SOCIAL REPRESENTATIONS OF ALCOHOL USE AMONGST WOMEN WHO DRANK WHILE PREGNANT

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A minor dissertation submitted in partial fulfillment of the requirements for the award of the degree of Master of Arts in Psychological Research

Faculty of the Humanities

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2014

COMPULSORY DECLARATION

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

Signature:_____ Date:_____

ACKNOWLEDGEMENTS

I would like to thank Catherine Ward for supervising this research project. It has been a privilege learning from you, and I greatly appreciate all the time and energy you put into assisting me with this study.

I wish to thank Leslie London who originally proposed this project idea, Taryn van Niekerk for her helpful suggestions for my analysis process, Leon Van Wyk for transcribing the recordings, and Lila Richter for assisting me with the Afrikaans translations.

I would also like to thank my family – in particular my parents, Anthony and Philippa Kelly, as well as my aunts, Melanie Kelly and Anneke Koffeman, for their continued support of my education.

To Adrian Burger – thank you for always being so encouraging and supportive, and for your willingness to discuss my work.

I would like to thank the Foundation for Alcohol Related Research for providing access to the study participants and for all their support in the research process.

The financial assistance of the National Research Foundation (NRF) towards this research is hereby acknowledged. Opinions expressed and conclusions arrived at, are those of the author and are not necessarily to be attributed to the NRF.

Finally, thank you to the participants of this study for sharing your stories with me.

ABSTRACT

Despite the fact that some of the highest rates of fetal alcohol spectrm disorders (FASDs) in the world have been reported in the Western Cape of South Africa, little research looks at the experiences of pregnant women who consume alcohol and what influences their alcohol use. Gaining insight into the social, psychological and contextual processes that contribute to risky drinking during pregnancy will help in guiding interventions that aim to prevent prenatal alcohol use, thereby preventing the occurrence of FASDs. Using both social representation theory and a discourse analytic approach, fourteen narrative episodic interviews were conducted in a Western Cape community with women who consumed alcohol during their pregnancy, and two focus group discussions with 13 members of the pregnant women's community. Data collection aimed to elicit how these women and community members constructed and made sense of alcohol use. The interview and focus group data was analysed using thematic decomposition analysis. Alcohol use was represented by many participants as a social activity which was heavily influenced by their peers. Implicit in this representation was the notion that heavy drinking was a norm within this study community and offered one of the only ways in which to socialise. However, some participants also represented alcohol use as an individualised activity by constructing a clear boundary between drinking socially with friends and drinking to become inebriated. Although drinking during pregnancy was represented as a stigmatised activity, it was also understood by the pregnant women and community members as a way of dealing and coping with difficult domestic problems, such as infidelity. Furthermore, it was also represented as contributing to problems in the participants' lives as well as unwanted changes in their behaviour. For some interview participants the problems they faced, reservations they held about their pregnancy and becoming a mother, and the social nature of drinking in their community may have inhibited their ability to stop drinking during their pregnancy. For other participants access to some form of social support, a level of responsibility-taking and a desire to protect the fetus from harm as well as care for and look after their children seemed to contribute to their ability to give up drinking while pregnant. Future interventions should take the social context of alcohol use into account, and rather than ignoring it – as most interventions do – use it to not only shift the social norms that surround heavy alcohol use, but also to support pregnant women to stop drinking. Prevention and intervention initiatives should also take a non-judgemental and supportive approach that focuses on capitalising on the moment of pregnancy and on teaching psychosocial skills that enable pregnant women to manage their problems effectively.

Key words: alcohol use, pregnancy, social representations, discourse, narrative episodic interview, focus groups, thematic decomposition analysis

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CHAPTER 1: INTRODUCTION AND THEORETICAL FRAMEWORK

Across the world hazardous alcohol use is listed as one of the top five risk factors for disease, disability and death (World Health Organisation, 2014). As a result, the World Health Organisation in 2010 endorsed the global strategy to reduce the harmful use of alcohol. Included in this strategy is a call for "early identification and management of harmful drinking among pregnant women and women of child-bearing age" (World Health Organisation, 2010, p. 12). This is a reflection of the high prevalence rates of alcohol use during pregnancy in a number of countries (Osterman, 2011; Skagerström, Chang, & Nilsen, 2011). For instance, in Russia, the United States, England, Canada and New Zealand 20% to 34% of women report drinking during pregnancy (Balachova et al., 2012; Mallard, Connor, & Houghton, 2013; May et al., 2008). In some European countries the rate is higher, sometimes exceeding 50% (May et al., 2008).

In sub-Saharan Africa, research examining the prevalence of alcohol use amongst pregnant women is limited and has focused on varying sample sizes. However, the studies that have been performed indicate that the prevalence rates range from 2.5% to 50.8% (Culley et al., 2013). In Nigeria, 2.5% of women report drinking alcohol while pregnant (Abasiubong et al., 2013), in Ghana, 20.4% (Adusi-Poku et al., 2012) and in Uganda, 24.8% (Namagembe et al., 2010). In the KwaZulu Natal province of South Africa, 18% of women report alcohol use during pregnancy (Desmond et al., 2012), in Gauteng, 4.6% (Ramchandani, Richter, Norris, & Stein, 2010), and in Mpumalanga, 6.5% (Matseke, Peltzer, & Mlambo, 2012). The Western Cape is reported to have the highest incidence of alcohol use during pregnancy in South Africa: interviews conducted at antenatal clinics across the province indicate that 34.4% to 36.9% of women in the Cape Metropole area consume alcohol during pregnancy (Croxford & Viljoen, 1999; Petersen Williams, Jordaan, Mathews, Lombard, & Parry, 2014), while 46.1% to 50.8% of women in rural and small town areas report drinking prenatally (Croxford & Viljoen, 1999). Furthermore, over 55% of those who report consuming alcohol during pregnancy do so at a level that is high enough to put their fetus[1] at risk for the development of fetal alcohol syndrome (FAS) (Croxford & Viljoen, 1999) – FAS is associated with heavy episodic (binge) drinking (May et al., 2008; May, Blankenship, Marais, Gossage, Kalberg, Joubert et al., 2013). Accordingly, alcohol use during pregnancy is a critical problem within the Western Cape of South Africa.

[1] The South African Department of Health has chosen to use the American spelling when it comes to fetal alcohol spectrum disorders and this dissertation follows this example.

