensure that pregnant women conformed to other peoples' expectations of how they should appear; women did not suggest that it reduced risk, and I suggest that it potentially increases risk to women and their babies by compelling women to conceal their drinking.

8.3 Powerlessness

Although Rachel, Jaime, and Cathy, who were attending specialist drug and alcohol pregnancy services, were ostensibly positive about the specialist services they engaged with during pregnancy, they each recounted stories and thoughts throughout the course of the interviews which suggested that they were negatively affected by the policy approach to drinking during pregnancy. The three women described a higher number of contacts with the service than women attending standard services, often including drug and/or alcohol testing and unannounced visits. Cathy stated that one of the things she liked about the specialist service was its flexibility; she could see staff at these services on an ad-hoc basis as well as planned and unannounced staff visits, and she described frequent visits to the specialist service to check the baby's heart rate, at her request, after she had been drinking:

> 'But definitely like [specialist service] and my support worker, they helped me through the journey and I felt better. Like see if I had a drink the next day I would feel quite panicky thinking what damage have I done? But when I went and spoke to like the [specialist] midwife [and told her I'd been drinking]… and they checked the baby's heartbeat… it made me feel a bit of relief, a sense of relief if you know what I mean.'
>
> (Cathy)

The voluntary surveillance Cathy described here can be seen as a result of the individualisation of risk; being seen by the specialist services makes her feel a 'sense of relief' because they can tell her that the baby is ok despite the 'damage' she could have done by drinking. Cathy's assumption that if there was anything 'wrong' with the baby it would have been caused by her drinking is reflective of the individualisation of risk to women's bodies, which positions mothers' behaviour during pregnancy; in this case drinking; as the cause of any problems that occur (see section 2.6.2). Although

Cathy describes the surveillance provided by the service as reassuring, it also reinforces the idea that she is a risk which the baby must be protected from. It also perpetuates the inaccurate idea that any 'damage' would be visible with a heartbeat monitor, and that surveillance from a specialist service can therefore mitigate risk.

Cathy's descriptions of aspects of her maternity care highlighted her powerlessness within maternity and child protection services, although not the specialist pregnancy service. She recounted disclosing her alcohol consumption to the midwife at her booking appointment and then being informed that the midwife would be making a referral to social work because of her drinking, leading to social workers contacting her older children's schools to check the children were ok:

> 'And then I did tell her, how dare you, I says, you've got no right. … you go to my kids' school and ask for information. So then right away it's going to put it into those teachers' heads what's going on here? Which is a total red neck for the children to be honest with you and then that's why children get singled out because of these actions. That's what I was really angry about… my kids are my life and because I have a glass of wine here or there, she thought she would have the right to go to social work and put my name forward, so I was really angry about that…'
>
> (Cathy)

Aside from the potential implications this treatment of drinking during pregnancy as a child protection concern has for women's likelihood to conceal their drinking during pregnancy (see section 8.2), it increased the powerlessness Cathy felt, in a situation in which she was already marginalised due to her financial and housing situation, '… you've got no right'. Although it is possible that this midwife was acting in line with child protection guidance, Cathy was angry that practitioners were making decisions about her that she strongly disagreed with, and that even when she expressed her disagreement, they did it anyway; she had no control over the situation and her opinion was irrelevant compared to that of the practitioner. Cathy expressed her resentment of the practitioner's assumption that she may not be adequately caring for her children because she drank alcohol ('my kids are my life and because I have a glass of wine here or there…'), and that once she had disclosed the drinking she had no

control over the degree of intervention in her and her children's lives. She described feeling throughout her pregnancy that it was often assumed by practitioners that because she was drinking and pregnant, she would not want or be able to be involved in decisions about her children. An example of this was the baby being assessed for FASD following her birth on a specialist drug and alcohol maternity ward without Cathy's knowledge or permission:

> '...even in the hospital… they didn't tell me but I found out after, it was marked on my records and they actually were checking her for...checking my baby for alcohol withdrawal symptoms but they never told me that...my health visitor told me they checked her to see if she was in withdrawal from alcohol, which she wasn't. But I think you should get to know in a hospital if they're checking a baby for that, but I never knew until I was out.'
>
> (Cathy)

Cathy seemed angry about this as she recounted it; her repeated emphasis that the staff did not seek her consent to test her baby underlined her shock and surprise at the assumption that she would not expect or require any power or control over her life as a mother 'I think you should get to know…'. Cathy expected to be respected as her child's parent – possibly because she had two teenage children who had always lived with her and had never experienced child protection interventions before her current pregnancy - and consulted about her baby's care and was shocked when this did not happen. She appeared to see this as part of a wider disregard for mothers who used alcohol or drugs, going on to describe women who needed to leave the ward to smoke being left waiting outside the ward by staff, and a subtle but unmistakeable harshness of tone from practitioners to new mothers in the ward, which she felt reflected their disapproval of maternal smoking, drinking and drug use. Cathy's anger at and resistance to the assumption that she should accept her own powerlessness as a mother contrasted with Rachel's account.

Rachel, who had experienced repeated child removals and was pregnant during the interview, was very familiar with having social work and child protection intervention in her life. I was struck by Rachel's powerlessness within these systems; the multiple child removals she had experienced had taught her that it was state services, not her

as a mother, who would make decisions about her children's futures, and it was evident throughout the interview that she had come to accept this powerlessness. For example, Rachel described remaining silent in meetings with social work:

> 'You're allowed to [put your point of view across in social work meetings] but at times it's like what's the point, you know, they've just turned around and telling you you're not getting your baby. What can I say? You know? But sometimes I feel like argh, you know, going crazy, and they make you feel like you want to do that, but it's like, no I'm not gonna give them what they want, but ehm, aye [yes], it's whatever they say, it's like sometimes you sit there and think well I can't say that because I'm not getting him back, you know? But then like the [specialist care] team's like no you tell them how you're feeling, you know… don't sit there and let them get at you and judge you, you get up and tell them how you feel. You know so I'm gonna start doing that, maybe make me feel a bit better' (Rachel)

Rachel indicated that she had learned that it was ultimately pointless to put her view across in meetings (what's the point…') because practitioners were the decision makers who held all the power and made decisions about her life ('telling you you're not getting your baby'). She was not allowed to express emotion by 'going crazy' in meetings because this would count against her (it is 'what they want'). This is an example of the 'silencing' described by previous qualitative research which has found that parents describe feeling coerced, not treated as equal decision-makers, and silenced within the child protection system (Smithson & Gibson, 2017), and that it is almost impossible for mothers who have experienced previous child removals to resist this silencing and stigmatisation because to do so may jeopardise their chances of keeping their children and increase chances of future child removals (Morriss, 2018). Even when Rachel considered expressing her opinion in meetings, it was notable that she did not appear to expect this to make any difference to the outcome of the meetings or to make a material difference to her life or the practitioners' decision-making – she would just be doing it to make herself 'feel a bit better'. This contrasted with Cathy, who expected to be considered a partner in decision-making and to bring up her own children with minimal intervention, and even more strikingly with middle class women like Ellie and Maddy, who described a high level of autonomy and

decision-making and were openly critical of policy and practice throughout their interviews.

Further compounding her powerlessness, Rachel did not appear to understand why her children were removed, or why she was receiving support from a specialist service when she had not received this in her previous pregnancies. This not knowing appeared to be very hard for her to cope with, because from her perspective not having this support during earlier pregnancies (or earlier than this) had ruined her life, because it had enabled the removal of her children. Not knowing whether her baby was going to be removed at birth clearly caused Rachel a lot of anxiety and distress, and she was expected to live with this level of uncertainty until the baby was born:

> '… we don't know yet, like you've got to wait and find out what's happening… they're giving yin that chance and working with you, then to get told the baby's going away forever, it's like why did you get the [specialist care] team involved then, you know? So you dinnae ken [don't know] … what's happening.'
>
> (Rachel)

Rachel spoke as if she had no power over whether she kept her baby or not; it was all in the hands of the practitioners ('you've got to wait and find out what's happening'). She therefore had no choice but to engage with the services that were offered to her throughout pregnancy if she wanted to keep her baby. This made me question how far Rachel's repeated positive comments about the specialist care team, which she appeared to see as separate from social work, could be taken as evidence that she viewed the service positively; as I reflected on the interview afterwards I wondered whether this need to repeatedly describe the service positively might have been an attempt to present as patient and grateful for their 'help' in order to increase her chances of keeping her baby. An example of this was when Rachel described the alcohol testing she was subject to in the specialist service; she appeared to be proud and hopeful that this would count in her favour and make it more likely that she would be able to keep her baby:

> 'I'm getting tested with alcohol as well, and they've all… come in at zero…

Annie: Ok so how does that work then? Do they test you at your antenatal appointments?

Rachel: Eh, no, she just, like, whenever she wants to see me… And it's been coming up negative, negative, negative, negative, which is good, so the social work, cos that's what they're wanting to see.'

(Rachel)

Rachel was keen to tell me about these consistently negative alcohol tests near the beginning of the interview and returned to this topic throughout the interview; she seemed to offer them as evidence that she was a good enough mother, as previous research has found with parents using opioids (Chandler et al., 2013). It would be possible to interpret this as meaning that drug and alcohol tests during pregnancy were a positive experience for women, and some of the practitioners appeared to interpret women's willingness to be tested as evidence that they welcomed testing. It is also possible, however, to see Rachel's account of testing as indicative of her powerlessness within services; she had to be tested in order to prove she was fit to care for her own child, who she had already been informed would likely be removed from her at birth; and she had to agree to testing 'whenever [the practitioner] wants to see me', and was expected to adhere to the abstinence guidelines as part of proving worthy of keeping her baby. Although alcohol testing was not mandatory she had been given the impression that it would help her case if she complied with it ('that's what they're wanting to see'); and she is right about this - practitioners described women's engagement with alcohol testing and other forms of surveillance as key factors in child protection decision-making (see section 7.4.2) so she had no meaningful choice about whether to comply with the abstinence goal if she wanted to keep her baby.

8.3.1 Resistance and compliance

Practitioners described advising women not to drink as a major component of their work (see section 7.4.1), and although all the women participants were aware of the abstinence framework, they suggested that this advice-giving had not affected their drinking. Conversely, some of the women appeared to resist the advice and guidance relating to drinking.

Middle class women described complex ways of controlling their bodies and weighing up and balancing risk during pregnancy, which often required seeking out additional information and evidence, and they often described these personal risk assessments as leading them to go against government advice in many areas, including but not limited to alcohol related guidance. All the middle-class women in the study (apart from Kate, who sought to eliminate all risk by following all the guidance) described doing this to varying degrees by choosing aspects of government advice that they would follow, and aspects that they would ignore or modify. In relation to alcohol all the middle-class women (with the exception of Kate) said that the existing guidance on alcohol was not detailed enough, took a one-size-fits-all approach and was over-simplistic:

> Eilidh: '… because they [the Government] just say, zero tolerance, it's almost like they take away that ability for you to actually make a…'
>
> Alison: 'Personal decision.'
>
> Eilidh: '…a more, a more informed risk assessment because there's no information as to …whether five units a week is or isn't harmful, or whether 20 units a week is. And it's probably because every person is different and every pregnancy is different. And I can understand they [the Government] probably don't have a choice but it makes it harder because then their only advice is, don't take any at all.'
>
> (Eilidh and Alison)

The words that women used here, about being able to make a 'personal decision', a 'more informed risk assessment', and the importance of accessing enough information to make a decision, reflected the individualisation of risk; women had been responsibilised for the safety and wellbeing of their unborn babies so they sought out more information than was provided by government guidance in order to help them come to a decision that they felt was right for them. When talking about guidance relating to alcohol they kept coming back to the precautionary principle (without specifically calling it 'the precautionary principle' with the exception of Ellie, who did use this phrase); women made it clear that they understood that the focus on abstinence was intended to eliminate all risk and did not mean that all drinking was necessarily dangerous. They were aware of the lack of evidence around low-level

drinking and described taking various factors into account when deciding whether and how much to drink during pregnancy. This may reflect an unintended consequence of the risk paradigm– women have been responsibilised for risk to the extent that individual women are enacting reproductive citizenship by weighing up risk themselves, therefore simultaneously 'doing' reproductive citizenship by taking responsibility for and avoiding risk and resisting or rejecting it by going against government guidance.

Practitioners also talked about this middle class resistance, suggesting that women with higher SES could be harder to work with because they were less compliant than the women they usually worked with. When practitioners described middle class women who drank during pregnancy there was often an undertone of irritation that these women would not do what they were told and just stop drinking:

> 'Yes, professional, highly educated females, are probably most problematic to work with. Because they're in denial, constantly. I've had a good few cases where, I don't like getting them, but I'm always allocated these cases… a very superior attitude, you know, thinking that she knew all… Give me your wee woman, on benefits, coming from a deprived area, they are the most open and honest, and wanting help.'
>
> (Val, Social Work Practitioner)

Implicit in this practitioner's account was that women who did not accept the abstinence framework were 'in denial' because abstinence was right, and women's drinking caused risk and harm (see section 7.4). Asserting that she would rather work with 'your wee woman on benefits' implied that she could be sympathetic to women who complied; middle class women were annoying because they refused to comply with practitioners' ideas about what they should be doing, while women with lower SES were more likely to do - or at least appear to do - what they were told.

Women's accounts confirmed this practitioner's observation that some women were more resistant to abstinence-based advice than others. Those with lower SES, and particularly those who had been involved with specialist services, reproduced dominant abstinence narratives less critically than the middle-class women. Women with lower SES who had not been involved with specialist drug and alcohol services

(Isla, Dawn, Charlie) did not describe resisting in the same way as women with higher SES. Although they sometimes expressed scepticism about the advice they were given, they usually described following it anyway. Contrasting with the women who were not engaged with specialist services, and particularly with women with high SES, the three women who had been in specialist services did not use the interview to question or critique the guidance they had been given about alcohol during pregnancy. They all strongly and repeatedly emphasised the importance of abstinence during pregnancy throughout their interviews, stating that drinking in pregnancy is 'not good for the baby' (Cathy), 'you should… not drink when you're pregnant' (Rachel) and 'there's definitely no safe limit for alcohol' (Jaime).

The compliance which characterised these accounts contrasted with women who had not been in specialist services' positioning of the guidance as optional, not evidence-based, and part of a wider risk assessment which they had the right to make. It is possible that Jaime, Rachel and Cathy's interaction with specialist drug and alcohol services during pregnancy had increased their exposure to the abstinence-focused 'no alcohol, no risk' message that characterised the practitioners' portrayals of alcohol consumption during pregnancy. Jaime and Rachel both referred to reading about the way women's behaviour during pregnancy affected babies in baby books and websites. Jaime described doing this reading after her son was diagnosed with FASD, and Rachel had already had four children removed from her care and was currently pregnant at the time of the interview, so it is likely that both women had been highly exposed to the dominant abstinence narrative around drinking during pregnancy and had more of an incentive to and were more expected to accept the abstinence framework uncritically.

Although these accounts suggest on the surface that women who had experienced specialist services were more likely to agree with abstinence-focused guidance, it is also possible that they were more compelled to tell me that they agreed with it in the interviews; those who had more power and status were more able to resist or question narratives of reproductive citizenship, while those with less power and status had less freedom to share any concerns or queries about the abstinence framework. When seen in the context of the powerlessness experienced by these women, including the higher likelihood that their children would be removed (Bywaters et al.,

2018; Featherstone et al., 2019; Morris et al., 2018), this apparent compliance is unsurprising.

8.4 Marginalisation

The services that practitioners and women described reflected the narrative of women's drinking being the key source of risk and harm. The framing of drinking during pregnancy as a medical rather than social problem (see sections 2.4.1, 2.6, 7.4) means that medical responses with a strong emphasis on abstinence have been prioritised over social responses with a focus on family support. This medical focus further marginalises the most marginalised women, who cannot access these services due to the adversities they experience.

8.4.1 Abstinence focused services

Because alcohol dependence was constructed as the central problem for women who drink (see section 7.4), abstinence was portrayed as the solution, with advice giving, surveillance, and detox as the three possible ways to achieve this goal. Although this focus on women's drinking may provide some women with support to stop drinking, it perpetuates the centring of mothers as the cause of harm, frames drinking during pregnancy as a psychological rather than social issue, and focuses responses on individual women rather than the structural problems that can affect maternal and infant health. This aligns with previous research which suggests that interventions with parents who use alcohol or drugs often emphasise the 'recovery' of the parents, requiring them to demonstrate that they are abstinent, at the expense of understanding and providing support for contextual factors affecting their drinking and their lives (Boreham et al., 2018; Chandler et al., 2013).

When practitioners compared their experiences of working with women who drank to working with women who used drugs, they concurred that it was easier to support women who used opiates because practitioners could help them access and manage OST, whereas for drinking women, detox was their only option. Although this can be seen to reflect the contrasting policy approaches to alcohol and opiate use during pregnancy – treatment for other substance use occurs with a broadly harm reduction focused approach, including during pregnancy, while alcohol use during pregnancy is

met with a strictly abstinence- based approach - arguably neither approach addresses the broader contexts in which women use substances; they simply offer a medicalised 'treatment' which limits the baby's exposure, without supporting women and their families or addressing the wider structural harms they experience.

Practitioners all described alcohol detox during pregnancy as an inpatient treatment, usually over the course of five days, involving the short-term use of benzodiazepines, to limit risk to the baby. Practitioners portrayed detox as a medical, rather than therapeutic or social, intervention. Despite describing detox as the only medical treatment available for women who did not stop drinking after they were advised to stop, practitioners were not optimistic about its impact on women during pregnancy:

> '… it didn't work… I think if you have had a really strong dependency on alcohol for a long time people...if you're not pregnant people generally don't just stop overnight… we all want that for the baby… we put our effort and resources in, but it's hard to imagine really that it is going to be any different if you're in your mid to late 30s and you've been drinking like this for ten or 15 years or more, it doesn't stop overnight whether you're pregnant or not.'
>
> (Jane, Maternity/Child Health Practitioner)

There was a sense of hopelessness pervading Jane's account of detoxing pregnant women; 'it's hard to imagine that it's going to be any different'. This sense of hopelessness was shared in the accounts of many other practitioners who described women 'relapsing' during and after pregnancy, and women returning to the specialist service in subsequent pregnancies. Although she framed the difficulty with detox as mainly about alcohol dependence, some of the other practitioners reflected on 'relapse' as a response to contextual factors in women's lives once the detox was over. For women who were already experiencing multiple, complex, layered adversities (see chapter 6), detox was not perceived to work because once they left the inpatient setting and returned home, they were faced with the same complexity and adversity as before, except now they were unable to drink. Some of the practitioners specifically related this to trauma, with drinking as a kind of masking or numbing; a coping mechanism that was removed by detox (see section 7.4.3), therefore making it harder for women to cope with the adversities they faced.