The Harms Associated with Prenatal Alcohol Use

If alcohol, a powerful teratogen, is present in a woman's blood during pregnancy it freely crosses through the placenta into the blood and other tissues of the developing embryo and fetus (Dörrie, Föcker, Freunscht, & Hebebrand, 2014; Rendall-Mkosi et al., 2008). Prenatal alcohol exposure is linked to a number of adverse health consequences for the fetus including low birth weight, intrauterine growth retardation, spontaneous abortion, stillbirth, sudden infant death syndrome and fetal alcohol spectrum disorders (FASDs) (Bailey & Sokol, 2011; Ethen et al., 2009; Skagerström et al., 2011). Any alcohol use (as opposed to no alcohol use) during the first trimester of pregnancy increases the risk of having a child with a FASD by 12 times, first and second semester drinking by 61 times, and drinking in all trimesters by 65 times (May et al., 2013).

FASDs refer to a series of birth defects that lie along a continuum (Hoyme et al., 2005; May et al., 2009; Stevens et al., 2013), the most severe of which is FAS. FAS is characterised by facial deformities, delayed physical growth and development, and structural abnormalities of the brain. Partial FAS, the next disorder along the spectrum, includes facial deformities and abnormalities in one other area (i.e., problems in physical growth, or brain growth or structure). The other two recognised disorders along the spectrum are alcohol-related birth defects (ARBD), which is characterised by structural abnormalities, and alcohol-related neurodevelopmental defects (ARND), which involves behavioural and cognitive disabilities (Burd, Martsolf, Klug, & Kerbeshian, 2003; Hoyme et al., 2005; May et al., 2009).

In terms of physical deformities, individuals with a FASD can present with narrow or small eyes, thin upper lips, smooth philtrums, be short in height, have small heads and a low body mass index (Rendall-Mkosi et al., 2008; Sokol, Delaney-Black, & Nordstrom, 2003). Individuals affected by a FASD also present with a range of behavioural and neurocognitive difficulties including inattention, hyperactivity, problems with social interaction, poor impulse control, motor functioning delays, executive functioning deficits, and memory, language, reasoning and judgement problems (Adnams et al., 2001; Mattson, Crocker, & Nguyen, 2011; May et al., 2007; J. Salmon, 2008; Stevens et al., 2013; Stratton, Howe, & Battaglia, 1996).

Raising a child who has been exposed to alcohol prenatally presents difficult challenges (Johnston & Boyle, 2013): Biological and non-biological parents of FASD children describe how their children become easily confused and are very forgetful, how they have an inability to understand the consequences of their actions, that they have problems

with aggression, and also with making and keeping friends (Gardner, 2000; Johnston & Boyle, 2013; J. Salmon, 2008; J. L. Sanders & Buck, 2010).

Without early intervention those affected by FASD can also present with a number of secondary disabilities into adolescence and adulthood including a lack of commitment to school, poor mental health, substance abuse problems, inappropriate intimate relationships and sexual behaviour, unemployment and conflict with the law (Rendall-Mkosi et al., 2008; J. Salmon & Buetow, 2012). Clearly, FASDs not only negatively impact the individual, but also create a huge burden on the family caring for that individual, as well as on the society having to provide and cater for them (Credé, Sinanovic, Adnams, & London, 2011; C. Lupton, Burd, & Harwood, 2004). Children with a FASD have an array of health care needs, including the correction of physical defects, management of cognitive impairment and developmental delays, and assistance with behavioural issues (Stratton et al., 1996). In the Western Cape, the estimated annual financial burden of FAS and partial FAS is over R650 million (Credé et al., 2011).

The prevalence rates of FASDs in South Africa are particularly high. In-school studies show that the disorders affect 72.3 per 1,000 children, while in the United States and some Western countries in Europe, they affect 20 to 50 per 1,000 children (May et al., 2009). Within a Western Cape community in South Africa, FAS amongst school children in 1997 was recorded at 40.5 to 46.4 per 1,000 (May et al., 2000). This increased two years later in the same community to 65.2 to 74.2 per 1,000 (Viljoen et al., 2005). In 2002 both FAS and partial FAS were measured in this community and the disorders were found to affect 68.0 to 89.2 per 1,000 school children (May et al., 2007). Recently, a fourth study measured three of the disorders along the spectrum in this community and found that FAS affected 59.3 to 91.0 per 1,000 school children, partial FAS, 45.3 to 69.6 per 1,000 and ARND 30.5 to 46.8 per 1,000, with the overall rate of FASDs at 135.1 to 207.5 per 1,000 (May, Blankenship, Marais, Gossage, Kalberg, Barnard et al., 2013).

High rates of FASDs have been documented in other parts of South Africa too: in the Northern Cape, FAS/partial FAS was found to affect 74.7 per 1,000 children in Uppington and 199.4 per 1,000 children in De Aar (Urban et al., 2008). Furthermore, across several communities within the Gauteng province the overall rate of FAS was 26.5 per 1,000 children (Viljoen, Craig, Hymbauch, Boyle C., & Blount, 2003). These findings stand in stark contrast to estimated rates of 0.3 to 4.9 per 1,000 in the United States (May & Gossage, 2001; May et al., 2009). Clearly, FASDs – and therefore alcohol use during pregnancy - are a major public health concern in South Africa (Credé et al., 2011; Viljoen et al., 2003).

Factors that Contribute to Alcohol Use During Pregnancy

A number of complex and inter-related biological, demographic, socioeconomic and psychological factors contribute to alcohol use during pregnancy. These factors also affect the extent of damage to the fetus (Rendall-Mkosi et al., 2008). One area that has been acknowledged as contributing to prenatal alcohol use is the drinking patterns of women before and during the early stages of their pregnancy. A potential reason as to why women drink during the first trimester of their pregnancy is that they may be unaware that they are pregnant (Rendall-Mkosi et al., 2008) - particularly if their pregnancy is unplanned. Indeed, over 1 in 4 women drink alcohol post conception, but before recognising that they are pregnant (O'Connor et al., 2011). However some women continue drinking even after discovering they are pregnant (O'Connor et al., 2011; Urban et al., 2008), which indicates that there are other factors at play – knowledge that one is pregnant is not sufficient to inhibit drinking.

One of these factors is adoption of drinking habits at an early age (May & Gossage, 2001). Another is high levels of alcohol consumption before pregnancy (Choi et al., 2014a; Ethen et al., 2009; Meschke, Hellerstedt, Holl, & Messelt, 2008; Skagerström et al., 2011). Mothers who have given birth to FASD children have been found to start drinking at a young age, and to drink significant amounts of alcohol before their pregnancy; some to the extent that they have been identified as alcohol dependent (Astley, Bailey, Talbot, & Clarren, 2000; Cannon, Dominique, O'Leary, Sniezek, & Floyd, 2012; May et al., 2005; May et al., 2008).