One Social Work Practitioner was explicitly critical of what she termed the 'recovery focused system of care'. She argued that the focus on recovery services raises several problems:

> 'We are now very much in a recovery focused system of care, that's the buzzword, which is fantastic, and it needs to be embraced, 'cause that's the way we need to go. But the difficulty I have is, it's all very well, if your mental health is stable, and you don't have any trauma issues, and you are, you know, you're okay. And you grasp, your motivation is good, and you grasp the recovery bug, and that's fantastic. But on the other hand, we have a high percentage of women out there, where they are self-medicating constantly, they're constantly being impacted by trauma, after trauma, after trauma, they're chaotic, and we don't have anything. We don't have another resource for these women, we don't, because these resources are gone… Because it's recovery focused, budgets are going to recovery, rather than looking at the most chaotic aspects of women. There's nothing, I don't feel there's anything there… So, but I get it, it's budgets, it's money, yeah, it is, it's money.'
>
> (Val, Social Work Practitioner)

Implicit in this critique was that abstinence-based recovery services required service users to take individual responsibility for their recovery, and that this was harder for some women than others. This focus on personal responsibility which Val criticised was evident in the accounts of many of the other practitioners, who described 'teachable moments', the 'cycle of change', 'motivation' etc – all well-used recovery 'buzzwords'. SW's criticism of these foci was not that recovery was necessarily a bad goal, or that addiction did not exist – it was that a focus on abstinence-based recovery to the exclusion of outreach and support services further excluded women who were already marginalised, because it created a situation in which, for financial reasons, 'we don't have another resource for these women… these resources are gone.'.

This sense of hopelessness about the impact of abstinence-based recovery services on women was mitigated somewhat by the sense that they may offer a way to minimise the impact of alcohol on the unborn baby; the maternity/child health practitioner's account above stating that 'we all want that [detox] for the baby' implicitly suggested that detox was for the baby, not the mother. Other practitioners also alluded to detox

as being mainly aimed at the baby by focusing on the decreased total alcohol the baby would be exposed to over the course of the pregnancy in their accounts. This focus on the baby, and the accompanying assumption that detoxing the mother would minimise the impact on the baby, reflected the individualisation of risk to the mother's drinking; alcohol was framed as the main risk being faced by the baby and treatment to limit exposure was therefore prioritised rather than meaningful support to help women address the complex situations that may be related to their reasons for drinking in the first place.

For women who were unable to access abstinence-based services, or who could not become abstinent, this focus on abstinence exacerbated their marginalisation because it meant that the only option was for their babies to be removed. The impact of this was a sense of hopelessness for women who were trapped in a cycle of repetitive child removals. Practitioners explained that for some women child removals were part of a cycle that kept repeating itself; many of them told me anecdotes about women who had experienced repeated child removals, and some of the practitioners described a sense of hopelessness in these cases; one of the Social Work practitioners, for example, described women who continued drinking because their children had been removed, situating child removals as a cause, rather than simply a consequence, of drinking during pregnancy:

> 'It's interesting as well, we do work with women who've had repetitive removal of children and it's not enough to stop the cycle happening. That's not just about physical dependency, that's about, I think, hopelessness as well. It's almost like, well, there's no point [in trying to stop drinking], because if it's happened already… it's kind of heart-breaking really working with that group of women.'
>
> (Lynne, Social Work Practitioner)

This 'heartbreaking' 'repetitive cycle' of child removals described by this practitioner echoed previous work on child removals which highlighted the profound and permanent impact on women's lives (Broadhurst & Mason, 2013, 2017; Kenny et al., 2015; Morriss, 2018; Tyler, 2013), compounded by the fact that women who have a

child removed are likely to experience subsequent child removals (Broadhurst et al., 2015).

Rachel, who had had four children removed, reinforced this feeling of hopelessness, arguing that practitioners had in the past made assumptions about her ability to care for her children because previous children had been removed, and that therefore stopping drinking was pointless as it would not lead to the children being returned or prevent subsequent children being removed (see section 6.2.1).

8.4.2 Lack of outreach/ intensive support

Some of the practitioners questioned the efficacy of the medical focus of responses to drinking during pregnancy, because they were aware of the wide ranging and complex structural and social issues faced by women who drink during pregnancy and understood that this could not be 'fixed' by a medical intervention:

> 'I would say, over the years, we've had quite a lot of women in, and had their detoxes in [hospital]. And it's quite good. They don't get any therapeutic interventions… it is purely for a medical detox, and nothing else… I would like to see a bit of kind of therapeutic intervention, but then they'll say that's up to us to go up on a daily basis, and deliver that. Which, we can't do, probably once, twice a week, is the best that we can get up there and try and get some coping strategies taught, for them coming back out into the community, about what happens if, you know, somebody approaches them, and what to do with your cravings, all that kind of stuff… That I would like to see done, you know, while they're going through the detox. But obviously, there's no scope for that to happen.'
>
> (Val, Social Work Practitioner)

Val asserted that women should be supported to prepare for going home without drinking but was clear that women currently left detox without being adequately prepared because of resourcing constraints ('there's no scope for that to happen'). Although some of the other practitioner accounts were not as explicit about this lack of support, they all acknowledged the impact of austerity on families who needed support (see section 6.3). Practitioners' accounts often alluded to this lack of social

support but were working within a system that offered no other options. These resourcing constraints are the result of policy decisions and cuts to public services and austerity; despite an increasing focus on the early years in Scottish and UK Governments in recent years, services to support parents in these years have been systematically defunded, and punitive austerity-based policies have made it harder for families to survive. For parents who drink or use substances, there are fewer intensive support services than there previously were, which is what the practitioner alludes to here. This lack of social support services sets women up to fail, because it addresses women's drinking without addressing the other aspects of their lives; they receive a detox without appropriate additional support. The impact of the lack of adequate intensive family support services was also highlighted by Rachel, who had experienced multiple adversities including several child removals and drank at a high level during previous pregnancies.

> '[My Mum) died in front of me, a heart attack… Cos she tried to get off the drink… And they were giving her that, ehm, can't remember what it's called, you know that pill that you swallow so you don't drink… my mum was actually taking it when she took a heart attack, like 2 days later… She tried [to come off alcohol], yeah, then 2 days later she died. She was going into hospital all the time, and trying to get help, like me… I'd been going into hospital to get help and they don't help and they don't help… And for them to shove you out the door, you know, it's happened four times to me… you've got to go attend to the hospital for like an assessment, but if you've had a drink, they can't take you… you've got to be sober… And for my mum getting chucked out all the time, I think probably why she took a heart attack. Cos I always remember a week before she died ehm she took an overdose… and she just got out the hospital that day, and it's like I wish she was still here to ask her… was it because they were chucking you away like what they do to me? That's when you turn to drink, it's like what's the point? You're not going to help.…You go in, you come out… Like you can go to AA and that, you can go to like AA groups, you can go to counselling, and I'm like that's not helping, I'm needing professional help.'
>
> (Rachel)

Rachel described her mother's heart attack as a result of 'trying to get off the drink' rather than the drinking itself, and her mum as overdosing on the day she left hospital, implying that the hospital treatment was inappropriate and ineffective. She implied that she viewed her mother's death as due to a lack of appropriate services, with the only treatment available being purely medical - being detoxed and prescribed disulfiram - rather than any kind of supportive, therapeutic, or practical intervention. Rachel's account hinted that her mother's overdose may have even been a direct response to this treatment; she 'turned to drink' because it was clear that 'you're not going to help', and she imagined asking her mother 'was it because they were chucking you away like they do to me?'. Rachel described feeling rejected by services in the past (they 'shove you out the door'; they 'chuck you away') because she did not fit the requirement to be 'sober' before being admitted, which resonated with the social work practitioner's account of women being further marginalised by inappropriate services because they could not 'grasp the recovery bug'.

Rachel's account of her mother's death, and its juxtaposition with Rachel's account of her own experience with services, suggested that the abstinence focus of the services available to both women was not only unhelpful but harmful to them. Rachel and her mother were looking for something more than a medicalised, detox-focused treatment from services, 'they don't help and they don't help'; but they were not provided with what they needed, which was much more than a detox ('you go in, you come out…'), and was itself a source of disappointment, rejection and trauma, possibly leading to further drinking, rather than a supportive, understanding and helpful service. Throughout her interview Rachel described being told by practitioners that her mental health problems (for which she described being offered some treatment such as anti-depressants and counselling) were the reason for her children being removed, reflecting dominant narratives around illness as a reason for drinking (see section 2.3) and centring any potential responses to her problems as focusing on her mental illness, minimising her understandable distress in the face of multiple adversities which were too complex and challenging to be accommodated by existing services.

The focus on abstinence-based psychological recovery at the expense of other more intensive, support- based services has according to one social work practitioner led to a situation in which meaningful outreach and support is not available for women until

they reach crisis point. She described this recovery focus as a way of saving money in the short term, alleviating stress on local authority and health board budgets, but as largely ineffective for women who experience multiple adversities and probably harmful for women who were really struggling:

> 'If you're chaotic, chaotic alcohol or drug user it used to be, we could get people into residential, but now it's, you know, we need to test their motivation… But how do we support somebody who's caught up in that chaotic cycle… it is totally just making sure they're safe… And then, eventually, something will happen, where their health will become really, really poor, and they end up in a spell in one of the hospitals, and they can be in there for five days, and it's your chance to get in there… … Or they end up in a spell in [prison]... And sometimes for our women, it's a blessing, when they actually do get a [jail] sentence. Because they need it, because that's the only place that can keep them safe, is a wee jail sentence. And you think, that's it, at least she can get time to heal, physically and mentally. I know it's the worst, and it's really punitive, but if it keeps her alive, you know.'
>
> (Val, Social Work Practitioner)

Val's contention that we are now in a situation in which 'a wee jail sentence' is a 'blessing' is shocking because it highlights the dearth of resources to support women who are most marginalised; the prominence of the recovery model, with its focus on individual capacity to, and responsibility for, change, means that those who are coping with multiple adversities are often unable to access services. This resonates with Rachel's account of her mum's death and her own difficulties accessing appropriate support. Val suggests that the current system makes it inevitable that some of the most marginalised women will end up in prison or in hospital with 'really, really poor' health because all we can offer them until they are in crisis is 'harm reduction' rather than any 'therapeutic work'; the best anyone can hope for with a 'chaotic' alcohol user is to 'keep her alive'.

8.5 Conclusion

This chapter has described how the UK's current approach to drinking during pregnancy, which focuses on abstinence and child protection, exacerbates the powerlessness and marginalisation of marginalised pregnant women who drink.

Current approaches, which focus on mothers as the main source of risk to babies, compel some women to hide their drinking, which may further increase risk to mothers and babies. Those who do access specialist services, although ostensibly positive about services, may be rendered powerless within systems that consider the needs and interests of babies separately from their mothers, and which prioritise medical treatment over practical support and are therefore unable to offer intensive support for women's complex contexts.

The next chapter will highlight the contribution of this study to wider knowledge on the topic of drinking during pregnancy, including how it relates to previous research on this topic, critically evaluate the approach I took, and consider the implications of this research and associated recommendations, for policy, practice, and further research.

Chapter 9 – Discussion

9.1 Introduction

The previous three chapters have presented my findings, highlighting three main areas: first, the interconnected contextual factors such as trauma, poverty and social factors that women and practitioners described as important in relation to drinking during pregnancy; second, dominant narratives about individual responsibility, reproductive citizenship, and child protection which responsibilised women for the adversity they faced; and third, the ways in which the UK's current approach to drinking during pregnancy, which focuses on abstinence and child protection, exacerbates the powerlessness and marginalisation of pregnant women who drink.

This chapter will critically evaluate the approach I took, including the strengths and limitations of the study. It will then highlight the contribution of this study to wider knowledge on the topic of drinking during pregnancy, including how it relates to previous research on this topic. There are two main parts of this chapter: first, a discussion of the methodology and methods I used, including the theoretical approach, recruitment and sample, photo elicitation and second interviews. Secondly, I will discuss the implications of my findings. The second section contains three parts: first, acknowledging complexity, individualising responsibility; second, structural problems, individual responses; and finally, exacerbating inequality.

9.2 Discussion of methodology and methods

The many challenges experienced throughout the data collection period have been documented in the methods chapter (see chapter 5). Here I discuss the methodological issues and questions raised by this research.

9.2.1 Theoretical approach

My feminist perspective was an integral part of the study, the methods and findings of which would have been completely different if I had chosen a different theoretical perspective. I drew on standpoint theory, intersectionality theory and feminist fractured foundationalism, which highlight the importance of challenging dominant assumptions during the design of the study and throughout the analysis (Crenshaw, 1991; Kleinman, 2007; Wise & Stanley, 2006). This theoretical perspective enabled me to decentre the issue of drinking during pregnancy by situating women's drinking within its broader contexts, thereby challenging the dominant assumption that women alone are responsible for causing FASD. My theoretical perspective also helped me to respond to the ethical challenges that arose when I changed the study design in response to the difficulties of recruitment, helping me to remain mindful throughout of the group of women who had been unable to participate, and the potential reasons for this; paying close attention to who was *not* included, as well as who was able to participate.

Sociologists have since the beginning of the 20th century highlighted the social determinants of illness and distress (Brown et al., 2011; Durkheim, 1897; Rose, 2020), and feminist research has underlined the gendered aspects of women's experiences of motherhood (Oakley, 1979) and substance use and treatment (Ettorre, 2004, 2018). Feminist sociological analyses of drinking during pregnancy still, however, appear to be lacking, paving the way for a predominance of medicalised psychological research and policy perspectives. Those analyses that do take a feminist sociological approach, such as Lee and Lowe (Lee et al., 2014; Lowe et al., 2010; Lowe & Lee, 2010), and Armstrong (Armstrong, 2008) have not generally included empirical qualitative research with women and were published before the most recent change in UK government guidelines (Department of Health, 2016).

Previous qualitative research about drinking during pregnancy has not usually included the perspectives of women who drink at 'high risk' levels during pregnancy or explored broader contextual factors. This individualising research is reflected in- or perhaps is reflective of - FASD policy and practice development, which centres individual women as the source of risk and harm to their children. Exploring this topic from a feminist

perspective and focusing on the inclusion of the perspectives of women who drink, enabled me to challenge these dominant individual-focused perspectives and approach it from a different angle, which has resulted in a socially focused analysis of drinking during pregnancy. By exploring the perspectives of women who reported drinking at a 'high risk' level through a feminist sociological lens, this study has made a key contribution which has previously been missing from UK research on this topic.

9.2.2 Recruitment and sample

Recruiting women who drank during pregnancy for this study was, as expected, challenging. Although this was probably partly due to women's reluctance to participate due to the perceived risks involved, it is also possible that alternative approaches to recruitment may have improved participation.

On reflection, if I were to repeat this research or plan a similar project, I would consider recruiting practitioner participants first, before recruiting women, because this may have improved their engagement with recruitment. This was not possible during this study because the original research protocol did not involve including practitioner participants, so recruitment of women had already begun by the time practitioners became participants. Similarly, it may have made a difference to recruitment if I were a midwife or nurse because it is possible that being an 'insider' may have led to better engagement from gatekeepers (Yoon et al., 2021), or at least would have meant that I had contacts within the NHS that I would have been able to utilise.

It is unlikely, however, that changing the recruitment phase in this way would have completely overcome the challenges of recruitment because the barriers to NHS recruitment appeared to be more about seeking participants from a hidden population than gatekeeping by practitioners. Many practitioners and teams welcomed the study and were enthusiastic about supporting the research, but practitioners were often unaware of who was drinking during pregnancy, or were no longer in contact with women, so were unable to refer women to the study. This challenge was also highlighted by women participants, many of whom questioned the current approach to drinking during pregnancy and told me they had concealed their drinking, so these women would not have been known to practitioners.

It is also possible that my data would have been different if I were seen as an NHS 'insider' by participants; women participants may have been reluctant to discuss some aspects of drinking during pregnancy, for example concealment, if I were perceived to be aligned with the abstinence framework. Although I did not find women's discussions around concealment surprising as a mother, this is not something that I have seen acknowledged in previous qualitative research exploring pregnancy with women, and it may be a topic which is inherently difficult to research because of the risks involved in disclosure because of the cumulative impact of the child protection and abstinence frameworks.

During the initial recruitment period I was very focused on recruiting 'high risk' drinkers, but this was not a successful approach within the time and financial constraints of a PhD. If I were planning the research again, I would make the inclusion criteria broader from the beginning and invite women to choose whether to participate in a focus group or interview, enabling women to participate without disclosing drinking during pregnancy and therefore make participation seem less threatening. If resources were no object, I would also recruit women over an extended period of two or three years.

9.2.3 Photo elicitation

Interviewer-led photo elicitation worked well in the first interviews; as hoped, and as pointed out by researchers who had previously used photo-elicitation, the photos provided a focus for discussion, particularly about structural aspects such as gender, class, and policy – Stanley and Wise's 'extra-local' - which may otherwise have been difficult to broach (Elliott et al., 2015; Wise & Stanley, 2006). All the women took part in the photo-elicitation aspect of the first interviews, and the photos enabled discussion about topics that may otherwise have been difficult to discuss (for example, what it means to be a good mother, our judgements about other people). In some of the interviews the photo-elicitation worked better than others – some of the participants seemed to find it helpful to have pictures to look at, while others came to the interview with something to say and did not reference the pictures very often. With others, the pictures were a good way of providing structure and supporting participants to return to the topic area.

Ostensibly, the photo-elicitation task between interviews was not as successful as the photo elicitation in the first interviews; only one participant fully completed the task and brought photos to the second interview, whilst three others brought the task sheet with them to the second interview having made notes or had reflective conversations but not taken photos. I had included participant-led photo elicitation to help participants to reflect on their lived experience (Drew et al., 2010; Lapenta, 2011; Tinkler, 2013), and despite the lack of uptake of the photo aspect of the task, the inclusion of the task itself helped women to reflect. All four second interviews were led by the participants, because they had all prepared for the interview, so whether participants had taken photos made little difference; it was the time to reflect, and questions to support this, that were helpful. In her research on young people's drinking, Samantha Wilkinson reflected on how offering participants a 'methodological toolkit' with various options to opt into made her research more inclusive as people with differing skills and experiences could engage with the research in different ways (Wilkinson, 2016). In practice the 'photo task' aspect of my own study was reminiscent of Wilkinson's toolkit; women used the task flexibly according to their own preferences and available time. For this reason, if I repeated the study, I would still build in time and space to reflect but would consider taking a more flexible approach, giving participants the questions, and encouraging them to prepare however they wished for the second interview.

9.2.4 Second interviews

I was unable to answer the research question 'In what ways, and to what extent, do women's contexts and accounts vary between the prenatal, postnatal, and early years periods?' because only four of the women participated in a second interview and second interviews all took place within eight weeks of first interviews, so there was not time for women's contexts to have changed between interviews. During the analysis I compared data from first interviews with data from second interviews to see if they differed, but there were no significant differences in women's accounts between the two.

None of the women who had been involved with specialist services during pregnancy participated in a second interview. In one case this was because I was unable to

contact the participant because she no longer had a phone, in another it was because her circumstances had changed, making it difficult for her to participate, and another told me at the beginning of the first interview that she only wanted to participate in one interview. This meant that three of the four women who participated in second interviews had high SES, and none of them were involved in specialist services. It is possible that the complex contexts and adversities faced by women involved with specialist services means that they faced greater challenges to completing a second interview, but as these women may be more likely than others to experience multiple ongoing adversities, and to be negatively affected by the current policy and practice approach, it is important to consider how to remove barriers to participation. If I had implemented a contact tracing system (see section 10.3) this may have avoided some of the problems with re-contacting participants.

9.2.5 Focus groups

I used focus groups to explore the views and opinions of women who had been pregnant, but who had not necessarily consumed alcohol during pregnancy, and practitioners. I chose focus groups to enable discussion, with different views and opinions explored in relation to each other, and to allow for 'questioning discourse' within each group (Barbour, 2013, p43). In practice, I took a flexible approach to these aspects of the research, carrying out some focus groups and some interviews. This was a pragmatic decision because finding places and dates that suited a variety of professionals proved challenging, and it became clear early on that a more flexible approach was required. Similarly, the availability of participants who had very young children was unpredictable, and I had to make pragmatic decisions, in one case once I had arrived at the focus group venue, about how to enable women to participate in this situation.

Some focus group texts suggest that the ideal size for a focus group is 10-12, although Barbour argues that these suggestions are usually based on market research methodology rather than social science research approaches, suggesting instead a maximum of eight participants and a possible minimum of three or four (Barbour, 2013). She highlights that the key features of focus groups are the discussion and interaction within the group as well as meaningful analysis by the researcher, rather

than each participant simply answering researcher questions in turn, and she questions how possible this would be in a larger group.

For logistical reasons, my focus groups were relatively small – two focus groups (one women's focus group and one practitioners' focus group) had four participants each, and an additional two practitioners' groups had two participants in each. I also carried out some interviews separately where focus groups were not possible due to participant availability (see chapter 5 for details). Although there is relatively little literature concerning pragmatic decisions about focus group size, some researchers have reflected on the practical and ethical implications of excluding potential participants based on small group numbers (Toner, 2009). Despite the small size of my focus groups, they all involved interaction between participants, including 'questioning discourse', and provided helpful, meaningful data which contributed to the development of my analysis. Although larger size may have been preferable, and probably would have led to different group dynamics and therefore data, the decisions I made led to the availability of data which enabled my analysis, and which may not have been available had I waited for larger groups.

9.3 Discussion of findings

My findings highlight that despite evidence that women's drinking during pregnancy is connected to other aspects of their lives, including structural aspects, the current policy and practice approach individualises blame and responsibility to women's bodies, thereby failing to address the structural conditions in which women drink during pregnancy. This perpetuates the inequalities and mother-blaming narratives which contribute to women's drinking, and disproportionately negatively affects women who are already marginalised. This section of the discussion will contextualise these findings in relation to previous research, highlighting the contribution of this study to wider knowledge on the topic of drinking during pregnancy.

9.3.1 Acknowledging complexity, individualising responsibility

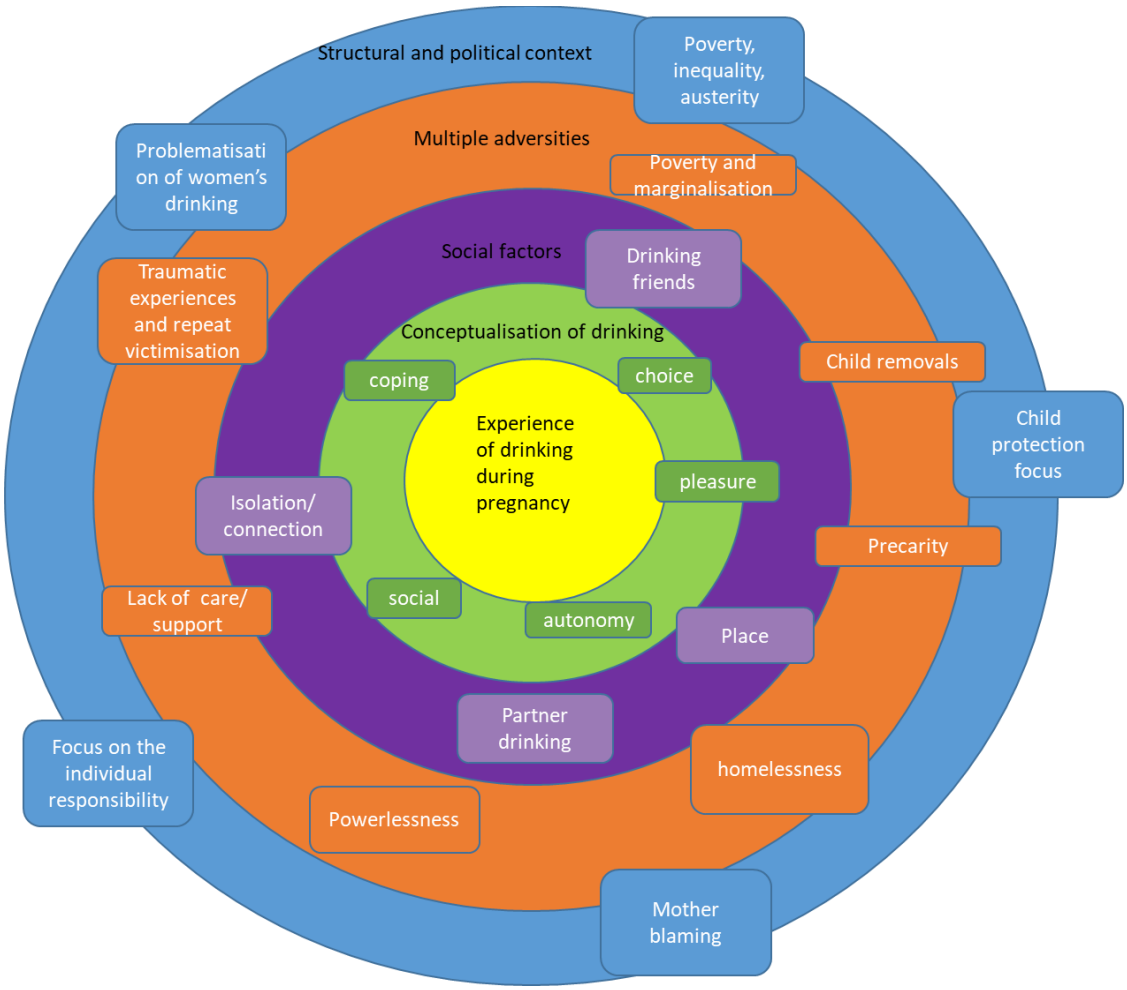
I set out to explore how alcohol consumption, and factors other than alcohol consumption, featured in women's accounts of pregnancy. I found that a range of interconnected factors, including traumatic experiences and repeat victimisation, poverty and homelessness, and social aspects such as isolation, were key to understanding women's drinking during pregnancy (see chapter 6). Jaime, Rachel, and Cathy, who were engaged with specialist services, described multiple intersecting adversities, mediated by structural inequalities, which affected every part of their lives including their drinking. In addition, many of the women described by practitioners had been marginalised by the multiple intersecting contexts and structural adversities they had experienced. The women who had been marginalised all framed their drinking largely as a way of coping with the adversities they faced, while other women framed their drinking as a choice.

My findings emphasise the importance of acknowledging and responding to the multiple interlinking contexts (see figure 12) affecting women's drinking during pregnancy, and particularly the *structural* aspects of women's contexts which have often been unexplored and unacknowledged in previous research. This supports previous research suggesting that drinking can be a response to living within systems of oppression, and that women whose drinking becomes defined as problematic have often experienced multiple adversities including domestic abuse, poverty, and powerlessness (Galvani & Toft, 2015; Staddon, 2012; Williams, 2005). Although previous studies had acknowledged multiple adversities, the multiplicity and connectedness of these adversities, and particularly the impact of oppression and marginalisation, has not previously been explored in UK research regarding alcohol and pregnancy (see section 3.4.3).

Social approaches to public health have highlighted the importance of acknowledging complexity when researching and responding to public health issues (Rutter et al., 2017). Staddon argues for a social model of drinking to understand the connections between women's drinking and the rest of their lives (Staddon, 2016), and complex systems approaches to health and social care research advocate for seeking to

understand complexity rather than simply collecting evidence about the aspects that are easiest to measure (Rutter et al., 2017; Salway & Green, 2017). These approaches do not, however, appear to have yet been applied to research around drinking during pregnancy. Previous research into alcohol and pregnancy has not generally acknowledged the complexity of the problem, instead tending to take an individual behaviour change or psychological approach (see chapter 3). Attempting to understand this complexity in relation to drinking during pregnancy is crucial because in order to understand how best to support women – and to prevent unintended consequences of policy and practice approaches – it is necessary to understand how drinking during pregnancy makes sense in terms of other aspects of women's lives.

Figure 12: Multi-layered contexts relating to women's experiences of drinking during pregnancy



Questions about the framing of public health problems as 'complex' have emerged recently, with critical public health researchers arguing that although it is crucial to acknowledge complexity, the term 'complexity' has itself been used by neoliberal governments and corporations to obscure their lack of action by representing complex problems as too difficult to tackle (Savona et al., 2020). My use of the term 'complexity' here refers to the multi-layered contexts relating to women's drinking during pregnancy, including structural and political contexts such as poverty, inequality, the child protection paradigm, and individualism (see figure 12). In emphasising complexity, my intention is to highlight, rather than obscure, these structural and political aspects.

Previous research suggests that maternal and infant safety and health is affected by a wide range of factors, many of which – such as poverty, domestic violence, access to healthcare and women's pre-existing health status – are not attributable to women's behaviour (Chung & Muntaner, 2006). Risk to babies, and their health, is therefore not solely about women's behaviour. Although my research did not aim to explore the causes of risk to women and babies, it does emphasise the importance of understanding the links between broader structural risk factors and women's drinking during pregnancy, arguing that women's drinking should not form the sole focus of interventions seeking to minimise risk to babies. Maternal drinking is intricately related to other harms women experience and require support for; but the focus of interventions is often on drinking to the exclusion of other, wider, more complex factors. My research attempted to explore these other factors, and this acknowledgment and exploration of the importance of taking a social approach to drinking during pregnancy is a unique contribution of this study.

Despite acknowledging that women's contexts were crucial to their experiences of drinking during pregnancy, women's and practitioners' accounts still reproduced dominant narratives about individual responsibility, reproductive citizenship, and child protection. These narratives placed an emphasis on women to keep their babies safe, positioning women's behaviour as the cause of risk and harm. Even when women and practitioners used narratives which avoided explicitly blaming women, they still situated mothers as the cause of harm and therefore the appropriate focus of interventions (see section 9.3.2). This responsibilisation of mothers reflects the cultural

idealisation of the role of 'mother' (Klee et al., 2002; Maushart, 1999; Oakley, 2019), which positions good mothers as self-sacrificing, disciplined, and able to protect their children (Bell et al., 2009; Salmon, 2004, 2011).

The lack of explicit acknowledgement of the impact of structural factors evident in my findings accords with previous research. A range of studies have found that policy action and public narratives in the UK consistently understate the impact of social determinants on health and family life, instead focusing on individual responsibility (Elwell-Sutton et al., 2019; Whittaker et al., 2020), and framing parenting during children's early years as the key to improving children's development and outcomes in later life (Edwards, 2015). Amy Salmon explored this individualisation in relation to indigenous women, finding that they were presented in policy and practice as bad mothers who presented a threat to their families (Bell et al., 2009; Salmon, 2011). Although my research took place in a UK context, a comparable narrative was visible in the accounts of practitioners and women, which responsibilised mothers for the safety and wellbeing of their babies and asked few questions about the impact of broader structural issues on women's ability to do so.

For the women in my study experiencing poverty, this permeated all aspects of their lives including their drinking and their parenting. Women and practitioners were, however, resistant to talking about the impact of poverty on drinking and on FASD. Similarly to previous research which found that practitioners may avoid acknowledging links between poverty and abuse as a way of attempting to avoid stigmatising poor families (Morris et al., 2018), some of the hesitance to draw connections between poverty, drinking and FASD may reflect practitioners' attempts to avoid further stigmatising women. It is important that FASD does not become conceptualised as something which only happens to 'poor' women, as this could lead to stigma and further entrench disproportionate state intervention, replicating the stigmatisation and over-surveillance of indigenous women in some countries such as Canada (Tait, 2008). The need to avoid further stigmatising women therefore necessitates careful, nuanced analysis when drawing links between poverty and FASD, but this does not mean that these links should be ignored altogether.

Critical social work scholars have highlighted the lack of political will to acknowledge and explore the links between poverty and child protection interventions (Bywaters et

al., 2018), and I argue that this lack of political will is also currently being played out through FASD policy: poverty is the 'elephant in the room' in dominant narratives around FASD, which centre women's behaviour as the sole cause of FASD (see section 2.6)(Armstrong, 2008; Lowe et al., 2010). The current absence of acknowledgement of structural factors including poverty relating to FASD in dominant narratives is part of the broader neoliberal depoliticization of motherhood. It has the effect of obscuring the structural factors which affect women's ability to parent their children, thus reinforcing narratives which responsibilise and blame women, and affecting the type of care and support that is available for women and their families (Featherstone et al., 2019; Gupta, 2017; Morris et al., 2018; Tyler & Slater, 2018).

While focusing on women as the cause of risk and harm to babies, practitioners often framed women's drinking as resulting from individual illness (addiction) or trauma. This reliance on biomedical or self-medicating understandings of addiction permeated practitioners' and women's accounts, and although I observed that this may be intended as a way of avoiding mother-blaming – women are ill, so their drinking is not their fault – it still had the effect of individualising drinking during pregnancy to a physiological or psychological problem; women are ill, or they have experienced trauma, and should be given medical or psychological treatment to help them overcome this. Practitioners' accounts often emphasised some traumatic experiences over others; they often described sexual abuse as particularly traumatic for women, and some appeared to consider this a valid 'reason' for drinking during pregnancy, whereas the stress and trauma caused by harmful social policy (for example, poverty and inequality, lack of housing, child removals) did not receive as much attention; the concept of 'trauma' was individualised, with practitioners' accounts reflecting current dominant understandings of trauma and distress as individual, rather than social (Callaghan, 2018; Davies, 2015; Davies, 2017; Tyler & Slater, 2018) .

Framing drinking during pregnancy as a medical, rather than social, problem, diverts attention from the structural problems such as inequality, which are related to women's experiences of drinking during pregnancy. My findings about the individualisation of the 'causes' of drinking to women's individual experiences accords with Ettorre's arguments around women's substance use, and Staddon's argument around women's drinking, that the dominance of the biomedical discourses can make

it hard for women, particularly marginalised women, to talk about how social issues and structural inequalities are related to their drinking (Ettorre, 2004, 2018; Staddon, 2012, 2016), because they do not want to appear to be seeking an 'excuse' for drinking. The accounts of Jaime, Rachel, and Cathy support Ettorre's and Staddon's arguments; even when they described their drinking as a way of coping, they always also emphasised the blame and individual responsibility they felt, and I argue that this is likely to be because they had to show that they were adhering to 'reproductive citizenship' by taking individual responsibility for their drinking. This is important because it may result in a form of silencing, in which women who drink during pregnancy are not able to openly discuss the structural inequalities related to their drinking, which in turn may perpetuate the obscuring of these aspects of drinking. Using a social model of drinking during pregnancy, such as the one I present in figure 12, in policy and practice design and delivery, could potentially help to mitigate against this if it were used as part of a broader commitment to anti-oppressive policy and practice (see section 10.3.1.1).

9.3.2 Structural problems, individual responses

The three responses to drinking during pregnancy which I identified in participants' accounts – advice, surveillance, and treatment – take place within a child protection paradigm which focuses on assessing and reporting risk in order to protect children from their families (Lonne et al., 2009), and a risk paradigm in which women are under pressure to avoid or minimise all risk. Because these paradigms situate risk to the baby within the woman, and particularly their drinking, these three responses focus on women's abstinence during pregnancy as the key way to ensure the safety and health of babies (Armstrong, 2008; Lowe & Lee, 2010). Although practitioners were aware of the multi-layered contexts affecting women's drinking, the responses they were able to offer within the current system focused on individual change. This accords with previous studies with health and policy professionals – although not around alcohol and pregnancy - which suggest that although participants were aware of the social determinants of health, their work focused on individual behaviour change (Rutter et al., 2017; Salway & Green, 2017; Smith, 2016). Responses to health inequalities often focus on individual behaviour change such as smoking cessation programmes and advice about diet, rather than addressing the more difficult to tackle issue of structural

inequality (Bambra et al., 2019; Blaxter, 1997; Garthwaite et al., 2016; Smith et al., 2016).