Aside from pre-pregnancy drinking patterns, several psychosocial factors are common to pregnant women who drink. The experience of physical and sexual abuse, as well as exposure to violence have been identified as risk factors for alcohol use during pregnancy (Esper & Furtado, 2014; Leonardson, Loudenburg, & Struck, 2007; Leonardson & Loudenburg, 2003; Meschke et al., 2008; Skagerström et al., 2011). A related factor is the experience of intimate partner violence (IPV) - high rates of IPV are associated with increased drinking during pregnancy (Eaton et al., 2012) and pregnant women in an abusive relationship report that they use alcohol as a way of dealing with the abuse (Astley et al., 2000). In South Africa, pregnant women who have experienced either IPV or childhood abuse tend to report drinking at elevated levels, regardless of their drinking levels before their pregnancy, and even if they were low risk drinkers beforehand (Choi et al., 2014a).

Some pregnant women also report that they feel unable to stop drinking because they are too depressed to do so (Astley et al., 2000). Indeed suffering from depression is another predictor of alcohol use during pregnancy. (May & Gossage, 2001; Meschke, Holl, &

Messelt, 2003; Meschke et al., 2008; Skagerström et al., 2011; Tomlinson et al., 2014; Vythilingum, Roos, Faure, Geerts, & Stein, 2012). The experience of low self-esteem and low self-efficacy, having few interests, and feeling sad and discouraged, are all predictive of drinking while pregnant (Leonardson et al., 2007; May & Gossage, 2001; May et al., 2005).

Psychosocial influences aside, a number of demographic and biological factors have been identified as contributing to alcohol use during pregnancy, and/or having a child a FASD. Women who drink while pregnant may have a biological predisposition to alcohol dependency – mothers of FAS children tend to present with a family history of alcohol abuse (Cannon et al., 2012; May et al., 2005). Other contributory factors include coming from a low socioeconomic background, being single, a smoker, unemployed and receiving a low income (Chien-Chung Huang & Reid, 2006; Desmond et al., 2012; Leonardson et al., 2007; May & Gossage, 2011a; May & Gossage, 2001; May et al., 2008; May et al., 2009; Meschke et al., 2008; Morojele et al., 2010; O'Connor et al., 2011; Peadon et al., 2011; Powers, Mcdermott, Loxton, & Chojenta, 2013; Skagerström et al., 2011).

Education and religion also play a role in alcohol use during pregnancy. Lower education levels and less regular religious practices have both consistently been identified as characteristics of mothers of FASD children (Cannon et al., 2012; May et al., 2005; May et al., 2008; May et al., 2009; Morojele et al., 2010; Urban et al., 2008; Viljoen, Croxford, Gossage, Kodituwakku, & May, 2002). Because of a lack of education, women could be unaware that prenatal alcohol use is harmful to the fetus, or they may hold misconceptions with regards to the risks associated with drinking while pregnant (Branco & Kaskutas, 2001; Eaton et al., 2014; Morojele et al., 2010). Women who hold the belief that any amount of alcohol is safe during pregnancy, as well as women who lack the knowledge of the effects of alcohol on the fetus, have been identified as at risk for drinking while pregnant (Leonardson et al., 2007; Peadon et al., 2011). Furthermore, even if women are aware of the risks, they may lack the social support needed to abstain (Branco & Kaskutas, 2001; Deshpande et al., 2006; Powers et al., 2013). Religious practices may be able to play an important role here as high religious attendance is associated with delayed and less frequent substance use (Meschke & Patterson, 2003). Indeed religiosity plays an important role in the prevention of substance use and other risk behaviours (Kovacs, Piko, & Fitzpatrick, 2011).

While having low levels of education, being unemployed and receiving a lower income have been identified as risk factors for drinking while pregnant, this is not always the case across different contexts: having higher levels of education, being employed and receiving a higher income have also been identified as predictive of alcohol use while

pregnant (Ethen et al., 2009; Skagerström et al., 2011). However, this association between high socioeconomic status and higher alcohol consumption is primarily due to frequent light social drinking as opposed to heavier binge drinking (Ethen et al., 2009).

Contextualising Alcohol Use

Health-related behaviours, like alcohol use, do not occur in a vacuum – rather, they are contingent on multiple social structures that influence and shape this behaviour (Benoit et al., 2014; Sun, 2014). Various social conditions of pregnant women's lives - including structural and health inequalities - can make them more vulnerable to alcohol use (Benoit et al., 2014; Hunting & Browne, 2012). For instance, South Africans in poorer communities face considerable barriers in accessing substance misuse treatment services (Myers, Louw, & Pasche, 2010). This, coupled with the stigma attached to prenatal alcohol use (Finnegan, 2013; Greaves & Poole, 2005), may make it very difficult for pregnant women with alcohol dependency problems to give up drinking.

Another contextual factor that may play a role in the alcohol use of pregnant women is the social norms that exist within a community as these can influence individual behaviour (Perkins, 2002; Rosenthal, Christianson, & Cordero, 2005). Human beings are interconnected through their social networks and the behaviours they choose are often framed by the social norms of their group (Perkins, 2002; Phua, 2013). An individual's perception of how other members of their social group think and act heavily influences their behaviour (Perkins & Berkowitz, 1986). For example, student's drinking behaviour is positively correlated with their perception of the social norms of their group with regards to alcohol use - students who believe that their social group engage in risky alcohol use (even if in actual fact they do not) have an increased likelihood of engaging in risky alcohol use themselves (Berkowitz, 2004; Dunnagan, Haynes, Linkenbach, & Summers, 2007; Perkins, 2002). The overestimation of substance abuse can create a norm within a social group that can have a substantial impact on substance use within that group (Prentice & Miller, 1993).

Furthermore, individuals can feel pressure to conform to this perceived social norm in order to be accepted by their peers: this has been demonstrated amongst students (Borsari & Carey, 2003; Halim, Hasking, & Allen, 2012) and can also be applied to pregnant women who may feel pressure to continue drinking because of their social group (Branco & Kaskutas, 2001; Deshpande et al., 2006; McKinstry, 2005; A. Salmon, 2007). Indeed pregnant women who are surrounded by family members, friends and partners who use (or abuse) alcohol are at an increased risk for drinking alcohol themselves (Deshpande et al.,

2006; Leonardson et al., 2007; May & Gossage, 2001). This may be particularly pertinent for pregnant women in South Africa where heavy and episodic (binge) drinking (6 or more standard drinks on at least one single occasion, at least monthly) is common amongst the drinking population (Peltzer & Ramlagan, 2009; World Health Organisation, 2014). South African pregnant women identified as drinkers of alcohol report that one of their motivations for drinking is to maintain social connections (Watt et al., 2014).

In the Western Cape, the norm of binge drinking is embedded in a particular socio-political context; namely, the legacy of the "dop system" (Horn, 2013; Russell, Eaton, & Petersen-Williams, 2013) which dates back to European colonialism in the Western Cape. During this time payment in crude and acidic wine for farm labour was established, which played a pivotal role in farm workers' dependency on alcohol (Mager, 2004; McKinstry, 2005; Russell et al., 2013). The illegal distribution of alcohol during the apartheid era also played a role in this. While the prohibition on the sale of liquor to Africans was lifted in 1961, racial restrictions on the rights of people of colour to engage in selling alcohol remained in place. This resulted in widespread illicit liquor trading and created a social environment in which heavy drinking was considered socially acceptable (Mager, 2004; Mager, 2008).

Although the "dop system" was outlawed in 1960, the ban was only really enforced in the 1990s when apartheid came to an end (McKinstry, 2005; Russell et al., 2013) and the repercussions of the system still remain today: alcohol is a valued commodity amongst the farming populations, and it is quite common for regular and extended drinking parties to take place. Furthermore, commercial beer, wine and spirits are inexpensive and readily available (London, 1999; May & Gossage, 2011b; McKinstry, 2005; October & Zolotova, 2011; Viljoen et al., 2002; Viljoen et al., 2005). Drinking alcohol while pregnant has therefore become normalised in some impoverished areas of the Western Cape (Eaton et al., 2012).

Exploring Alcohol Use from the Perspective of Pregnant Women

To date, most research on alcohol use during pregnancy has tended to focus on identifying risk factors that contribute to prenatal drinking as well as on how alcohol affects the development of the fetus (Eaton et al., 2014; Söderström, 2012). While these research areas demonstrate important findings, they tend to be lacking in an in-depth understanding of *why* some women drink while pregnant and what mechanistic process takes place from risk to actual drinking. Indeed little research has explored alcohol use specifically from the perspective of pregnant women.

However, on an international level a few research studies have looked at substance use (including both drug and alcohol use) from the perspective of women who used substances while pregnant. Findings from these studies highlight the role that trauma and stress play in substance use during pregnancy: pregnant women report turning to drugs or alcohol in an attempt to cope with past or present stressors in their lives (A. Jackson & Shannon, 2013; Kruk & Banga, 2011; Zabotka, 2012). However, women also report that their pregnancy and related desire to care for their children was a motivating factor in their stopping of alcohol and drug use (A. Jackson & Shannon, 2013; Kruk & Banga, 2011; Söderström, 2012).

Other international research has also explored pregnant and post-partum women's perceptions of alcohol use during pregnancy. However, while some participants reported light or moderate drinking during their pregnancies, the focus of these studies was not on heavy users of alcohol (Branco & Kaskutas, 2001; Hammer & Inglin, 2014; Raymond, Beer, Glazebrook, & Sayal, 2009). Those pregnant women who drank lightly or moderately felt that the advice and information given by health professionals when it came to alcohol use during pregnancy was unclear and conflicting, and that their own personal experiences with some alcohol consumption while pregnant had not adversely affected their children's health (Hammer & Inglin, 2014; Raymond et al., 2009). Furthermore, the social networks of pregnant women may not always support abstinence during pregnancy and light or moderate drinking may be seen as a social or cultural practice, as opposed to a health issue (Branco & Kaskutas, 2001; Hammer & Inglin, 2014). This points to the importance of providing pregnant women and women of child-bearing age with clear and specific guidelines when it comes to the harms associated with prenatal alcohol use: As little as 2 to 2.5 servings of wine or full-strength beer per week during pregnancy is associated with neurodevelopmental problems and preterm birth (O'Leary & Bower, 2012).

In South Africa very little research has been performed that explores alcohol use during pregnancy from the perspective of women who drank while pregnant. Similar to international studies, research that *has* been done draws attention to the use of alcohol during pregnancy as a coping mechanism: pregnant women report drinking in an attempt to avoid confronting stressors in their lives (for instance, unemployment or domestic abuse), or as means of self-medicating negative emotions they are experiencing as a result of these stressors (Watt et al., 2014). For women who have been marginalised as a result of the legacy of apartheid, this may be particularly pertinent: drinking during pregnancy for some South African women could be seen as a way of responding to living in a traumatised society in which they have been exposed to adverse socio-political and economic conditions for a prolonged period of

time (Cloete, 2012). Furthermore, the environments in which these women live may support and maintain their drinking: alcohol use and abuse is often a socially accepted and normalised practice in certain parts of South Africa (Cloete, 2012; Watt et al., 2014). And when pregnant women drink it may not be seen as problematic in relation to the heavy alcohol use of others in their community (Cloete, 2012).

While these two South African studies highlight important findings, there is still a need for more research in this area. The alarmingly high rates of FASDs within parts of South Africa (particularly within the Western Cape) - and accordingly high rates of alcohol use amongst pregnant women - call for a better understanding of the social, psychological and contextual processes that contribute to alcohol use during pregnancy (Choi et al., 2014a; Rosenthal et al., 2005; Watt et al., 2014). Gaining insight into these processes will help in guiding interventions that aim to prevent and treat alcohol use during pregnancy (April, Audet, Guyon, & Gagnon, 2010; Choi et al., 2014a; Watt et al., 2014), thereby ultimately preventing the occurrence of FASDs.

Given that alcohol use is a behaviour that is influenced by various social structures (for instance, health inequalities and social norms), research on alcohol use during pregnancy should be performed within a theoretical framework which contextualises drinking behaviour and pays attention to the factors that influence it. Social representation theory coupled with discourse analysis - which will be discussed in the following section - offer two ideal frameworks for this purpose.

This research places itself within a social constructionist paradigm that draws upon both a social representation theoretical framework as well as a discourse analytic framework. Research conducted from a social constructionist perspective aims to explore how social realities are constructed within a particular culture and what implications this might have for human experience and social practice and action (Burr, 1995; Willig, 2008). It challenges the view that what we know is based on an objective truth, and asserts instead that knowledge is highly dependent on social context, culture and history (Gergen, 1985; Guise & Gill, 2007).