The first response was advice. Practitioners' accounts emphasised the importance of educating women about FASD and the need for abstinence during pregnancy, and they framed advice giving as a key aspect of their roles. Although practitioners acknowledged throughout the fieldwork that the women they worked with had usually faced multiple adversities and poverty throughout their lives, they still often implied that women's ignorance about the impact of drinking during pregnancy, rather than the multiple intersecting adversities they faced, was the key problem. This reflects the UK and Scottish Governments' increasingly abstinence-focused approach to drinking during pregnancy, which frames awareness-raising as the key way to mitigate harm from women's drinking during pregnancy: Scotland's 2018 alcohol strategy pinpoints FASD as a key area, but focuses on FASD awareness-raising, diagnosis and treatment, mentioning nothing about supporting women who drink, thereby framing awareness-raising as adequate FASD prevention (Scottish Government, 2018).

Focussing on awareness raising implicitly frames women's perceived lack of knowledge and individual behaviour, rather than their wider contexts, as relevant to FASD policy, reflecting and reinforcing dominant narratives around FASD being caused by women. It also implies there is a direct link between awareness-raising and behaviour, with education about the risks being conflated with women choosing not to drink. This simplistic and naïve approach contradicts a wide range of alcohol and substance use research which suggests that simply advising people who are alcohol dependent to stop drinking does not work (Willenbring, 2010; Young, 1994); that women's problematic drinking is often entwined with structural harms they experience (Moon, 2016; Staddon, 2012); and that social policy that idealises abstinence can lead drug users to hide their behaviour (Chandler et al., 2013).

In relation specifically to drinking during pregnancy, previous research has suggested that FASD prevention efforts which raise awareness about the potential harmful effects of drinking during pregnancy may prevent women from disclosing their alcohol use, and pregnancies, or from seeking care, if they do not also offer significant practical support (Armstrong, 2008; Bell et al., 2009). My research supports these arguments: my participants described changing their behaviour because of perceived

social and policy expectations to remain abstinent during pregnancy, but this did not cause them to *stop* drinking, it simply caused them to *hide* their drinking. I argue, therefore, that although advising abstinence during pregnancy serves the social function of defining and delineating deviant behaviour (see section 2.3.1), it is likely to have only very limited impact, if any, on the alcohol consumption of women who are most at risk of having a baby with FASD. For marginalised women whose drinking is not a simple rational choice, but is intertwined with challenging structural contexts, and who are already aware of the abstinence-based guidance, as all my participants were, population-level abstinence advice may increase the stigma associated with drinking during pregnancy and make it harder for women to seek support because they know their behaviour is considered deviant (Foucault, 1979; Lupton, 2013a).

The second response was treatment, encompassing detox and mental health services. Detox was situated by practitioners as a medical response to a medical problem, reflecting biomedical approaches (see section 2.3). Detox was described mainly as a way to minimise the extent to which babies are exposed to alcohol *in utero*, although participants were not optimistic about the success of these treatments at doing so: all the practitioners and some of the women talked about 'relapse' and repeat pregnancies in which women were still drinking and reflected on the lack of broader support provision for women who had experienced detox. This accords with previous research which has highlighted that interventions with parents who use alcohol or drugs often emphasise the 'recovery' of the parents, requiring them to demonstrate that they are abstinent, at the expense of understanding and providing support for contextual factors affecting their drinking and their lives (Boreham et al., 2018; Chandler et al., 2013).

When I asked what could be improved for women who drink during pregnancy, many practitioners talked about more mental health or trauma services, framing women's drinking as a result of individual trauma and reflecting self-medicating theories of addiction (Khantzian, 2017). The focus on individual trauma, though well intentioned, obscures the wider socio-political causes of adversity, failing to make connections with the structural inequalities which make these experiences, and their impact, more common and more severe for those experiencing multiple inequalities (Callaghan, 2018; Tyler & Slater, 2018; Wilkinson & Pickett, 2010). It frames therapy as the

solution to problematic drinking but does not take broader contexts such as poverty, gender inequality, and racism into account (Hunt et al., 2016; Moon, 2016). I argue that narratives and treatments which foreground certain types of trauma or illness (addiction) as the source of women's drinking obscure the wider challenging contexts, powerlessness, and marginalisation which the most marginalised women continue to experience throughout repeat pregnancies.

The third response was surveillance, a high level of which was standard for women who were involved with specialist services. Reflecting dominant narratives which situate women as the cause of risk and harm, and FASD as caused solely by women's drinking, drinking women were described by practitioners as inherently threatening to their babies, who needed protecting from them by services. Staddon's assertion that mothers' drinking presents a cultural challenge to idealised notions of mothering (Staddon, 2012) was supported by my findings: although women in specialist services were ostensibly there because of their drinking, once they became involved with specialist services, all aspects of their identity as mothers were in question. The resulting surveillance included an intense focus on women's drinking but also judged women's perceived ability to attach to their unborn babies and protect them from harm; the extent of their support networks; their financial security and housing status. These factors were included as evidence when assessing women's perceived fitness as mothers, and although some practitioners described providing support as well as surveillance, judging women's capacity to parent was framed as their main priority because of the short timescales with which they were working during pregnancy, and the need to make child protection decisions before or immediately after birth.

The high level of surveillance described by practitioners reflects the child protection focus of the UK and Scotland's policy and practice approach to drinking during pregnancy (Featherstone, 2019; Featherstone et al., 2014; Lonne et al., 2009; White, 2017) and specifically the 'prevailing culture of child rescue' in pre-birth child protection which responsibilises women and individualises risk (Critchley, 2020 p517), rather than identifying need and providing appropriate family support. All the women participants in my study were aware of the potential for surveillance-based child protection interventions, and fear of child protection processes were central to women's accounts of drinking during pregnancy. Many of the women described

concealing their drinking from practitioners and the public because of their fear of these interventions.

9.3.3 Exacerbating inequality

Elizabeth Armstrong argued over a decade ago in her book about FAS that population-level attempts to stop women drinking during pregnancy are unhelpful, and probably harmful, for women who may be at a high risk of FAS. Armstrong contended that broad, abstinence-based messages are effective as a method of social control but ineffectual at preventing FAS because they individualise blame and give the illusion of tackling the problem of FASD without providing meaningful support for women who need it (Armstrong, 2008, p188). My findings support Armstrong's argument; I found that although current approaches to drinking during pregnancy may harm all women by exacerbating stigma and blame, those who are already marginalised are disproportionally affected.

Since Armstrong's book was published in 2008, the UK Government has implemented regressive austerity policies which are associated with rises in foodbank use, infant mortality, mental health problems, health inequalities and homelessness (Taylor-Robinson et al., 2019; Walsh et al., 2020; Wilkinson & Pickett, 2010). Services to support parents have been systematically defunded, including those aimed at parents who drink or use substances, and punitive austerity-based policies have made it harder for families to survive. Simultaneously, neo-liberal ideals of self-regulation, good mothering, and individual responsibility have ignored the social and political context in which both drinking and family life take place, thereby depoliticising trauma and distress by obscuring their wider socio-political causes (Callaghan, 2018; Davies, 2015, 2017), and conflating the impact of inequality with adversity caused by the family (Treanor, 2020). This has positioned some mothers, especially those experiencing poverty, especially if they drink, as potential sources of risk and harm to children (see section 2.6.2).

The accounts of Jaime, Rachel and Cathy, who had been marginalised by multiple intersecting adversities and had been involved with specialist services, were much more characterised than others by powerlessness and marginalisation, and aspects of their accounts suggested that they were adversely affected by reproductive citizenship

and the risk paradigm in ways that those with the highest SES were not. The disproportionate impact of these paradigms on marginalised women was also evident in practitioners' accounts of the women who were involved with specialist services. I identified three ways in which marginalised women may be disproportionately affected by the current approach:

Firstly, within the context of an abstinence-focused child protection paradigm, current approaches, which focus on mothers as the main source of risk to babies, compel some women to try to avoid services. I found that women who had experienced specialist services were more aware of the potential impact of child protection interventions than other women, and those who described taking concrete steps to avoid further interventions during pregnancy all had low SES and previous knowledge or experience of child protection services. This raises serious concerns about the acceptability and accessibility of public services and how they may exacerbate existing inequalities. My findings suggest that not only were women with lower SES more likely to take concrete steps to avoid further interventions, but they were also the ones who described having been in need of help and support during pregnancy, making it even more disturbing that they were compelled by the current approach to avoid seeking it. Jaime, for example, had a sibling whose child had been removed and therefore understood the implications of child protection involvement, so saw it as necessity to conceal her drinking. This meant that she ended up detoxing alone while pregnant, which was potentially medically risky for both Jaime and her baby.

Women's attempts to avoid child protection involvement reflect the disproportionate state intervention in the lives of families who have experienced poverty. Women with low SES, especially those who have experienced previous child removals, are more at risk of experiencing child removals; families living in Scotland in one of the most deprived areas in the UK are 10 times more likely to have their children removed than families living in one of the least deprived areas (Bywaters et al., 2018), and Scotland has the highest rate of child removals in the UK (Bywaters et al., 2018). Previous research suggests that families whose children who are diagnosed with FASD are also more likely to experience state intervention including child removals (Astley et al., 2000; Sood et al., 2001), and my experiences of recruitment support this assertion. I was unable to recruit any birth mothers of children with FASD through paediatricians,

and one paediatrician mentioned informally that most of their patients with FASD no longer live with their birth mothers. This is also implicitly acknowledged by the location of 'Scotland's national FASD support services' within an adoption website (Adoption UK).

My findings suggest that women – especially those who have previous experience of the child protection system - know that they will likely be subject to punitive child protection measures, rather than being offered practical or financial support, if they seek help, and therefore, understandably, avoid doing so. Disproportionate state intervention in families experiencing poverty, coupled with the individualisation of FASD to women's bodies and the corresponding wilful ignoring of the structural aspects of FASD, may therefore cause harm to the most marginalised women by making it harder for them to seek support. Despite this potential for unintended harm, women's views, and particularly the views of those who are the most vulnerable, do not appear to have been explicitly sought or included while reviewing evidence around pregnancy guidelines (see section 2.7).

The second way in which the current policy approach disproportionately affects marginalised women is that, by individualising risk to women's bodies and behaviours it leaves marginalised women vulnerable to structural harms. An example of the current approach not adequately engaging with the structural harm women experience was domestic abuse. Women and practitioners' discussions about domestic abuse implicitly blamed women for allowing men to abuse them and their unborn babies. I found that instead of positioning the mother and unborn baby as at risk in an abusive situation, practitioners' and women's accounts positioned babies as at risk and women as failing in their duty to protect their babies. This is an example of Lupton's 'discourse of risk' (Lupton, 2013 p94), in which the unborn baby, not the mother, is positioned as at risk, and it reproduces dominant 'failure to protect' narratives of mother-blaming, in which mothers are held accountable for harm inflicted by others (Carlton et al., 2013).

The women being described by practitioners had experienced multiple adversities including abuse, poverty, and powerlessness, and appeared to me to be at risk of harm and in need of support and care. Despite these women's ongoing marginalisation, the focus of interventions appeared to be on their babies. This focus almost solely on the

baby in complex situations in which women are also at risk, in combination with the individualisation of risk to women's bodies, reduces women's situations during pregnancy to lifestyle choices rather than the result of multiple, complex, intersecting factors including systems of structural oppression. By framing these complex situations as lifestyle choices, domestic abuse becomes one of many factors to be surveilled and counted against women when making decisions about whether they would be allowed to keep their babies.

Galvani and Toft (2015) argue that women with alcohol problems and who experience domestic abuse face a double stigma; their drinking is stigmatised because they are women, and they are also stigmatised because of their perceived 'failure to avoid their own victimisation' (p91). Furthering Galvani and Toft's argument, I argue that because of the intersection of the individualising policy framework surrounding drinking during pregnancy, idealised notions of motherhood (Klee et al., 2002), and punitive child protection practices, women who are involved with specialist services may experience stigma on multiple compounding levels: they are stigmatised by simultaneously being poor and pregnant; by being women with alcohol problems; by being perceived as causing harm to their babies by drinking; and for failing to protect their babies from abuse. This stigma has moral and practical consequences. Firstly, it is morally reprehensible to effectively punish women for experiencing oppression, marginalisation and abuse by taking their babies away. Secondly, it has potential to compel women to avoid telling practitioners about abusive situations, which could put women and children at further risk, rendering women who are already marginalised unable to seek support from services.

Third, as well as failing to address the structural conditions of women's lives, the abstinence and child protection focus of policy and services may itself have unintended negative consequences for marginalised women. Rachel's account in particular raises questions about the potential unintended consequences of an abstinence-based model which focuses on alcohol rather than broader contexts; rejection, hopelessness and powerlessness are all central in her account (see chapter 8). Rachel's account suggests that for women who have experienced multiple intersecting adversities, structural harms may actually be exacerbated by interventions which cause further pressure, trauma and distress, for example through the trauma caused by repeated

child removals, the pressure involved in being surveilled and scrutinised throughout pregnancy, and the silencing and coercion experienced as a mother involved in the child protection system.

Rachel's story, and practitioners' accounts, support previous research which has pointed out that child protection processes, and child removals in particular, have a profound and permanent impact on women's lives, by causing trauma, shame and stigma to women who are often already marginalised (Broadhurst & Mason, 2013, 2017; Kenny et al., 2015; Morriss, 2018; Tyler, 2013; Wall-Wieler et al., 2017). Rachel and the practitioners highlighted the lack of services available to support women with the trauma caused by child removals, a problem which has repeatedly been pointed out previously (Broadhurst & Mason, 2017; Kenny et al., 2015; Morriss, 2018).

Although child removals were the most obviously traumatic aspect of the current system, they were not the only aspect of the current policy and practice provision which disproportionately harms marginalised women. Critics of 'recovery' based approaches argue that they can cause harm to women whose drinking is intertwined with experiences of abuse, poverty and powerlessness because they require adherence to a moral framework in which individual responsibility is accepted by the person attending (Staddon 2012, Ettorre 2007), thus exempting broader neoliberal structures from examination and blame (Room, 2011). If abstinence-based recovery services were one of a range of approaches to supporting women, this may not be harmful, but my findings suggest that a lack of alternative approaches leaves the most marginalised women unable to access appropriate services. Practitioners pointed out that the availability of intensive support services for parents who drink or use substances has drastically decreased, reflecting the impact of austerity and local authority budget cuts (Marmot, 2018; Webb & Bywaters, 2018). This lack of practical support services sets women up to fail, because it addresses women's drinking without addressing the other aspects of their lives; they receive a detox without appropriate additional support, while continuing to be surveilled for their fitness to parent. For Rachel and her mum, the medicalised services they were offered were themselves sources of disappointment, rejection, and trauma.

Practitioners described the repeated return of women drinking at 'high risk' levels, and with multiple confounding factors, to specialist services during subsequent

pregnancies, often resulting in repeated child removals. My experiences during recruitment and comments from practitioners, as well as previous research (Broadhurst & Mason, 2017; Kenny et al., 2015; Morriss, 2018) suggest that the women who have been most harmed by the current child protection policy and practice approach may go 'under the radar' after pregnancy, particularly if their children had been removed, and are therefore left alone to deal with the trauma caused by child removals, thus exacerbating the exclusion they already face (Broadhurst & Mason, 2017; Kenny et al., 2015; Morriss, 2018). It is therefore crucially important to remember the women who were unable to participate in the study because they were no longer contactable by services. Although it is impossible to know why these women did not participate, or what they would have said if they did, it is likely that those who did not participate were even more marginalised and powerless than those who were able to participate (see chapter 8.2.1). Future research should continue to engage with the importance of these women who have been rendered invisible in research, practice, and policy, and be mindful that in the contentious and mother-blaming case of FASD, women who are willing and able to engage with research are unlikely to include the women who have been most harmed by the current approach.

9.4 Conclusion

This chapter has critically evaluated the approach I took and highlighted the contribution of this study to wider knowledge on the topic of drinking during pregnancy, including how it relates to previous research on this topic.

I have argued that despite evidence that women's drinking during pregnancy is connected to other aspects of their lives, including structural aspects, the current policy and practice approach individualises blame and responsibility to women's bodies. In doing so, it draws attention away from the structural conditions in which women drink during pregnancy, thus perpetuating the inequalities and mother-blaming narratives which contribute to women's drinking, and disproportionately negatively affects women who are already marginalised.

The next and final chapter will consider the recommendations arising from this thesis, for policy, practice, and further research.

Chapter 10 - Conclusions and recommendations

10.1 Introduction

The previous chapter critically evaluated my methodology and methods and highlighted the contribution of this study to wider knowledge on the topic of drinking during pregnancy, including how it relates to previous research on this topic.

The aim of this research was to explore the views and experiences of women who drank alcohol during pregnancy, and professionals who provided treatment and care, by: exploring the ways in which alcohol consumption, and factors other than alcohol consumption, feature in women's accounts of pregnancy; exploring women's views of the effects of the current policy and practice approach to drinking during pregnancy on women who drink/ drank during pregnancy; exploring professionals' views on alcohol consumption during pregnancy and the current policy and practice approach to drinking during pregnancy; and considering implications for policy and practice. This chapter will conclude the thesis by outlining how it has met these aims and objectives, and considering the recommendations arising from this thesis, for policy, practice, and further research. It has two sections: first, recommendations; and second, conclusion of thesis.

10.2 Recommendations

My literature review highlighted the lack of previous research with women who drink during pregnancy, particularly those who report drinking at 'high risk' levels. This thesis has attempted to begin to rectify this by including the perspectives of women who drink at this level. While further research is needed to further explore this area, I make the following recommendations:

10.2.1 For policy

10.2.1.1 A social model of drinking during pregnancy

Current policy approaches to drinking during pregnancy focus on the importance of abstinence and awareness-raising, which situate the 'problem' of drinking during pregnancy within individual women who drink. My research, however, suggests that women's experiences of drinking during pregnancy are inextricably linked to their wider contexts, and that interventions which focus solely or primarily on abstinence and/or advice-giving may have unintended negative consequences, particularly where women are already marginalised.

Instead of focusing on women's personal responsibility to abstain from alcohol use, policy makers should use a social model to reframe the issue of drinking during pregnancy as a health inequalities issue, including consideration of the many complex factors connected to women's drinking, including, crucially, the impact of structural or state-perpetuated factors such as poverty and child removals. Policy could then be designed which supports the safety and health of families, prioritising the meeting of families' needs by providing practical and financial family support, focusing on keeping families together and ameliorating the impact of decades of policy decisions which have led to budget cuts which have harmed families. Taking this social approach to drinking during pregnancy would avoid the perpetuation of mother-blaming and the resulting additional marginalisation.