Social Representation Theory

Social representation theory arose as a move away from individualistic research approaches to approaches which "take the social seriously" (Flick & Foster, 2008, p. 196). It was originally proposed by Serge Moscovici in the 1970s and initially focussed on scientific knowledge and its role and use in society (Flick, 1998). It was later extended to cover social knowledge more generally and has been used to understand a variety of complex

sociocultural phenomena (Deaux & Philogène, 2001; Flick, 1998; Markova, 2008) including HIV/AIDS, (Joffe & Bettega, 2003), health and illness (Flick, 2000; Flick, Fischer, Neuber, Schwartz, & Walter, 2003) and mental illness (Jodelet, 1991). The theory is concerned with the social construction, transformation and distribution of social knowledge amongst individuals (Flick, 1998).

According to the theory social representations are produced as a result of an interactive process (Flick, 1998) – they "are the outcome of an unceasing babble and a permanent dialogue between individuals" (Moscovici, 1984b, p. 950), and "are built on shared knowledge and understanding of common reality" (Deaux & Philogène, 2001, p. 4). They are specific and largely consensual ways of understanding the world that are co-constructed by and particular to a specific social group (Joffe, 2003; Moscovici, 2001; Wagner et al., 1999). Social representations shape our ideas, beliefs, attitudes and opinions. It is therefore through social representations that we make sense of the world and also communicate that sense to one another (Deaux & Philogène, 2001). Importantly, representations are not universal - they are specific to a group, culture and context (Markova, 2008). The theory therefore proposes that social representations need to be understood within the cultural, historical and social context in which they are generated and used (Flick, 1998; Wagner et al., 1999).

The aim of social representations is to make the "unfamiliar…familiar" (Moscovici, 1984a, p. 24). Two processes are central here, namely anchoring and objectification. With anchoring, new phenomena (for instance, experiences, practices, objects) are integrated into pre-existing categories and worldviews (Deaux & Philogène, 2001; Flick, 2000). In other words, anchoring is to "classify and name something" (Moscovici, 2001, p. 42). For example, when computers first emerged as a new technology, they became a part of an existing classification system of electronic machinery (Flick, 1998). With objectification, phenomena move from being abstract to concrete and crystalised in our minds - they move from being an idea to being a part of our social and perceptible reality. An example of this would be when a flag becomes the symbol for a nation (Deaux & Philogène, 2001). It is difficult to study anchoring and objectification as they occur naturally because experiences and objects are usually discovered for studies in social representation *after* they have produced a certain effect or gained some sort of meaning (Flick, 1998). Flick (1998) therefore suggests using retrospective anchoring as a method for study.

Retrospective anchoring allows for the exploration of how people, when looking back, anchor a phenomenon (in the case of this study, alcohol use) into certain contexts, and

also what pre-existing categories and concepts they use to make sense of the phenomenon (Flick, 1998). This process can be used for specific groups, and also for certain social, cultural and historical contexts. Retrospective anchoring therefore gives us access to not only the subjective construction of the phenomenon under study, but also the social construction of it. It is through retrospective anchoring that one can "simulate and stimulate the 'unceasing babble', in which social representations are created, transformed and transported" (Flick, 1998, p. 86). This is done by asking a specific group of people to tell their story of a particular phenomenon. One then studies in which situational contexts they remember this phenomenon, and also what topics or processes they connect with it (Flick, 2000). In the present research retrospective anchoring was used in individual interviews performed with women who drank while they were pregnant, who were asked to explore their understanding of alcohol use.

However, because alcohol use cannot be understood in isolation, and human behaviour is influenced by the perceptions and behaviour of others (Perkins, 2002; Phua, 2012), and because social representations are also said to be formed in an interactive process between individuals (Flick, 1998), the social representation framework was also used in focus group discussions to explore the representations of alcohol use held by the wider community of these women. Doing this gave a broader understanding as to the patterns of drinking and beliefs with respect to alcohol use within this particular community. It gave insight into the community members' perspectives of drinking and how they constructed and made sense of alcohol use within their community.

While some studies on substance use have been performed using a social representation theory framework (see Demers, Kishchuk, Bourgault, & Bisson, 1996; Drabble & Trocki, 2013; Echabe, Guede, & Gonza-Lez Castro, 1994; Echabe, Guede, Guillen, & Garate, 1992; Trocki, Michalak, & Drabble, 2013), almost no research to date on alcohol use during pregnancy makes use of social representation theory. One study by April et al. (2010) explored representations of alcohol use amongst pregnant women in Quebec, Canada who either abstained from alcohol use or who drank lightly. However, while there is some useful discussion in this study of what influences a pregnant woman's decision to drink or not drink, the findings speak more to what pregnant women know about the harms of drinking prenatally as well as their perception of prevention messages, as opposed to how pregnant women understand and give meaning to their alcohol use.

This research project aimed to address this gap in the literature, and social representation theory (along with discourse theory, which will be discussed in the following

section) offered an appropriate way in which to do this: It allowed for exploration into how these pregnant women and members of their community made sense of alcohol use and the meaning they gave to it (Joffe & Bettega, 2003), as well as rooting this understanding within its social, cultural and historical context (Flick, 2000; Wagner et al., 1999). Furthermore, it is important to employ a theoretical approach that seeks to understand and legitimate the voices and perspectives of those who are traditionally marginalised and disempowered in society (Rappaport, 1995; Stein & Mankowski, 2004), such as women who drink while pregnant. Social representation theory does this by recognising the multiplicity of perspectives and voices in society – it does not assume that some forms of knowledge hold more value than others (Flick & Foster, 2008). The knowledge held by women who drank while pregnant and by their communities is important because it can be used to inform intervention strategies.

The theory of social representation is not, however, without its limitations. Various critiques have been levelled against it including its potential for cognitive reductionism (McKinlay, Potter, & Wetherell, 1993; Potter & Edwards, 1999), which provides a substantive argument for using social representation theory in conjunction with discourse analysis. Social representation theory asserts that representations are primarily cognitive phenomena which people use to make sense of the world, while discourse analysis argues that representations are discursive objects that people construct in talk and texts. In particular, discourse analysts are interested in examining how representations are constructed and how they may be oriented towards action (Potter & Edwards, 1999). Critics argue that in social representation theory this is largely absent – that the theory focuses primarily on the content and structure of representations and fails to explore the functions and broader implications of these representations for individuals and their choices and actions, and for society (McKinlay et al., 1993; Potter & Edwards, 1999; Voelklein & Howarth, 2005). A discourse analytic framework can be used to address these shortcomings.

Discourse Analysis

There are two major approaches within the discourse analytic framework; namely, discursive psychology and Foucauldian discourse analysis. Although they are both concerned with the role that language plays in the construction of social reality, they differ in terms of the sorts of research questions they aim to address (Willig, 2008). While discursive psychology examines what people do with language and highlights the performative qualities of discourse, Foucauldian discourse analysis is concerned with "the discursive resources that are available to people, and the ways in which discourse constructs subjectivity, self-hood

and power relations" (Willig, 2008, p. 95). It is this latter approach which guided this research project.

Discourses provide a system of meaning for experiencing, understanding and acting in the world (Willig, 2008). They are structuring principles in society that are constituted and reproduced in social institutions, modes of thought and individual subjectivities (Weedon, 1987). They are also dynamic and changing as they are located within a particular time, context and history (Parker, 1992). From a Foucauldian perspective, discourses are seen as opening up a number of subject positions which individuals take up (Gavey, 1989; Rolfe, Orford, & Dalton, 2009; Weedon, 1987). It is from these subject positions that individuals perceive and interpret the world (Tirado & Gálvez, 2008). Accordingly, subject positions provide individuals with the content and form of their subjectivity (Wilbraham, 2004).

Subject positions and subjectivity are central elements of the theory of poststructuralism (Weedon, 1987) which challenges the traditional psychological view of the person as a stable and coherent self (Wilbraham, 2004). Poststructuralists argue that subjectivity should not be viewed as innate or genetically predetermined, but as socially and historically produced – it is constantly being reconstituted through discourse and as a result it is multiple, fluid and contextual (Shefer, 2004; Weedon, 1987; Wilbraham, 2004). According to poststructuralism, subjectivity refers to "the conscious and unconscious thoughts and emotions of the individual, her sense of herself and her ways of understanding her relation to the world" (Weedon, 1987, p. 32).

The various subject positions that constitute our subjectivity and are made available through discourses offer different amounts of power to individuals (Gavey, 1989). Each subject position has a set of rights and duties which demarcate what an individual can say and do from a particular position (Andreouli, 2010; Ofreneo & Montiel, 2010; Wilbraham, 2004). Accordingly, positions are relative to other positions. For instance, the subject position of a doctor is afforded more power than the position of a patient (Allen & Wiles, 2013; Wilbraham, 2004). However, while subject positions are constrained by dominant discourses in society, they can also be actively shifted, resisted and questioned by individuals (Allen & Wiles, 2013; Shefer, 2004; Tirado & Gálvez, 2008).

Employing both social representation theory and a Foucauldian discourse analytic framework as complementary approaches recognises that representations are formed through both an internal and external process, where knowledge and thinking are seen as "inner realities" and discourse and communication as "outer realities" (Flick & Foster, 2008), p. 199). Through social representation theory the ways in which pregnant women and members

of their community understood and made sense of alcohol use could be studied, and this understanding could be rooted within its particular context. With the Foucauldian analytic framework - along with the related poststructuralist notion of subject positions - these social representations could be rooted within broader discursive frameworks, the consequences these discourses may have for the participants' subjectivity could be explored, as could the possible implications the social representations may have for the participants choices and actions, as well as for society in general.

Specific Aims

Guided by the theory of social representations and a discourse analytic approach, the overarching aim of this research was to explore alcohol use from the perspective of women who drank while pregnant, with the auxiliary aim of also exploring alcohol use from the perspective of members of the pregnant women's community. Accordingly, the following research questions were addressed:

1) What are the social representations of alcohol use amongst women who drank while pregnant and also amongst members of their community, and how do these representations dovetail?
2) How are these representations constructed in the participants' talk of drinking?
3) What discursive frameworks are these representations rooted in, what subject positions are made available through these discourses, and what are the consequences for the participants' subjectivity in taking up these positions?
4) What implications do these social representations of alcohol use have for the participants' choices and actions and for society in general?

The following section will lay out the research design and method used in order to achieve these aims.

CHAPTER 2: RESEARCH DESIGN AND METHODS

This study is qualitative in design. Qualitative research is concerned with how people experience the world, how they make sense of it and the meanings they attribute to events (Willig, 2008). It therefore aims to understand actions, behaviour and decisions from the perspective of the social actor (Babbie & Mouton, 2008). Qualitative research does not aim to work with representative samples, but rather to "create a comprehensive record of participants' words and actions" (Willig, 2008, p. 16). Therefore, this method is suitable for generating an in-depth understanding of alcohol use from the perspective of women who drank while pregnant, and also from the perspective of the community members of these women. Qualitative research also posits that subjective experiences can only be understood within their specific historical, social and cultural contexts (Yardley & Bishop, 2008), again making it an appropriate research design given that social representations are said to be rooted in particular contexts (Flick, 1998; Wagner et al., 1999). Indeed qualitative research is a well-suited method of inquiry into social representations - like qualitative research, meaning and interpretation are central to social representation research (Flick & Foster, 2008).

Participants and Recruitment

For this research 14 women who consumed alcohol while pregnant were interviewed individually. Furthermore, 13 members of the pregnant women's communities were interviewed in two focus group discussions. Purposive sampling was used for the individual interviews as the participants were selected on the basis of pre-determined criteria (Cozby, 2009), namely, having consumed alcohol while pregnant. They were recruited via a programme called Healthy Mother Healthy Baby© (HMHB©) implemented by the Foundation for Alcohol Related Research (FARR) in the Witzenburg area of the Western Cape.

The HMHB© programme was developed to support all pregnant women in areas with a high prevalence of FASD. Pregnant women before 20 weeks gestation are invited to join the programme at antenatal clinics; regardless of whether or not they consume alcohol. The aim of the programme is to assist and support them in having healthy pregnancies, with an emphasis on having substance use free pregnancies. Once pregnant women have been recruited they are categorised into four different groups according to the Alcohol Use Disorders Identification Test (AUDIT; Babor, Higgins-Biddle, Saunders, & Monteiro, 2001) (see Appendix A) - group 1 women did not consume alcohol, group 2 women drank very

occasionally, group 3 women were classified as binge drinkers, and group 4 women as addicted to/dependent on alcohol (Jaco Louw, personal communication, June 23, 2014). For my research I interviewed women who fell predominantly into group 4 (addicted to/dependent on alcohol), with two participants falling into group 3 (binge drinkers). These women were coloured,[2] first language Afrikaans-speaking, and ranged in age from 16 years to 42 years with the average age being 29.2 years. Five participants were pregnant at the time of being interviewed while the other nine had given birth, with two participants having lost their babies two to four weeks after they were born.