Using a social model of drinking during pregnancy could work as part of a broader commitment in health and social care to anti-oppressive policy and practice which explicitly acknowledges and seeks to address structural inequality, while identifying and fulfilling needs rather than prioritising the identification of risk. Although this would involve a paradigm shift and financial investment, I argue that it is both possible and necessary. Examples of anti-oppressive practice have in Child Protection included the PAP (Poverty Aware Paradigm) approach, the Community Mobilisers Scheme, which focused on supporting communities to identify and act on their priorities, rather than individual risk assessment, and Family Group Conferencing as an alternative to Child Protection Case Conferences (Featherstone, Gupta, et al., 2019). In the alcohol field, Patsy Staddon has emphasised the importance of working to address the

structural inequalities that are often intertwined with problematic drinking and its disproportionate impact on people who experience multiple intersecting social inequalities (Staddon, 2013), while Salmon (2000, 2004) and Badry (2008) have both explored the importance of acknowledging and responding to FASD by addressing the structural inequalities that disproportionately impact marginalised groups. What all these examples have in common is that they focus on the identification of sources of strength and support, and fulfilling need rather than identifying risk.

Provision of practical family support requires structural change at a policy level – my research demonstrates that it is not enough to simply require services or individual practitioners to provide support without the political and financial means to do so.

10.2.1.2 Involve women in policy decision making

My experience with recruitment (see section 5.2.4) and the accounts of women and practitioners make clear that this is a hidden population; the voices of women who drink during pregnancy are not currently represented in policy, and until this happens it is dubious how relevant policy and practice can be to meeting their needs. Without understanding why women drink during pregnancy, and how current services are working from women's perspectives, it may not be possible to provide effective care and support, yet women's perspectives do not seem to have been a key consideration in the development of FASD policy. Any policy development involving drinking during pregnancy should include women, especially mothers and pregnant women with alcohol related problems, at a strategic level. Although it would be challenging to ensure that the voices of those with lived experience are heard and represented, it is crucial to make meaningful plans to do so, as has been done in other policy areas which may be considered 'sensitive', for example suicide prevention (NICE, 2019).

10.2.2 For practice

My research suggests that although practitioners want to support women to care for their babies, and are sympathetic, respectful, and understanding of women's complex contexts, they are compelled by the system in which they work to focus on women's individual behaviours, thereby responsibilising them for aspects of their lives which they cannot control (see chapter 7). These mother-blaming narratives disproportionately affect those who are already marginalised. Although policy change

is necessary to change these damaging mother-blaming narratives, services working with women who drink during pregnancy could also consider the following.

10.2.2.1 Focus on family support rather than abstinence and child protection

My research suggests that women's ability to engage with services and seek support is related to their perception of services as connected to systems of child protection which may lead to child removals. In order to enable women to engage with services, it therefore makes sense to ensure that services are as focused on family support as possible, and that women are reassured wherever possible that their engagement with services or disclosure of drinking will not lead to child removals. As many critical social work scholars have observed, a well-funded, intensive, family-centred approach which aims to keep families together rather than surveilling women for their fitness to parent, would make it easier for women to disclose any problems, including alcohol or substance use, and would help to avoid the harmful repetitive cycle of child removals experienced by women like Rachel (Featherstone, 2019; Featherstone et al., 2014; Morris et al., 2018; White, 2017).

Within the current child protection system, it is not possible to guarantee women that their babies will not be removed, but examining services' use of language and assumptions may go some way towards enabling women to engage. For example, situating FASD support services within an adoption website implies that children with FASD are usually removed from their parents, which may add to women's need to conceal their alcohol use; presenting services as abstinence rather than harm-reduction based may appear to prioritise abstinence over other important aspects of women's lives, thus centring women as the cause of risk and harm to babies. In contrast with these approaches, alternatives focused on harm reduction and family support rather than abstinence and child protection may be more likely to enable women who are unable to abstain from drinking, or who are facing multiple adversities including structural harms, to engage with services. Managed Alcohol Programmes (MAP), which provide safer access to managed alcohol consumption alongside practical support, have successfully engaged and supported marginalised drinkers in Canada (Pauly et al., 2018) and are currently being piloted in Scotland (Carver, 2019). It is possible that MAPs could, in tandem with a meaningful, well-funded focus on family

support, be an alternative option in the future for pregnant women for whom an abstinence goal is unrealistic.

Using a social model of alcohol and pregnancy when designing services could help service providers to ensure that women's contexts are considered at this stage and therefore built into the service design, which would help to orient services towards supporting women.

10.2.3 For research

10.2.3.1 Alternative approaches to supporting women who drink during pregnancy

My research has highlighted the importance of women's contexts and the potentially harmful impact of current approaches to drinking during pregnancy, and further research is necessary to further explore alternative approaches. At times during the research women and practitioners alluded to potential alternative approaches to drinking during pregnancy, for example Val (Social Work Practitioner) was critical of the focus on 'recovery', Rachel argued that she needed 'professional help', and Jaime advocated for a model of meaningful family support.

Further research on this topic may benefit from using Participatory Action Research (PAR) methodology to consider possible alternatives to the current policy and practice approach. Using this methodology would enable the study to provide structure and support for women and practitioners to critically explore the impact of current approaches and their possible alternatives.

10.2.3.2 Explore inequalities in service provision

My study, although not a service evaluation, raises questions about the consistency of care currently available to women across Scotland and the UK. Although the three main approaches to care (advice-giving, surveillance and individual treatment) were evident in accounts from all the health boards in the study, aspects of women and practitioners' accounts highlighted differences in practice across health boards. Further research is required to explore these different approaches across Scotland in order to begin to understand the potentially different impact of these approaches and the ways in which this may contribute to health inequalities. This is beyond the scope

of this thesis because this study was not intended to be a service evaluation or scoping exercise, so further research is needed in this area.

10.2.3.3 Practical recommendations for recruitment and retention

My experience of recruiting and interviewing women and practitioners has led me to consider some practical recommendations for further research.

If I were planning the study again, I would broaden the inclusion criteria from the beginning, inviting women to choose whether to participate in a focus group or interview. This would enable women to participate without having to disclose any drinking during pregnancy and may therefore make participation seem less threatening. I would also recruit women over an extended period of two or three years.

I was unable to recontact one of my women participants when I tried to get in touch with her to organise the second interview because she no longer had the same phone number. Future studies on this topic may benefit from having a contact tracing system in place in which the researcher seeks permission as part of the consent process to contact a range of people if they are unable to contact the participant. This may help to ensure that participants are not lost to the research study, thus improving the likelihood that women are included in future research.

10.3 Conclusion of thesis

The impact of the current UK policy and practice approach on women who drink at a 'high risk' level or women with multiple confounders associated with FASD was previously not well understood (see chapter 3). Despite evidence that risk of FASD increases with dose, there was very little qualitative research, especially in the UK, including the perspectives of women who drink at 'high risk' levels during pregnancy. The effects of the current precautionary approach, particularly since the UK-wide guidance changed most recently in 2016, and views about health and social care services, did not appear to have been explored with women who drink at more than low levels during pregnancy. In addition, despite evidence that alcohol consumption is not the only factor that affects a baby's likelihood of being born with FASD (see

sections 2.6 and 2.7), most of the existing qualitative research did not explore broader contextual factors (see chapter 3). Women drinking at 'high risk' levels are more likely than others to have a baby with FASD, and may already be marginalised, so it is crucial to attempt to understand how the precautionary approach affects these women, and whether existing services are helpful for them. Without understanding why women drink during pregnancy, and how current services are working from women's perspectives, it may not be possible to provide effective care and support.

My thesis has addressed these research gaps by exploring women's perspectives of drinking during pregnancy, and foregrounding the perspectives of women who have been marginalised and may be at a higher risk of having a baby with FASD. I have argued that for these women, who are already marginalised and have experienced multiple repeated adversities, drinking during pregnancy is related to multiple interlinking contexts including structural inequalities. This thesis has demonstrated the importance of taking women's contexts into account when attempting to understand and respond to drinking during pregnancy, but has suggested that current neoliberal structures, policies and narratives based around individual responsibility, reproductive citizenship and child protection make it difficult for women and practitioners to do so. An emphasis on women's individual responsibility contributes to a climate of mother blaming and exacerbates the marginalisation and powerlessness of women who are already marginalised and have experienced multiple repeated adversities. The current policy context, which focuses on women's drinking behaviour, and risk to the unborn baby, rather than the family's wider needs, renders services unable to offer intensive support for women's complex contexts, and may instead add further adversity and exacerbate women's powerlessness.

Although the need for a social approach to drinking during pregnancy has not specifically been raised in the UK, sociologists have previously highlighted the disproportionate impact of individualising policies on marginalised women. Researchers in the US, (Armstrong, 2008), Australia (Lupton, 2012, 2013a, 2013b), and Canada (Bell et al., 2009; Salmon, 2004, 2011) have all pointed to the neoliberal individualisation of health, personal responsibility, and reproductive citizenship as explanations for how FASD has become constructed as caused solely by women's drinking. Armstrong specifically raised concerns over a decade ago about the potential

disproportionate impact of abstinence approaches and FASD, yet UK policy has consistently moved towards a precautionary approach, apparently without consideration of the potential unintended consequences for some women (see section 2.7). Within the context of the UK's punitive child protection system and following years of austerity measures and the corresponding closure of many family support services, I argue that this policy approach is failing the most marginalised women.

Critical social work scholars argue that a paradigm shift away from the current unethical and ineffective child protection model is required. This would involve moving towards a humanising model promoting social good, using principles of anti-oppressive practice (Featherstone, 2019; Gillies et al., 2017; Hyslop & Keddell, 2018; Skinner et al., 2020) (see section 2.5.5). This anti-oppressive practice would require policy and practice to take into account the structural aspects of adversity including the ways that systems of oppression affect families; support families, rather than narrowly assessing risk within them; and explicitly address poverty as a problem of financial deprivation caused by neoliberal capitalism, rather than an individual or community deficit (Featherstone, 2019; Skinner et al., 2020, The Promise Scotland, 2020). I argue that these principles of anti-oppressive practice should be applied to working with women who drink during pregnancy, but that this will only be effective if policy and funding enables this to happen.

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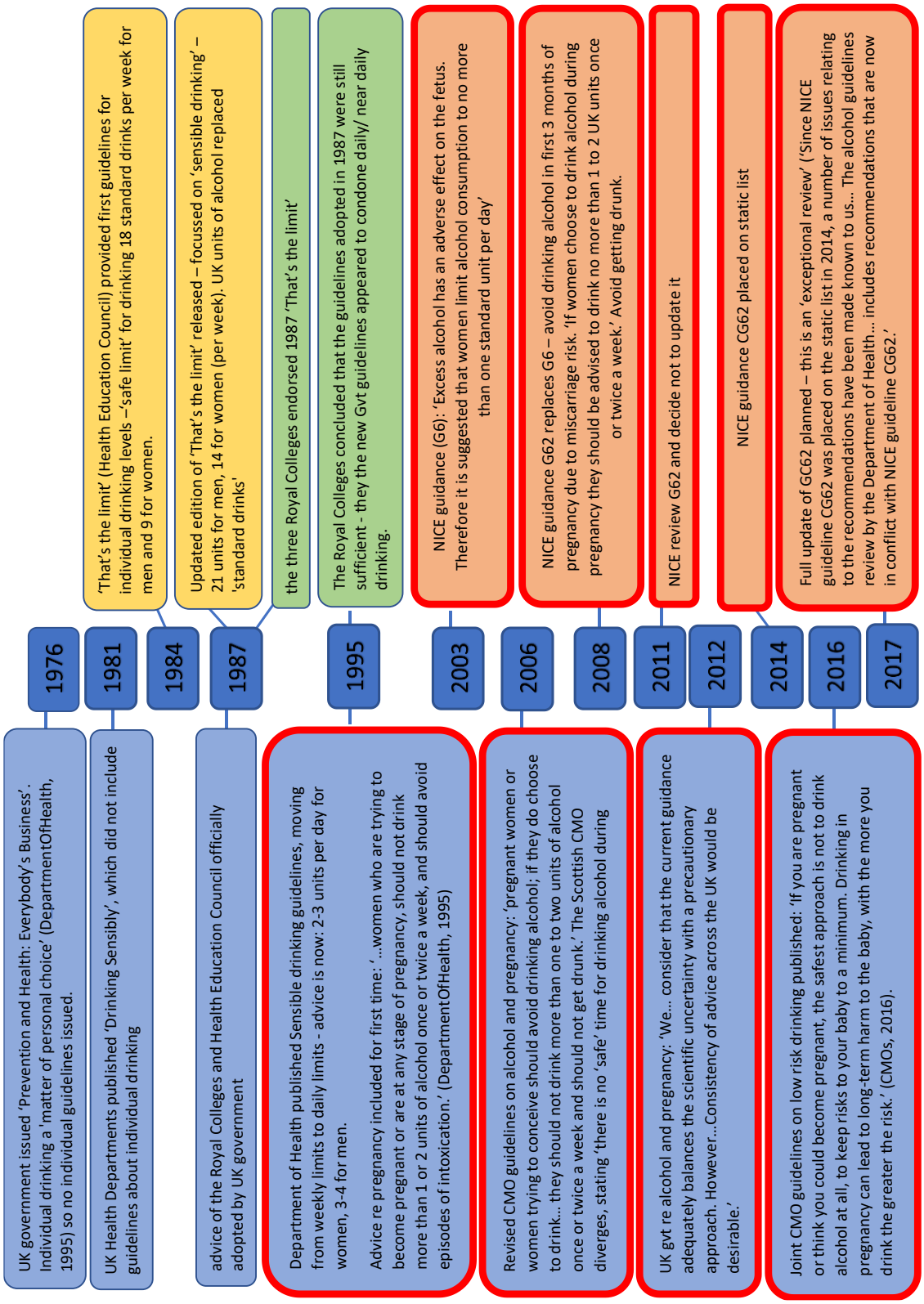
Appendices

Appendix 1: Timeline summary of UK guidance regarding alcohol and pregnancy



Appendix 2: Summary of systematic reviews

Summary of systematic reviews included in 2013 review published for the Health Evidence Expert Working Group (Jones, McCoy, Bates, & Bellis, 2013)

Systematic review	**Bay & Kesmodel, 2011**	**J. Henderson et al., 2007a**	**Henderson et al., 2007b**	**Latino-Martel et al., 2010**	**Patra et al., 2011**
Outcome measure	Motor skills	Miscarriage, stillbirth, intrauterine growth restriction, prematurity, birthweight, small for gestational age at birth, birth defects (including FASD)	Miscarriage, stillbirth, intrauterine growth restriction, prematurity, birthweight, small for gestational age at birth, birth defects (including FASD) or neurodevelopmental outcomes	Childhood leukaemia	Low birthweight, preterm birth, small for gestational age (SGA)
Number of studies included	39	46	14	21	36
Meta-analysis undertaken	No	No	No	Yes	Yes
Type of studies included	Follow-up or case control.	Case control, cohort, cross-sectional	Case control, cohort, cross-sectional	Case control	Case control or cohort
how was outcome measure assessed?	In order to be included, studies had to use standardised or validated tests to measure motor skills. In 12 of the studies, the testers knew which children had been exposed to alcohol prenatally.	Various	Various	Child diagnosed with leukaemia	Various
How and when was maternal	Varied – sometimes antenatally	Varied	Varied	Interview with mother in all cases	Various – some used an average of more than

alcohol consumption measured?	by questionnaire or interview, sometimes postnatally			except 3 (self-administered questionnaire).	one interview during pregnancy, others asked at one timepoint postnatally
How old were children when measured?	3 days – 26 years	Not stated	Not stated	0-20 years	Not stated
How was alcohol measured/ defined	Moderate-high daily: 4.5 – 7.5 UK units per day Low daily: 1.5-3 UK units per day Low-moderate: <=1.5 UK units per day Binge drinking: various definitions FASD studies: children diagnosed with FAS or with reported maternal alcohol consumption an specialist-confirmed alcohol traits.	Low-moderate = up to 10.4 units per week	Binge drinking: studies used various definitions – most commonly 7.5 UK units per drinking occasion. Studies only included if reported on binge drinking separately from other drinking, including 'general heavy drinking' (p1071)	Alcohol intake during pregnancy: yes versus no	1) Drinker versus non-drinker 2) Dose-response meta-analyses
Findings	Low-moderate: Little evidence suggesting low level has any effect. Moderate – high: some studies found an association, others did not.	No consistently significant effects of low-moderate alcohol exposure on any of the outcomes considered	No consistent effects of binge drinking on any of the outcomes considered	Grouped leukaemias: 11 studies found no significant association with alcohol Acute lymphoblastic leukaemia: 11 studies found no significant association with alcohol	Drinker v non-drinker: no significant effects when only studies which controlled for confounders included Dose-response meta-analysis: 'heavy' alcohol consumption during

				Acute myeloid leukaemia: 3 of 9 studies found a statistically significant link	pregnancy increases the risk of low birthweight and preterm birth, 'light' alcohol consumption may not have any effect.
Were studies adjusted for potential confounders ?	Many were not adjusted for any confounders	Many were not adjusted for any confounders, most were not adjusted for SES	Some were not	Some were not	Some were not, so systematic review analysis undertaken twice – once including all studies, once only including those adjusting for confounders
Is the review mentioned in 2008 NICE guidelines (National Collaborating Centre for Women's and Children's Health, 2008)	No – too recent	Yes	Yes	No – too recent	No – too new
Is the review mentioned in evidence summary (Jones & Bellis, 2014)?	No	Yes	Yes	No	Yes

Appendix 3: Data extraction from scoping review

Study, Journal	Location	Aim	Theoretical perspective	Sample	Methods	Themes
Allen et al. 2014, BMC Health Services Research	Ghana, Kenya and Uganda	uncover the types of exposure data under or inaccurately reported at antenatal clinics, the underlying reasons, and how women prefer to be asked questions.'	Not stated - refer to Strauss and Corbin associated with grounded theory, but this is not explicitly stated	208 women, some enrolled in WHO pregnancy registry, some not.	27 focus groups	1) women said they knew they should report everything they had used to staff, but did not always report alcohol use in case they were 'scolded'. 2) influences on formal antenatal care (whether women attend antenatal clinic, whether they used traditional birth consultants, confusion about alcohol). 3) social context of pregnancy healthcare-related behaviour
Anderson et al. 2014, BMC Public Health	Australia	Explore women's perceptions of information received about alcohol use during pregnancy…	Realist/ pragmatic (talk about 'semantic' thematic coding)	Women from the Australian Longitudinal Study on Women's Health (ALSWH). Random	19 semi-structured telephone interviews	Much of the discussion focused on determining safe levels of drinking – the aim was to talk about information women

				sampling. 100 women invited.		received so it wasn't about any other aspect of their pregnancy related to alcohol.
April et al. 2010 Drogues, sante et societe	Canada	'… improve interventions to prevent the consumption of alcohol during pregnancy, this study was to document the representations [of] pregnant women in relation to this behavior, and their perceptions of the nature and impact of messages sent out to them about it, and that, taking into account belonging to different socio-economic contexts'	Sociological	33 pregnant women recruited through antenatal classes, including one for pregnant women living on a low income. Purposive sampling.	Face to face interviews (30 min-1hr45). Interview schedule used. Interview followed by short survey to collect socio-economic data.	Findings section compares the attitudes of the two groups of women to: Alcohol consumption (higher SES group more likely to drink some alcohol), frequent consumption and in large quantities is unacceptable, views about moderate alcohol consumption, knowledge, impact of social network, the role of the doctor in alcohol consumption, [lack of] social norms re not drinking during pregnancy, context of motherhood (eg nutrition during pregnancy), perceptions about impact of

						prevention messages
Badry 2008 PhD thesis,	Canada	To develop deeper understandings of the lived experiences of birth mothers of children diagnosed with FAS	Hermeneutic phenomenology, feminist perspective	8 women aged 25-60, all of whom had given birth to one or more child medically diagnosed with FAS, accessed through 'trusted sources', contacts through career in social work. Feminist perspective.	'meaningful, non-threatening conversations [in depth interviews] about their life experiences'	The birth mother's experience in their family of origin, the birth mother's experiences of alcohol, the birth mother's pregnancy experience, the birth mother's relationship with the father of the child diagnosed with FAS, the birth mother's experience of trauma including violence, the birth mother's involvement with child welfare, the meaning of the child diagnosed with FAS to the birth mother.
Brahic, Thomas and Dany 2015 Les Cahiers Internationaux de Psychologie Sociale	France	Looking at social construction of risk. 'Investigate the social representations of alcohol risk in	Sociological (theory of representation)	64 interviews were conducted with pregnant women recruited from public and private institutions in Marseille	Semi-structured interviews using interview guide, thematic content analysis.	Lifestyle changes during pregnancy (including nutrition), alcohol consumption during pregnancy (including views on 'safe' limits), social context (impact of views of

						others, including health professionals)
Cloete and Ramugondo 2015 South African Journal of Occupational Therapy	South Africa	Influence of contextual factors on alcohol consumption during pregnancy	Takes 'a critical occupational therapy stance towards maternal alcohol consumption.' Alcohol consumption as imposed occupation.	3 women, all low SES, previously or currently 'drunk excessively' during pregnancy. Instrumental case-study using observation and semi-structured interviews	Instrumental case-study using observation and semi-structured interviews	Nothing comes easy, trying to make this life bearable, rekindling hope, and baking bread with little
Coathup et al. 2017 Midwifery	UK	To investigate relationships between maternal dietary patterns and alcohol consumption, and explore which factors influence women's decisions about what to eat and drink during pregnancy.'	epidemiology	6 women participated in qualitative aspect of study	Semi-structured, in-depth interviews	Pregnancy as a time to review behaviour; listen to your body - it will tell you what you need; treats are still important - on special occasions; social and cultural expectations constrain behaviour; inconsistent or ambiguous information creates uncertainty; confidence increases following a

						successful pregnancy
Crawford-Williams et al. 2015 BMC Pregnancy and Childbirth	Australia	In order to improve prevention strategies, we sought to understand the knowledge and experiences of pregnant women and their partners regarding the effects of alcohol consumption during pregnancy	Not stated - focused on healthcare	Convenience sample, 21 participants (17 female). Pregnant women, newly delivered mothers and their partners	Five focus groups. Six-stage thematic analysis framework used to analyse.	Lack of clarity about effects of drinking whilst pregnant, lack of information from those providing antenatal care, content of these messages not consistent, role of society (e.g. social norms), importance of partner, evaluation of risk, and motivation (health of baby, stress)
Doi 2012 PhD thesis	Scotland	increase understanding of the factors that are likely to influence the effectiveness of screening and ABIs.	Realist evaluation	As part of a wider study (with midwives), interviews with 17 pregnant women (23 drinkers, 4 abstainers). Only women who 'do not meet the criteria for alcohol	Semi-structured interviews, analysed thematically.	Attitudes and views about drinking in pregnancy, external influences (including partners and social circumstances – special occasions, holidays), previous pregnancies and experiences of other women, planned and unplanned

				dependence' included.		pregnancies, assessment of risk, awareness of policies, guidelines and debate (including advice being confusing), clinical settings of screening and ABIs
Ford 2013 PHD thesis	Scotland	Explore women's attitudes towards drinking during pregnancy and their awareness of the risks of consuming alcohol during pregnancy; social and cultural context of women's alcohol consumption during pregnancy; how women respond to health interventions; attitudes towards public health campaigns and health interventions.	Feminist	22 women with a child under the age of 2 (in Edinburgh and Inverness), recruited from mother and toddler groups	Narrative interviews using Biographic-Narrative-Interpretive Method, single question aimed at inducing narrative. single question in interviews was about lifestyle and health choices	The importance of lay knowledge, Inconsistent Messages, and Othering, The Surveillance of Women and the Discourse that you Should Abstain During Pregnancy, Positive Drinking and Pleasure, The Feminisation of Wine and the Acceptability of Certain Types of Alcohol

Frost-Pineda 2009 PhD thesis	USA	Variety of questions relating to fertility, contraception, alcohol and substances, and pregnancy and parenthood.	Anthropological. Focuses on lived experiences.	5 women in residential addiction treatment services. Alcohol was not the main problem for all 5 women (because this study looks at addiction more generally) – one participant relevant to this literature review	Life stories – 2 hour interviews, 5 times with each woman. Very loosely structured; women talk, very little use of questioning or prompts. Researcher introduces topic each time.	Family history of addiction Availability of drugs and alcohol Violence, trauma and abuse Substance use by partners Loss Promiscuity, prostitution and arrests Relapse Illness, injuries and near-death experiences Social isolation Importance of sharing and connection Spirituality (12 step treatment programme)
Gonzales et al. 2018 Ethnicity and health	USA	To build on Evans-Campbell's...multilevel framework of historical trauma and health by focusing on the cycle of FASD in the socio-cultural, historical and interpersonal context of trauma shared by American Indian (AI) and Alaska Native (AN) peoples.	Evans-Campbell's (2008) multilevel framework of historical trauma - researchers should study 'indigenous health'in its wider communal and historical context (e.g. colonial trauma)	74 AI/ANs who were 15 years or older	Community based participatory action research - focus groups	Knowledge of and experiences with FASD; the cycle of FASD risk (coping, historical events/ traumas, family impact and influence, mistrust with the healthcare system)
Grant et al. 2019 BMC Pregnancy and Childbirth	UK (Wales)	To understand the subjective experiences of pregnant women from deprived communities regarding	Interpretivist	10 pregnant women living in deprived areas and on low income	Creative techniques (timelines, collage, dyad sandboxing), resulting in 28 elicitation interviews	Relevant to this review: 'remaining abstinent from alcohol during pregnancy'

		health in pregnancy				
Gray and Nosa 2009 Pacific Health Dialog	New Zealand	To explore the binge drinking behaviours and attitudes of women	Not stated	Nine New Zealand born Niuean women who are 'heavy binge drinkers'	Semi-structured interviews. Interviews 1-2 hours long	Pregnancy related (this is a small section with no analysis): heavy drinking before pregnancy/ during conception, stopped drinking during pregnancy, some resumed drinking post-pregnancy.
Hammer and Inglin 2014 Health, Risk & Society	Switzerland	Explore 'differences in how pregnant women perceive the risks related to alcohol and tobacco use in everyday life.'	Sociocultural approach to risk (understandings of risk are not intrinsic but depend on context)	50 pregnant women - high risk pregnancies and women with any 'pathology' excluded. All had male partners and were educated to at least secondary level.	Semi-structured interviews, 75 minutes average length	Abstinence: compliance and questioning; contextualisation of risk in daily life; the morality of maternal drinking and smoking;
Hocking et al. 2019 Women and Birth	Australia	Explore and interpret the messages women receive during their first antenatal care visit, relating to alcohol consumption	Phenomenological - IPA	12 women who had attended a first antenatal appointment within previous 2 years	Semi-structured interviews	Messages received about alcohol consumption, ways of intpreting messages relating to alcohol consumption

Holland et al. 2016 Health, Risk & Society	Australia	Identify the factors that influenced participants' understandings and behaviours, including their responses to health advice and media reporting.'	Social constructionist	20 women either pregnant or had children or planning for pregnancy	Semi-structured interviews and focus groups (60-90 minutes)	Experiences and views of alcohol in pregnancy (receiving reassurance after drinking in early pregnancy, opting to abstain as the safest option in the face of uncertainty, having an occasional drink if they felt like it), Awareness and interpretation of NHMRC abstinence guidelines (a responsible public health message, policing women through guilt)
Hunt, Joe-Laidler and MacKenzie 2005 Youth & Society	USA	Examine the impact of the process of motherhood at its different stages (from pregnancy to parenthood) on both the "homegirls'" involvement and membership in the gang and their alcohol consumption	Sociological ('good mother' ideals)	118 self-identified female gang members, who were located using a snowball sampling approach.	Face-to-face interviews as part of an ongoing, larger, comparative study of gangs.Quant questions then qual semi-structured interview.	Unplanned pregnancy. Self-regulation of risk-taking behaviour, including alcohol use
Jensen et al. 2016 Sex Education	USA	To describe tribal community input on the importance of expanding the OST CHOICES	Not stated	58 AI participants - 20 women aged 18-44, 20 elder	Focus groups, thematic analysis/ content analysis	Prevention of AEP with youth; education; family; culture

		programme and its curriculum to Al youth.'		women, 18 adult men		
Jones et al. 2011, Jones and Telenta 2012 Midwifery	Australia	To explore attitudes towards alcohol consumption during pregnancy, the factors that encourage or inhibit women from following recommendation to abstain from drinking, advice women receive, comfort discussing alcohol consumption in antenatal appointments	Not stated	12 pregnant women were initially contacted and consented via a midwifery group practice (MGP) program in the same area health service.	telephone interviews lasting between 10 and 25min (also spoke to midwives)	Remembering conversations [with midwives etc] about alcohol, knowledge and use of alcohol guidelines, other information sources, Perceived risks associated with alcohol consumption in the population, Perceived risks associated with alcohol consumption during pregnancy (including conception and pregnancy), The social implications of not drinking during pregnancy
Laing 2015 PHD thesis	UK, Newcastle	explore pregnant women's understanding of their drinking behaviour.	Sociological: reproductive citizenship	20 women recruited through community midwifery service within Newcastle upon Tyne.	Semi-structured interviews , grounded theory. Thematic coding.	Alcohol use before pregnancy, medical norms in women's narratives, social norms in women's narratives, discourse of good motherhood and creation of stigma, understandi

						ng of and reaction to alcohol as a risk in pregnancy
Loxton et al. 2013, Youth & Society	Australia	This study aimed to explore how pregnant women and service providers acquire and utilize information about alcohol use during pregnancy.	Not stated - healthcare focused	74 mothers of young children in urban and rural areas of New South Wales	10-minute semi structured interviews Recruited in public places e.g. shopping centres/ parks	Confusion about guidelines etc, mixed messages from variety of sources, mothers' decision making (including social norms and perceptions of risk – this is interesting, talks about process of internal bargaining), perceived hierarchy of substances
Meurk et al. 2014 BMC Pregnancy & Childbirth	Australia	inform debates about strategies for discussing alcohol consumption with pregnant women	Not stated	40 women aged 34–39 from Australian Longitudinal Study on Women's Health, who were pregnant, or had recently given birth	Semi-structured face-to-face interviews with 40 women in their homes (30-60 minutes). Framework analysis	Risk perceptions in relation to identity as a driver of behaviour [importance of retaining a sense of self – women play a role in perpetuating or challenging existing drinking norms], Impact of perceived external judgement on maternal drinking during

						pregnancy, Conceptualising alcohol consumption [women with clear ideas about acceptable levels and types of drinking during pregnancy], Role of healthcare practitioner in maternal alcohol use during pregnancy [inconsistent, informal]
Pati et al. 2018	India	Exploring perceptions and practices related to the consumption of alcohol by pregnant tribal women in… India	Cultural anthropology	19 women who reported alcohol consumption during pregnancy (all scored 3 or 4 on AUDIT test)	Face-to-face in-depth interviews	Relevant to this review: Custom, tradition and rituals; Indigenous, non-injurious and relaxant; Curiosity, addiction and lack of knowledge
Raymond et al. 2009 BMC Public Health	UK, Nottingham	Explore pregnant women's attitudes towards drinking alcohol in pregnancy and their attitudes towards sources of information about drinking in pregnancy	Not stated	20 pregnant women recruited from community organisations in the UK	Semi-structured telephone interviews (20-40 mins). Thematic analysis.	The influence of evaluation of risks on drinking in pregnancy, Unborn child has precedence over drinking in pregnancy, Influence of previous and other women's pregnancies on drinking in pregnancy, Need to respect individual

						differences, Facilitators to drinking in pregnancy [stress relief], Influence of confusing or unclear advice on drinking in pregnancy, Attitudes towards available advice: Advice lacks reasons, evidence or sufficient detail, Taking responsibility for own health
Ross 2012 British Journal of Midwifery	UK (England)	explore the influences on women's engagement with healthy practices during pregnancy, particularly the effect of maternal–fetal attachment.	Analysis informed by existing sociological literature	17 women recruited through a pregnancy and parenting charity in Edinburgh (high SES)	Focus group and semi-structured interviews	Personal experiences of pregnancy; interpretation of risk to the pregnancy; feelings of attachment towards the fetus
A.Salmon 2000, PhD thesis	Canada	Understand how a group of young Aboriginal mothers… articulate their own needs, interests, concerns and experiences, and how these may be similar to or different from the ways they are constructed in texts of the [FAS/FAE 'prevention'] initiative.	Feminist, materialist, anti-colonial, anti-ableist	6 women recruited from a community FASD prevention initiative, all had experienced substance/ alcohol use during pregnancy, most have either a child with	Group interviews attended by all 6 women twice.	Dis/abling citizenship: negotiating citizenship in the home, in the streets, and on the margins; claiming Dis/Ability: Medicalization as a mechanism for securing substantive citizenship; Dis/Abling states: the contestations and

				diagnosis of or suspected FAS/FAE		contradictions of medicalization for substantive citizenship and social justice; Getting the information: what Aboriginal mothers want and need to know about FAS/FAE; "It needs to be everyone's responsibility": the role of male partners and friends in women's substance use; Engendering "risk": education, intervention, and the roles of Aboriginal women and men; "Education" and "role modelling": strategies for sharing FAS/FAE knowledge in the context of Aboriginal women's live;
Salmon 2008 The Canadian Journal Of Clinical Pharmacology	New Zealand	' to describe the 'lived' experiences of New Zealand birth mothers, from pregnancy onwards, of a child/ren diagnosed with Fetal Alcohol Spectrum	Feminist standpoint theory. Focus on lived experience	Purposive sampling (through FASD agency) plus snowballing. 8 biological mothers	Interviews lasting up to an hour (at home), semi-structured (really quite open questions). Analysis by constant	Relevant to pregnancy and alcohol: Feelings of responsibility and guilt Lack of knowledge about FASD Drinking during

		Disorder (FASD).' Not just about pregnancy but subsequent parenting experiences too.		whose children have FASD	comparative method.	pregnancy (all mothers did so, some before aware pregnant)
Scholin et al 2018 The European Journal of Public Health	UK (England) and Sweden	explore perceptions and practices of alcohol use during pregnancy in England and Sweden'	socio-ecological model of health	21 parents (women and partners, up to 18 months postnatal) in Merseysi de, England and 22 parents in Orebro County, Sweden.	Semi-structured interviews, thematic analysis	Changing drinking habits when getting pregnant, Changes in drinking habits amongst partners, Views on foetal rights vs. women's autonomy, Reasons for changing alcohol habits
Thomas and Mukherje e 2019	UK	Explore the experiences of birth mothers following a diagnosis of FASD in their children	Phenomenol ogical (researchers are psychiatrist and FASD clinician)	5 women who are birth mothers of children diagnose d with FASD	Semi-structured interviews, IPA	To blame or not to blame?
Toutain 2010 Drug And Alcohol Review	France	identify future mothers' representations of alcohol consumption during pregnancy, and then to have a better understanding of their perception of the messages meant to influence behaviour.	Not stated	42 women at various stages of their pregnanc y.	Collected and analysed the contents of the inputs on Internet forums. Analysed thematically.	'Acceptable' alcohol consumptio n [including levels and types of drinking], The consequenc es of drinking during pregnancy, Information [including importance of women's mothers and lack of social pressure to stop drinking],