The fieldworkers of the HMHB© programme arranged for me to meet with the women who fell into groups 3 and 4 in order for me to brief them on my research project and invite them to participate (see Appendix B for the English version and Appendix C for the Afrikaans version). At this meeting 14 women expressed an interest in participating, and the fieldworkers thereafter arranged individual interview times with each of them. Because the participants spoke Afrikaans as a first language the recruitment material as well as the consent forms were provided in both Afrikaans and English. The interview and focus group schedules were also in both languages. This material was translated by a first language Afrikaans speaker.

For recruitment of members of the pregnant women's community, convenience sampling was used (Cozby, 2009). I liaised with one of the fieldworkers from FARR who recruited members of the study community to take part in the focus groups (see Appendices D and E for the English and Afrikaans recruitment advertisements). The only requirement for the community members was that they were over the age of 18 years. I was interested in exploring alcohol use amongst the "general" population of this community, and they did not necessarily have to be drinkers of alcohol in order to qualify. Once the fieldworker had 15 interested participants she and I made arrangements for the two focus group discussions. Out of these 15 individuals 13 were available.

Data Collection

Social representations are said to be present within both individual minds and within communications (Joffe & Haarhoff, 2002), therefore making it appropriate to make use of

[2] Coloured (mixed race origin) refers to one of four racial categories defined by apartheid legislation in South Africa (Black, Coloured, White, and Asian/Indian). I make note of these classifications here not because I endorse them, but because of continuing disparities across racial groups in terms of access to health care generally (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009), and substance abuse treatment in particular (Myers et al., 2010).

both individual interviews and focus groups as a way of studying social representations of alcohol use. Indeed (Flick & Foster, 2008) highlight the benefit of using multiple methods in studying social representations. Through individual interviews I was able to study the social representations of alcohol use held by women who drank while pregnant by retrospectively tracing how alcohol use became a part of their lives, and through examining how they made sense of and constructed alcohol use (Flick & Foster, 2008; Flick, 1998). Through the focus groups I was able to uncover the social representations of alcohol use that arose through the interactions and communication between community members (Deaux & Philogène, 2001; Wilkinson, 1999).

Individual interviews

Following on from the notion of retrospective anchoring, a particular type of semi-structured and narrative interview method was used in this research; namely, the episodic interview (Flick, 1998). With the episodic interview a specific social group tells their story around the phenomenon under study in individual interviews. It is through the episodic interview that the researcher is able to retrospectively explore the appearance and effects of this particular phenomenon (Flick & Foster, 2008; Flick, 1998).

The assumption behind the episodic interview is that knowledge has two components: the first component is narrative in character - our experiences are said to be stored in narrative episodes around concrete situations. The second component is semantic in character - "generalisations of [our] experiences are [said to be] represented around images, concepts, and relations among concepts" (Flick, 1998, p 86; Flick et al., 2003). The episodic interview therefore aims to elicit narrative episodes around the topic under investigation as well as the network of meanings the participants attribute to this topic (Flick, 2000).

For the narrative episodes the researcher asks the participants to tell their story with regards to their first experience with the phenomenon under investigation, and also to share more recent stories around the phenomenon (Flick, 1998; Flick, 2000). Through this the researcher is able to gain access to the situational contexts in which the participants make sense of the phenomenon (in other words, in which contexts they retrospectively anchor it) (Flick, 1998). For the semantic component the researcher asks more general questions on the topic of enquiry that focus on subjective definitions the participants hold and the concepts they use to describe the phenomenon under study (Flick, 2000). In this way the researcher is also able to determine how the participants' define the phenomenon and what concepts they use to describe it (Flick, 1998; Flick, 2000). It is therefore through the episodic interview that

I was able to gain an in-depth understanding of the social representations the pregnant women in this study held with respect to alcohol use.

With the episodic interviews in this research (see Appendices J and K for the full English and Afrikaans schedules), the participants were asked to describe and reconstruct an experience with alcohol during their pregnancy, an experience with alcohol before their pregnancy, and their first experience with alcohol. (Flick, 1997). Sharing their first experience with alcohol use gave insight into when and how drinking alcohol moved from being "unfamiliar" to "familiar" in their lives (Moscovici, 1984a, p. 24). Exploring an experience with alcohol during their pregnancy as well as an experience with alcohol before their pregnancy gave insight into whether their representations changed over time. These narrative episodes also demonstrated into which contexts the participants retrospectively anchored their experiences with alcohol (Flick, 1998). The participants were also asked more general questions on their understanding of alcohol use, and also of alcohol use during pregnancy. In line with the theory of social representations, the aim of these questions was to uncover what drinking meant to these participants, and in what ways it was relevant to them (Flick, 1997).

In order to ensure that the interview participants were able to select which episodes or situations they wanted to recount, and that their personal meaning frame was elicited, open-ended and non-directive questions were asked (Flick, 1997; Joffe & Bettega, 2003; Joffe & Haarhoff, 2002; Wilkinson, Joffe, & Yardley, 2008). Leading questions were avoided here: Rather than asking, for instance, "Did you drink alcohol while pregnant" I asked "Could you tell me about your alcohol use?" (Joffe & Bettega, 2003; Riessman, 1993; Wilkinson et al., 2008). Probe questions were also included in the interviews where the participants had difficulty relaying their stories (Riessman, 1993). Where necessary, I also responded with deepening enquiries to the stories and answers the participants gave in order to ensure that the data collected was as in-depth as possible (Flick, 1997). I also used calendars as a visual aid (see Appendix L) when asking the participants about their pregnancies.

At the end of the interview the participants were also asked several demographic questions that are based on established risk factors for alcohol use during pregnancy. For example, they were asked about their education level as lower education is said to contribute to drinking while pregnant (Cannon et al., 2012; May et al., 2009). These demographic questions helped to contextualise the answers the participants gave and the stories that they shared (Flick, 1997).

The participants were interviewed individually over a period of two weeks, with each interview lasting approximately 45 minutes to 1 hour. Once the participants indicated that they were willing to take part in the study, (see Appendices B and C) the fieldworkers set up individual interview times and dates with them, according to what best suited their work/personal schedule. The interviews took place at the FARR office in the study community in a private room and were conducted predominantly in Afrikaans. One of the FARR fieldworkers was present when the interviews took place – she was positioned away from the interview, but could be called upon when I needed assistance in understanding the participants' dialogue. While I have a good comprehension of Afrikaans, I was not always familiar with the participants' local patois. Each of the interviews were also recorded with the consent of the participants.