Toutain 2013 Alcoholism	France	As above but two years later to assess change	Not stated	35 pregnant women in various stages of pregnancy (some drinking, some not – not easy to tell who drank what).	As above, but internet forums two years later. Observations of internet forums where alcohol and pregnancy were discussed. Thematic analysis.	False information on alcohol consumption during pregnancy, information sources, Imperfect knowledge about pregnancy
van der Wulp, Hoving and de Vries 2013 Midwifery	Netherlands	aimed to explore what information Dutch pregnant women and partners receive about alcohol in pregnancy [there is another part of this study which looks at midwives]	Behaviour change	25 pregnant women and nine male partners recruited through midwife practices, pregnancy courses, antenatal childbearing classes, and pregnancy yoga classes	I-Change model used as theoretical framework. Five focus groups and four interviews (1 hour)	Discussion with partners about alcohol use during pregnancy, information received, awareness of FAS
Wahab 2014 PhD thesis	UK, London	Investigate medicine and recreational substance use during pregnancy in an antenatal population of London (quant and qual study). Qual component was re health beliefs of pregnant women	Health beliefs	Purposive sample, women in 3rd trimester who used at least 2 types of medicine. 6 participants drank alcohol. Mainly white and university educated.	Semi-structured telephone interviews, Health Belief Model as a framework for data collection and analysis.	There are some discrete findings about alcohol and these were based on 6 women in sample who drank [any] alcohol. From section on alcohol use: Information, communication with healthcare professionals (including not telling midwife about

						alcohol consumption), The influence of maternal perceptions on alcohol consumption (including risks and benefits), friends or family consumption
Watt et al. 2014, Watt et al. 2016 Maternal and child health journal, Social Science and Medicine	South Africa	Experiences of pregnant and postpartum women who reported alcohol consumption during pregnancy, and knowledge and attitudes about maternal alcohol consumption	Not stated. Used memoing in analysis (they ref Birke et al 2008), which is generally associated with grounded theory, but this is not explicitly stated	24 women pregnant or within 12 months postpartum, who reported any alcohol consumption during pregnancy.	Interviews in language of choice, 60-90 minutes, face-to-face, semi-structured. Analytic memos written to start organising data from each transcript, codes developed, nvivo used.	Competing attitudes about drinking while pregnant Internalization of misinformation (relying on intuition) Dilemma of drinking during pregnancy Drinking patterns during course of pregnancy Factors that explain drinking behaviour during pregnancy Coping with stress and negative emotions (context) Drinking as a social connection Social norms Lack of attachment to the pregnancy/ unplanned pregnancy Addiction (affected all

						women but acknowledged by few)
Zabotka 2013 PhD thesis	USA	To describe and understand the feelings, coping behaviours and thoughts of biological mothers who have given birth to and are parenting children diagnosed with Fetal Alcohol Syndrome	Not stated – focuses on psychological issues, is a Social Work PhD	11 biological mothers of children with FAS	Purposive sampling through National Organisation on Fetal Alcohol Syndrome, telephone interviews (1hr 40 mins average), analysed using transcendental phenomenological reduction.	This PhD is not just about pregnancy and alcohol but also life with a child with FAS. Childhood trauma Physical or sexual abuse Witnessing domestic violence Separation and loss during childhood Partner abuse during adulthood Possible undiagnosed FAS among birth mothers Feelings of guilt Disease model used to help cope with guilt Attempted moderation of alcohol consumption during pregnancy Lack of knowledge (or retrospectiv

						ely claiming lack of knowledge) Social norms (particularly if surrounded by alcoholics) Denial about the amount of alcohol consumed Unplanned pregnancy/ drinking before realised pregnant/ denial of pregnancy

Appendix 4: Example search strategy

#	Query
S44	S42 AND S32 AND S36
S43	S42 AND S32 AND S36
S42	S41 OR S33
S41	S38 OR S39 OR S40
S40	"alcohol"
S39	"alcohol us*"
S38	"drink*"
S37	S32 AND S33 AND S36
S36	S26 OR S27 OR S35
S35	qualitative
S34	S5 OR S6 OR S10 OR S11 OR S12 OR S13 OR S21 OR S22 OR S23 OR S28 OR S29
S33	S3 OR S4 OR S14 OR S15 OR S19 OR S20 OR S24 OR S25
S32	S30 OR S31
S31	(MH "Pregnancy Complications")
S30	S1 OR S2 OR S7 OR S8 OR S9 OR S16 OR S17 OR S18
S29	"substance dependen*"
S28	"substance misus*"
S27	"qualitative research"
S26	(MH "Qualitative Research")
S25	"binge drink*"
S24	"alcohol addict*"
S23	"drug addict*"
S22	"drug misus*"
S21	"substance abus*"
S20	"alcohol use"
S19	"heavy drink*"
S18	maternal
S17	parent*
S16	pregnan*
S15	"alcohol misus*"
S14	"alcohol dependen*"

S13	"illicit drug use*"
S12	"drug use*"
S11	"drug dependen*"
S10	"drugs dependen*"
S9	(MH "Parenting")
S8	antenatal
S7	prenatal
S6	(MH "Drug Users")
S5	(MM "Substance-Related Disorders+")
S4	(MM "Alcohol Drinking") OR (MM "Binge Drinking")
S3	(MM "Alcohol-Related Disorders+")
S2	(MM "Mothers")
S1	(MM "Pregnancy")

Appendix 5: Inclusion and exclusion criteria for meta-synthesis

Inclusion criteria (all answers should be yes)

1. Does the study population include women who:
   - are currently drinking or drank 30 units or more per week during pregnancy, or
   - describe themselves as alcohol dependent and were drinking during pregnancy, or
   - have been diagnosed as alcohol dependent and were drinking during pregnancy?
2. Does the study involve women talking about alcohol consumption during pregnancy?

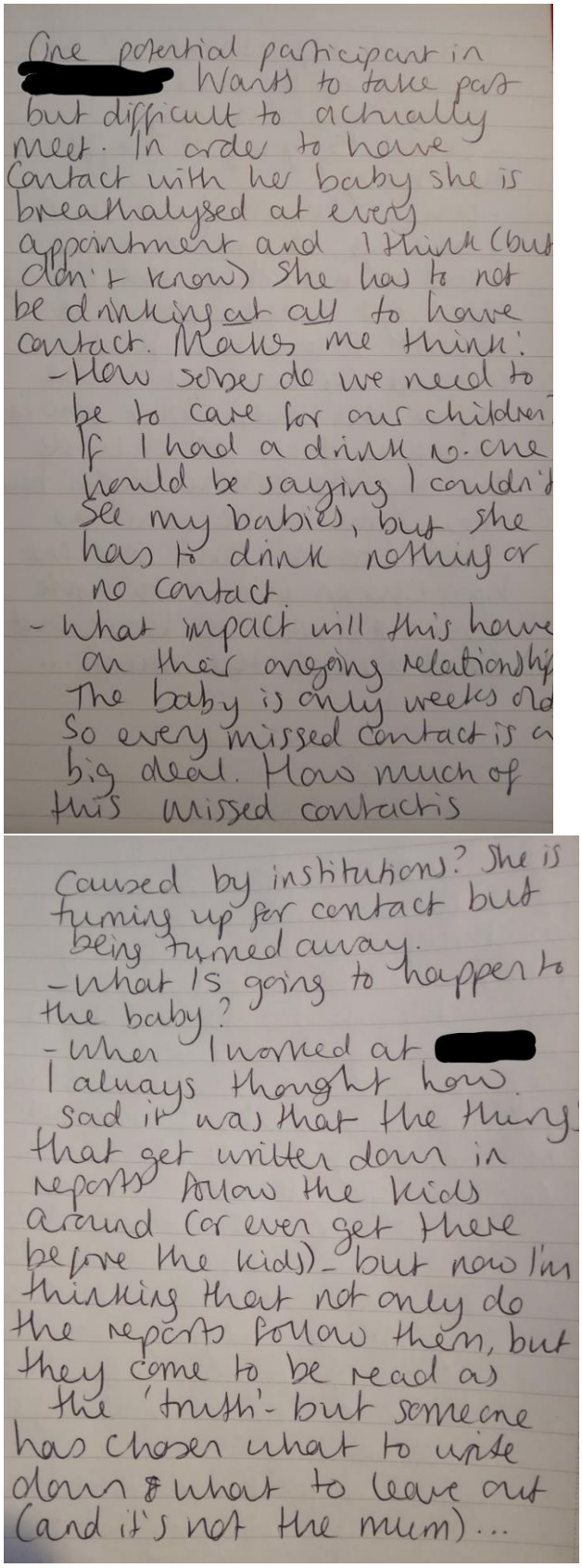
Exclusion criteria

3 Does the study only include women who consume less than 30 units per week?
4. Is it impossible to tell how much women were drinking/ say they were drinking during pregnancy?
5. Is it impossible to tell whether the study includes pregnant women/ discussion about pregnancy?
6. Does the study deal only with population level data about alcohol and pregnancy?

Appendix 6: List of amendments

Date	Amendment	Reason	Approval
Jan 2019	Allow home visits/ telephone interviews; allow more flexibility in second interview timings; allow focus groups with practitioners	Remove barriers to participation (home visits/ phone interviews/ timings); analyse/ explore practitioner experience	From NHS (ENU notified)
March 2019	Create study website and add link to study materials; use of social media to share information about study	Enable women to see PIS without having to contact researcher; can share study info more widely and may improve recruitment	From ENU (only applies to non-NHS recruitment)
April 2019	Broaden inclusion criteria to women who were pregnant and drinking up to 12 years ago; remove requirement to report drinking 7+ units per week; add women's focus groups (no requirement to disclose drinking)	Improve recruitment; responds to early feedback re complexity of defining/ reporting alcohol consumption	From ENU (only applies to non-NHS recruitment)
August 2019	Allow approved transcription company to be used for forthcoming interviews (with permission of participants)	Timescales	From ENU (NHS confirmed this only requires approval from ENU)

Appendix 7: Extract from reflective journal



One potential participant in [redacted] wants to take part but difficult to actually meet. In order to have contact with her baby she is breathalysed at every appointment and I think (but don't know) she has to not be drinking at all to have contact. Makes me think:
- How sober do we need to be to care for our children? If I had a drink no. one would be saying I couldn't see my babies, but she has to drink nothing or no contact.
- What impact will this have on their ongoing relationship? The baby is only weeks old so every missed contact is a big deal. How much of this missed contact is caused by institutions? She is turning up for contact but being turned away.
- What is going to happen to the baby?
- When I worked at [redacted] I always thought how sad it was that the things that get written down in reports follow the kids around (or even get there before the kids) - but now I'm thinking that not only do the reports follow them, but they come to be read as the 'truth' - but someone has chosen what to write down & what to leave out (and it's not the mum)...

Will my taking part be kept confidential?

All the information you provide during the research study will be kept confidential. However, there are some circumstances where information would need to be shared - for example, if a child or vulnerable adult was at significant risk of harm. In these cases we will talk to you about our need to share information.

Any information that identifies you (like your name and address) will be kept on a paper copy only, in a locked cupboard in a locked room in the University. All other non-identifiable information, like your anonymised interview document will be stored securely on a University computer. Only the researcher and her academic supervisors will have access to your data.

With your consent we will inform your GP that you are taking part in the study.

What will happen to the results of the study?

The results of the study will be written up and reported in academic journals and websites. The researcher may also present the results of the study at training events or conferences. Your identity will not be revealed in any report or presentation.

Who is organising and funding the research?

This study is funded by the School of Health and Social Care at Edinburgh Napier University. Annie Taylor, the researcher, is a PhD student at the university. Other staff involved in the research include Dr Elaine Carnegie, Dr Anne Whittaker, Dr Amy Chandler and Dr Rhona McInnes. The study is sponsored by Edinburgh Napier University.

Who has reviewed the study?

Research is looked at by an independent group of people called a Research Ethics Committee (REC). A favourable ethical opinion has been obtained from Edinburgh Napier University Research Integrity Committee.

Independent advice:

If you have any concerns or questions about any part of the research, you can speak with an independent person who is not involved in the study. Her name is Dr Janette Pow and you can contact her on 0131 455 5303 or by email j.pow@napier.ac.uk

Researcher contact details

If you have any questions about the study, please contact Annie Taylor, who is the researcher for this study, on 07981 188017 or annie.taylor@napier.ac.uk

Edinburgh Napier UNIVERSITY

PARTICIPANT INFORMATION SHEET

Women's views on pregnancy and alcohol

Do you want to take part?

You are being invited to take part in a research study. Before you decide, it is important to know why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the research about?

The study aims to find out about women's views and experiences of drinking during pregnancy and what life is like for them before, during and after pregnancy. Women in the UK are now advised not to drink alcohol during pregnancy, but many women drink alcohol when they are pregnant, for lots of different reasons. Research about drinking during pregnancy has not usually asked women who drink during pregnancy about their views and experiences. It is important to know what women think about drinking, and what life is like for them, because this may affect the type of support that would be helpful.

Why have I been invited to take part?

You have been asked to take part because you are: pregnant, or you have a child under the age of 12, and you drink/ drank alcohol during pregnancy.
In this study, we are interested in hearing from women who carry on drinking after their first appointment with the midwife.

Do I have to take part?

No, it is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision not to take part, or to withdraw at any time, will not affect the standard of care you currently receive from any service.

What will happen if I take part?

If you do decide to take part, you will be asked to attend two interviews with the researcher, at a time and place that suits you.

- At the first interview the researcher will ask you to talk about:
    - your views and experiences of being pregnant and being a parent,
    - your current and past health and social circumstances,
    - your current and past drinking,
    - your day-to-day life, and
    - your views about any help or support you have received, or would like, from health and social care services.

  This interview will last about 1½ hours.
- At the first interview you will also be asked if you would like to take part in an activity involving taking some photos on a camera. The researcher will give you a camera to keep and will explain the activity to you. The aim of the photo activity is to help you think about different parts of your life and what drinking means to you, so it is easier to talk about this at the second interview. It is up to you whether you do this or not. If you do take photos, they will belong to you and it is up to you whether or not you show them to the researcher.
- At the second interview, between 1 and 10 months after the first one, the researcher will ask you about:
    - Whether anything has changed for you since the first interview
    - The good and not so good things about your life
    - What drinking meant to you when you were pregnant, and what it means to you now.

  If you took part in the photo activity you can bring the photos with you, and use them to help you talk about the topic.
  This interview will last about 1 hour.
- The researcher will tape each interview using a voice recorder so that she can listen to your interviews and write them up word for word afterwards.
- Your name and any other personal information that you provide in the interviews which might identify you will be removed or changed so that you cannot be recognised.

Will I get expenses and payment for taking part?

You will be given a £20 voucher after each interview to cover any expenses for taking part in the research.

What are the possible benefits of taking part?

The interviews will hopefully involve discussing issues that are important to you and will give you the chance to talk about your experiences and express your views on the topic. The study may not have any direct or immediate benefit to you but the information that you provide will help us to develop better policies and services for women and families in the future.

What are the possible disadvantages of taking part?

Sometimes people can become upset in interviews when they discuss personal thoughts or feelings about issues which are important to them. If you become upset during an interview the researcher will stop and ask you if you would like to continue or not. The researcher will ensure that your thoughts and feelings are respected at all times.

What will happen if I don't want to carry on with the study

If you don't want to carry on with the study you can withdraw at any time. You do not need to give a reason. Taking part in the study, or not taking part in the study, will not affect the care that you currently receive from any services.

What happens when the study is finished?

After you complete your second interview with the researcher (or before this if you choose not to take part in the second interview), your involvement in the study will end. We will write up a summary of study findings and will send you a copy if you wish.

Appendix 9: Study poster

have your say
about pregnancy and alcohol

Are you pregnant, or is your child younger than 12 years old?

Did you drink alcohol throughout your pregnancy?

This study involves talking with a researcher in two interviews, where you would have the chance to share your experience of pregnancy, and your thoughts about drinking during pregnancy.

The interviews will last up to 90 minutes each and are private and confidential. You will receive a £20 voucher to cover any expenses.

To find out more, please contact Annie Taylor, the researcher, on 07981 188017 or annie.taylor@napier.ac.uk, and she will tell you more about the study, or go to https://pregnancyandalcohol.wordpress.com

Research study: Women's views on pregnancy and alcohol.
School of Health and Social Care, Edinburgh Napier University
Poster_04 April 2019_v1.2

Edinburgh Napier UNIVERSITY

Appendix 10: Topic guide for first interview

Topic guide for first interview

Introduce study and researcher, remind about confidentiality, obtain written consent and permission to record the interview

Life now

Example question for this section – reactions to being pregnant:

Let's start with the news of the pregnancy - When did you find out you were pregnant and what was your reaction to the news?

- pregnancy/ being a parent
- family/ friends
- local area
- things like/ dislike about life

Life history

Example question for this section – childhood/ family:

What was it like for you growing up?

- childhood/family
- education/ work
- health (including mental health)
- drinking

Experience of pregnancy and alcohol (prompt with images 1, 2 and 3)

Example question for this section – the abstinence approach

If it's ok with you, I'd like us to think now about drinking alcohol during pregnancy. You might have seen this picture before (show image 1). What do you think or feel about it?

- views on drinking during pregnancy
- Scottish/ UK guidance re alcohol and pregnancy
- How much/ what type of drink, when, why, who with

Partner (prompt with image 4 and 5)

Example question for this section – fatherhood:

People have different ideas about what it means to be a good father. What do you think about the fathers in these pictures (show images 4 and 5)?

- Role in family/ as father
- Drinking

Experience of services (prompt with images 6 and 7)

Example question for this section – experience of services during pregnancy:

And thinking about since you've been pregnant [this time], what kinds of help and support have you had?

What about from services like the one in this picture (show image 6)?

- Experience of services as a child

- Experience of services as an adult and/or during pregnancy, including drug/alcohol specialists, midwife/ GP/ obstetrician/ health visitor/ social worker

Anything else participant wants to say

Complete participant details sheet, introduce photo task, invite to second interview, offer copy of findings when study completed, debrief and give debriefing sheet

Study Title: Women's views on pregnancy and alcohol

To be filled in with participant at first interview

Participant unique ID:	
Age:	
Geographical area:	
Pregnant? (If yes, gestation?)	
Number and ages of children:	
Are you living alone?	
Do you have a partner at the moment? How long have you been in this relationship?	
Are you working at the moment? If so, roughly how much do you earn?	
Are you receiving any benefits? If so, which ones?	
Any debts/financial worries?	
What is your housing status? *Homeless* *Renting from local authority/ housing association* *Renting from private landlord* *Mortgage/ own home*	
Do you have any significant physical health issues?	
Do you have any significant mental health issues?	
Are you currently involved with any alcohol treatment services?	
Do you have any legal/criminal justice issues?	
Have you been involved with any alcohol treatment services in the past?	
Are any services involved in your life at the moment? *Midwife* *Health visitor* *Social work* *Drug/ alcohol worker* *Other*	

Appendix 12: Images for photo-elicitation

Image 1 – wine bottle label

Images 2 and 3 (to be shown together) – different 'types'/ perceptions of drinking

Image 4 – role of father

Image 5 – father drinking

Image 6 – services

Image 7 – caring for a baby

(images from shutterstock)

Appendix 13: Photo activity sheet

Photo task

I would like you to take some photos on the camera I have given you (or on your phone if you prefer). The aim of the photo activity is to help you think about different parts of your life and what drinking means to you, so it is easier to talk about this at the second interview.

While you take the photos, think about the following questions:

When you were pregnant, what were the good things about your life?

When you were pregnant, what were the difficult things about your life?

What did drinking alcohol mean to you when you were pregnant and what effect did it have on your day-to-day life (good and bad)?

If you had cut down your drinking, or stopped altogether, when you were pregnant, what would that have meant to you and what effect would it have had on your day-to-day life (good and bad)?

It is up to you whether you do this or not. If you do take any photos, they will belong to you and it is up to you whether or not you show them to me.

If you want to, you can bring the photos with you to our next interview, and use them to help you think about the questions. I will not take any of your photos away with me.

Please do not take photos that could identify other people, either from their face or a particular place, or anything else that could mean that anyone could see who they are.

Thanks for your help

Annie

Appendix 14: Topic guide for second interview

Welcome, remind about confidentiality

Note: participants who completed the photo task were given the following questions to guide their photos. For participants who did not complete the photo task but do wish to have a second interview, still use these questions to form the basis of the interview

When you were pregnant, what were the good things about your life?

When you were pregnant, what were the difficult things about your life?

What did drinking alcohol mean to you when you were pregnant and what effect did it have on your day-to-day life (good and bad)?

If you had cut down your drinking, or stopped altogether, when you were pregnant, what would that have meant to you and what effect would it have had on your day-to-day life (good and bad)?

Recap photo task

Example question for this section – photo activity:

Some people really like activities like this, others find them really hard. How easy or hard did you find the photo activity?

- How did it go
- Remind photos and camera belong to participant, check whether or not participant wants to show researcher the photos.

Look at each photo together and consider

Example question for this section – reasons for choosing a photo:

Can you tell me a bit about why you took this photo, and what it means to you?

- Meaning of photo to participant
- Prompt participant to talk more about issue/ topic brought up by the photo
- Has the situation in the photo/ their views on this changed since they were pregnant/ since the last interview/ since they took the photo?

After all the photos have been discussed

Example question for this section – how things have changed

One of the things I am interested in is whether anything about your life has changed since you took these photos. If you did this activity again, today, would the good and not so good things in your life be the same or different?

- Are the good and not so good things in the participant's life the same or different now (since pregnancy and/or since last interview and/or since completing the photo activity)?
- What does drinking/ cutting down mean to the participant now?

Anything else participant wants to say

Thank participant, debrief and give debriefing sheet

Appendix 15: Women's focus group topic guide

Focus group topic guide – women

Reiterate purpose of study and focus group, audio-recording, anonymity, reporting, discuss confidentiality, encourage discussion and debate

Introductions – ask participants to introduce themselves (e.g. state name, ages of children)

Pregnancy and parenting

Example question for this section – reactions to being pregnant:

Let's start with the news of the pregnancy - When did you find out you were pregnant and what was your reaction to the news?

- pregnancy
- being a parent

Experiences of services

Example question: Can you remember discussing alcohol with your midwife or any other professionals?

Topics:

- Discussions with midwife/ reporting alcohol consumption
- Screening and ABIs (awareness, experience)
- Any differences in experience of this between different pregnancies?

Views on drinking during pregnancy

Example question: why do you think women might drink during pregnancy? Do you think there are any risks from drinking during pregnancy?

Topics:

- Views on drinking during pregnancy (including harm/ risk)
- Reasons why women might drink during pregnancy
- Other issues for women who drink during pregnancy?
- Scottish/ UK guidance re alcohol and pregnancy

Anything else participants would like to say?

Thank participants, debrief and offer any additional support if required

Appendix 16: Topic guide for practitioner focus groups

Focus group topic guide – professionals

Reiterate purpose of study and focus group, audio-recording, anonymity, reporting, discuss confidentiality, encourage discussion and debate

Introductions – ask participants to introduce themselves (e.g. state name, profession, team/organisation and role)

Example question: Can you say a little bit about your experience of working with women who drink alcohol during pregnancy and how you see your role in relation to alcohol consumption during pregnancy?

Topics:

Role, Experience, Knowledge/Confidence regarding drinking during pregnancy

Views on drinking during pregnancy

Example question: why do you think women might drink during pregnancy? who do you think is most at risk from drinking during pregnancy?

Topics:

Prevalence of drinking during pregnancy, Views on harm/ risk and reasons why women might drink during pregnancy, Awareness of/ views on current policy/ practice framework/ guidance on consumption/ screening / treatment and care approaches

Other issues for women who drink during pregnancy?

Ask participants to give examples of the points they are making.

Clinical issues

Example question: Can you talk me through what happens in [health board] when someone discloses that they are drinking during pregnancy?

Topics:

Confidence in discussing alcohol consumption with pregnant women and risks/harm (FAS/FASD), approaches to screening and assessment, Challenges involved in talking to pregnant women about drinking/screening and assessment, issues around low consumption (<7 units/wk) and higher consumption (>7 units /wk)?

Issues around the delivery of brief interventions, referral for alcohol treatment, detox, relapse, helping women who are alcohol dependent who have other health and social problems, breastfeeding and alcohol consumption, treatment and assessment of babies at risk of FAS/FASD?

Multidisciplinary / joint working (health and social care), sharing information about pregnant women who drink, care planning for mother and baby, child protection issues etc

Ask participants to give examples of the points they are making.

Support/models of care

Example question: If money and time were no object, how do you think we could best support women who drink during pregnancy?

Topics:

Views on effectiveness of current support (before, during and after pregnancy) – what's working/not working?

What approaches work best? why

Views on how to improve services/models of care for women who drink during pregnancy?

Ask participants to give examples of the points they are making.

Anything else participants would like to say?

Thank participants, debrief and offer any additional support if required

Appendix 17: Debrief sheet

We would like to thank you for taking part in this research. Your help and involvement is very much appreciated.

Your input will help us to develop a better understanding of the views and experiences of women who drink alcohol during pregnancy and what help they might need from services.

This project is not intended to upset you in any way. However, what we talked about in your interview may have raised some issues or concerns. If you feel you need more information, advice and/or support about some of the issues raised during the study, please contact myself or Dr Elaine Carnegie, at Edinburgh Napier University E.Carnegie@napier.ac.uk. We will respond to you as soon as we can.

Alternatively, there are a few suggestions for support services below.

This letter is for you to keep.

If you are feeling worried or upset about anything we have talked about, you could contact your midwife, health visitor or GP/ doctor. If you would like me to help you do this, let me know before I leave, or contact me afterwards.

If you don't want to talk to your midwife, health visitor or doctor, you could contact a friend, family member or support worker to talk things through.

If you want to talk to someone without them knowing who you are, you could call:

ParentLine Scotland, 08000 28 22 33, to talk about looking after a child

Citizens Advice Scotland, 0808 800 9060, for advice about any issue, including money worries

Scotland's Domestic Abuse and Forced Marriage Helpline, 0800 027 1234, to talk about domestic abuse or violence

Samaritans, Tele: 116 123, to talk about anything

Emergencies:

If you feel you are in crisis and need immediate help, please contact:

The Mental Health Assessment Service: The NHS emergency mental health assessment service is for people experiencing a mental health crisis. The service is available 24 hours a day, seven days a week. In Edinburgh, the service is located at the Royal Edinburgh Hospital. Telephone 0131 537 6000. Please see your local Health Board website for details or contact your local A&E department.

Information, advice and support about alcohol and other drug use:

There are many services that offer help to people with an alcohol or drug-related issue. These services are normally advertised via your local *'Alcohol and Drug Partnership'* website. In Edinburgh, the website is https://www.edinburghadp.co.uk/

I hope this of help to you, but please remember to contact myself or Elaine if you would like to discuss anything further or you would like us to help you access any support service.

Yours sincerely,

Annie Taylor, Researcher

Telephone: 07981 188017

0. Proposal name

Alcohol consumption and social contexts during pregnancy and the postnatal period – a qualitative, longitudinal study

1. Description of the data

1.1 Type of study

This qualitative, exploratory, feminist, longitudinal, photo-elicitation study, uses a social model of alcohol consumption (Staddon, 2016) to examine the ways in which women who drink (or drank) during pregnancy account for this.

1.2 Types of data

Qualitative data generated from interviews, participant details sheets, consent forms, audio files

1.3 Format and scale of the data

Verbatim transcripts and participant details sheets from interviews with up to 30 participants audio files (up to two interviews with each participant).

2. Data collection / generation

2.1 Methodologies for data collection / generation

Each participant may participate in one or two interviews and a photo elicitation task. This offers participants time and space to reflect on and develop their own views throughout the research process.

Once participants have decided to take part in the study and have given informed written consent, they will participate in an initial interview which will last up to 90 minutes, and which will include discussion of participants' own childhood, education, work and health history, experiences and views of drinking, pregnancy, and services, the local area, and friends, family and partners. This interview will include the use of photographs (see images) as stimulus material (photo elicitation) to elicit discussion about issues that are complex and difficult to explore. The participant's personal and social circumstances will be recorded using a participant details sheet (see participant details sheet), which will provide a detailed profile of each participant.

After the first interview participants will be asked if they would like to take some photos on a digital camera, and provided with a camera and task sheet which will help them to consider different aspects of their day-to-day lives, and their perspectives on the benefits and drawbacks of drinking during pregnancy. This

optional activity supports participants to reflect on their lives and generate stimulus The camera and photographs will remain the property of participants at all times, and women will retain their photos.

The second interview, about 6 months after the first one, will focus on the good and difficult things about participants' lives, how drinking intersects with other aspects of women's lives, and whether anything has changed for the participant since the first interview. If participants wish to do so they can use the photos they have taken as prompts for discussion in this interview. This interview will last around 1 hour.

2.2 Data quality and standards

This research is a doctoral research study and will be closely monitored by the student's supervisors. Progress and adherence to regulations will be regularly monitored through review meetings (which are separate from and additional to regular supervisory meetings), led by an Independent Panel Chair and signed off by the Edinburgh Napier University's School of Health and Social Care Research and Innovation Committee.

Interviews will be semi-structured, which will enable key questions, concepts and relationships to be explored, but flexible, to allow relevant discussion to develop; it is not intended that each interview is conducted in exactly the same way, but that the interviews are seen as social interactions, the content and tone of which depends on the participant and interviewer. Interview topic guides will be used to guide the interviews, in order to ensure the key topics are covered in each interview, aiding the consistency of the data and making analysis possible. The first interview will be conducted using an interview topic guide which have been informed by a systematic literature review. The second interview will be guided by discussions about the photographs participants take in response to a set of questions they are given at the end of the first interview.

3. Data management, documentation and curation

3.1 Managing, storing and curating data.

Interviews will be audio-recorded on an encrypted digital voice recorder to ensure security of data whilst in transit. Each time an interview is carried out this recording will be downloaded onto a University computer using the secure network and the recording will be deleted from the recorder. All transcripts will be fully anonymised with any names and data that could identify participants removed or changed to ensure anonymity. Only fully anonymised transcripts will be entered into NVivo v11

(a qualitative research software package) to aid coding and management of the data sets.

Research data will be stored on the University's X:drive. **University-managed data storage** is resilient, with multiple copies stored in more than one physical location and protection against corruption. Daily backups are kept for 14 days and monthly backups for an additional year.

3.2 Metadata standards and data documentation

All participants will be given a pseudonym name and unique identifier code at the start of the study, and this will enable participant details sheets and interview transcripts to be analysed together.

First and second interviews will be labelled accordingly so they can be compared.

3.3 Data preservation strategy and standards

All study data (excluding audio files) will be kept for 10 years from the end of the study, on the University's secure network, in accordance with the university's data management policy. After this time, the data will be destroyed by Dr Elaine Carnegie. Audio files and personal identifiable information (e.g. consent forms) will be deleted/destroyed within 12 months of end of study.

4. Data security and confidentiality of potentially disclosive information

4.1 Formal information/data security standards

Identify formal information standards with which your study is or will be compliant. An example is ISO 27001.If your organisation is ISO compliant, please state the registration number.

4.2 Main risks to data security

Risk: audio files accessed during transit (low risk). This risk will be managed by only recording interviews on an encrypted digital recorder, and travelling as directly as possible back to upload the audio files and store the consent forms securely.

Risk: Consent forms (containing personal, identifiable information) accessed (low risk). This risk will be managed by keeping paper copies only, stored in a locked cupboard in a locked room in a secure building.

Risk: transcripts accessed (low risk). This risk will be managed by ensuring that all transcripts are fully anonymised with any names and data that could identify

participants removed or changed to ensure anonymity. Only fully anonymised transcripts will be entered into NVivo v11 (a qualitative research software package) to aid coding and management of the data sets.

Risk: participant contact details accessed (low risk). This risk will be managed by ensuring that no personal identifiable data is stored on any University IT system or transmitted via University email address. A designated study mobile phone will be used to contact participants, for example to schedule or confirm interview times, and any text messages will be deleted immediately afterwards. This mobile phone will only be used for the purposes of the study and will not be the researcher's personal phone. Participant names and addresses will only be shared with supervisors as necessary to carry out the fieldwork safety protocol.

5. Data sharing and access

5.1 Suitability for sharing

Appropriate safeguards will be put in place to ensure that all sensitive or personalised qualitative data is summarised in a general form prior to data sharing. Data generated by the project (identified above) will be made open once appropriate changes have been made to honour assurances of confidentiality and anonymity.

5.2 Discovery by potential users of the research data

Datasets will be allocated a DOI and stored on our open access Research Repository in accordance with the University research data deposit process. The DOI and the datasets will be made available to the UK Data Service ReShare repository within three months of the end of the grant.

5.3 Governance of access

Dr Elaine Carnegie in partnership with RIO will comply with Edinburgh Napier guidelines and checklists to inform these decisions.

5.4 The study team's exclusive use of the data

5.5 Restrictions or delays to sharing, with planned actions to limit such restrictions

As part of the consent process, proposed procedures for data sharing will be set out clearly and current and potential future risks associated with this explained to research participants.

5.6 Regulation of responsibilities of users

Data sharing agreements will be set up for all external users in compliance with Edinburgh Napier's data sharing policy.

6. Responsibilities

The first point of contact for all queries in relation to this data is Dr Elaine Carnegie, who also has overall responsibility for the production and maintenance of metadata. Preparation and upload of the data will be carried out by the team with the support of the University's Information Services staff.

Dr Elaine Carnegie will be the custodian of the data, with overall responsibility for compliance with the data management plan, and Annie Taylor will be engaging with the data day-to-day, and will follow the data management plan. Others in the research team (PhD supervisors) will have access to anonymized data as necessary, in order to assist in data analysis.

7. Relevant institutional, departmental or study policies on data sharing and data security

Please complete, where such policies are (i) relevant to your study, and (ii) are in the public domain, e.g. accessible through the internet.

Add any others that are relevant

Policy	URL or Reference
Data Management Policy & Procedures	*http://staff.napier.ac.uk/services/research-innovation-office/Documents/Research%20Data%20Management%20Policy.pdf*
Data Security Policy	*http://staff.napier.ac.uk/services/cit/infosecurity/Pages/InformationSecurityPolicy.aspx*

Data Sharing Policy	*http://staff.napier.ac.uk/services/secretary/governance/DataProtection/Pages/DataSharing.aspx*
Institutional Information Policy	
Other:	
Other	

8. Author of this Data Management Plan (Name) and, if different to that of the Principal Investigator, their **telephone & email contact details**

Annie Taylor, PhD student

Annie,taylor@napier.ac.uk

Appendix 19: List of codes

baby as overriding mother

child removals

context important during pregnancy

Denial

descriptions of drinking

Development of participants' thinking over course of study

drinking as coping mechanism

drinking for pleasure

Experiences of drinking

social norms around drinking

Fatherhood

Fear

fear of social work involvement

Foetus as person

foetus child protection

gender and power

importance of place

individualisation - drinking as a choice

isolation or non drinking pregnancy affecting friendships

lack of autonomy during pregnancy

mental health issues

Motherhood

Boredom

Feelings of failure

feelings of guilt

Impact on relationship with partner

Motherhood and body

motherhood as natural

motherhood having negative impact on sense of self

Work

Multiple adversities

adverse childhood experiences

alcohol or addiction within family

partner violence

poverty and marginalisation

traumatic experiences and repeat victimisation

othering or trying to present self in a positive light within interview

photos of women

Pregnancy and alcohol

abstinence as obvious or common sense during pregnancy

advice about drinking during pregnancy

role of experience and personality of midwife

advice about pregnancy generally

'Attachment to baby' as natural during pregnancy

breastfeeding and alcohol

drinking as a way of maintaining self and autonomy

FASD

Biomedical model of FASD

broadening in scope of FASD

feelings of guilt

individualisation

panic about number of cases Armstrong democratization

social problem

women blamed for adversity

feelings about pregnancy

First or subsequent pregnancy

health inequalities

gender, class and alcohol

knowledge about risks

knowledge about risks

knowledge about risks

knowledge of guidelines v knowledge of evidence

policing of pregnancy

reproductive citizenship (Lupton)

risk model of pregnancy

women making complex risk calculations

worry or anxiety

knowledge of guidelines v knowledge of evidence

policing of pregnancy

reproductive citizenship (Lupton)

risk model of pregnancy

women making complex risk calculations

worry or anxiety

models of alcohol consumption

addictions model

biomedical epigenetics

social model (Staddon)

not reporting or disclosing drinking during pregnancy (2)

other drug use

other drug use easier to identify

other drug use prioritised over alcohol

Pregnancy and body

Services or support during pregnancy

child protection tension

clinical issues

detox

difficulty identifying women who are drinking

doing harm v helping with services

inadvertent harms from services or services consolidating vulnerability

Ineffective services pointlessness hopelessness

lack of knowledge about what's going on for women who drink during pregnancy (v women using other substances)

need for services to feel in control

Seeking services v avoiding services

Services need to address wider issues and not push women away

Substance using women treated differently to others

timescales unrealistic

Treatment as punishment

uncertainty or misunderstanding

Women's needs v minimising harm to fetus

Women's powerlessness in services

Stress

pregnancy as limiting

pressure to change during pregnancy

pressure to drink

problematisation of women's drinking

Resisting the problematisation of drinking

relapse

risk generally

stigma of service involvement

structural adversities

role of SES in drinking and pregnancy and service involvement

Structural issues v individualisation

support services

family and friends support

Partner support

relationship with partner

surveillance

importance of not being seen drinking

it matters what people think

foetus as a person or mother versus foetus

importance of context or structure or inequality

individualised risk

services or policy causing harm

surveillance

unintended consequences of abstinence framework

unplanned pregnancy

victimhood