Before each interview began the participants were given a consent form (see Appendices F and G). The researcher ran through this form, explaining what it entailed (see Appendices J and K) and gave the participants an opportunity to read through the form and raise any questions they had. The form was offered in both English and Afrikaans. The first interview was a pilot interview which was conducted in order to ascertain whether appropriate information had been gathered. Once this interview was completed I discussed it with my supervisor – we both agreed that the interview had been successful and I therefore continued with my data collection.

During the interview the participants were asked about an experience with alcohol while they were pregnant, an experience with alcohol before their pregnancy, and their first experience with alcohol. Thereafter, they were asked general questions on alcohol use, and lastly some demographic questions. While the participants were relaying their personal accounts, notes were made by the researcher on *how* they were being relayed, including what their body language portrayed, what non-verbal gestures they made use of, what words or phrases they put emphasis on and whether there were any silences, gaps or pauses in their stories (Fraser, 2004; Riessman, 1993).

After the interview I also made notes on my impressions of the interview context and the interviewee (Flick, 1997), focusing on things like the interviewee's behaviour during the interview, their comfort levels, in what circumstances the interview took place, and general impressions of the interview itself. The notes made during and after the interview helped to contextualise the data collected (Flick, 1997), and were of value when it came to the analysis process. Once all the interviews were completed they were transcribed verbatim by a first language Afrikaans speaker.

Focus groups

The focus group research method entails group discussions in which participants focus collectively on the topic under study (Wilkinson, 1999). Focus groups are used as a means to gaining insight into the beliefs, attitudes, feelings and experiences of group participants (Frith, 2000). They are characterised by collective discussion between group members, and therefore offer the opportunity to explore the process of collective sense-making (Frith, 2000; Överlien, Aronsson, & Hydén, 2005). With focus groups one can therefore study the construction and articulation of knowledge through the interaction and communication of the group members (Kitzinger, 1995; Wilkinson, 1999). In other words, focus groups present another way in which to study social representations (Flick & Foster, 2008).

Focus groups in this research were used to study the representations of alcohol use amongst individuals from the pregnant women's communities. They were used to explore the community members' views on and experiences with alcohol use in their community (Dixit, Mishra, & Sharma, 2008). Importantly, the creation and development of social representations is not an individual process, but a social one (Flick & Foster, 2008). The focus groups therefore shed light on this social process, thereby offering insight into how the community members understood alcohol use and how they collectively made sense of it. Furthermore, through studying the interpersonal communication within the group discussion I was also able to gain insight into the norms and values surrounding drinking patterns in the community (Grønkjær, Curtis, de Crespigny, & Delmar, 2011; Kitzinger, 1995).

The focus group discussions were semi-structured in nature; several broad and open-ended questions on alcohol use were asked (see Appendices M and N for the full English and Afrikaans schedules). The aim of these questions was to elicit conversation on drinking in the participants' community. Similar to the episodic interviews, the focus in the group discussions was on the group's experiences with alcohol use, how they subjectively defined alcohol use and how they described it (Flick, 1998; Flick, 2000).

Two focus group discussions took place. Group 1 had seven participants (three men and four women) and group 2 had six participants (one man and five women). These discussions, like the interviews, were conducted predominantly in Afrikaans; however, there were some instances in both the interviews and focus groups where they responded in English. The fieldworker who recruited the participants was present at the discussions: she acted as a research assistant and was there to interpret the parts of the discussion that I did not understand as a result of the participants' local patois.

Once the fieldworker had enough participants interested in taking part in the focus groups she and I scheduled the group discussions at a time that suited the participants' work and personal schedules. The discussions took place in a private room at the FARR offices and were recorded with the consent of the participants. Before beginning each focus group, I ran through the consent form with the group members (see Appendices H and I) and gave them an opportunity to raise any questions (see Appendices M and N for the full schedule).

Once the consent forms were signed I proceeded with the focus group. The participants were encouraged to talk to one another rather than to address the researcher (Kitzinger, 1995). Similar to the individual interviews, I made notes during and after the group discussions on my impressions of the focus group process; for example, how the participants interacted with one another. Once the two focus groups were completed they were transcribed verbatim by a first-language Afrikaans speaker. The analysis provides both the original dialogue of the interview and focus group participants as well as a translation of this dialogue into English. These translations were done by the researcher and then checked by a first language Afrikaans speaker.

Data Analysis and Procedure

The data from this research was analysed using thematic decomposition analysis – a method of analysis which provided an appropriate way in which to combine the two theoretical frameworks of social representations and discourse analysis. Thematic decomposition analysis refers to a particular type of thematic analysis that is situated within a poststructuralist discursive approach (Braun & Clarke, 2006; Gurevich, Bishop, Bower, Malka, & Nyhof-Young, 2004; Stenner, 1993; Ussher et al., 2013). It is informed by the notion that meanings are constituted through discourse (Gurevich et al., 2004; Stenner, 1993; Ussher et al., 2013) and is based on the premise that there is an ongoing and dynamic relationship between the subject positions individuals take up, the practices they engage in, and their subjectivity (Ayling & Ussher, 2008). With this method of analysis the researcher performs a close reading of the data organising it into themes where a theme refers to a coherent pattern in the participants' accounts (Gurevich et al., 2004; S. Jackson & Weatherall, 2010; Lyons & Willott, 2008; Stenner, 1993). Thereafter the researcher explores the connections between these themes and wider, socially produced discourses as well as highlighting the subject positions made available through these discourses (Ovenden, 2012; Stenner, 1993; Ussher & Perz, 2010). Importantly, these subject positions are seen as being multiple and fluid, as opposed to static and fixed (Stenner, 1993).

In the case of this research study the first phase of analysis involved reading the interview and focus group transcripts closely and coding the data inductively: a coding frame was developed that was generated from the data itself, which is an appropriate approach for relatively unexplored research areas (Joffe & Yardley, 2004). In the second phase I sorted these codes into themes – in social representation research, themes identified across a social group under study are said to illustrate social representations (Joffe & Yardley, 2004). Looking for these themes (or social representations) involved examining what key words or expressions and concepts and categories the participants used when describing alcohol use as well as what topics and processes they connected to it (Flick, 1998; Flick, 2000; Trocki et al., 2013). It also involved exploring which situational contexts the participants anchored their alcohol use into as well as their explanations of and attitudes and emotions towards drinking (Echabe et al., 1994; Flick, 2000). In the third phase I reviewed these themes in relation to the interview and focus group data, as well as in relation to past literature, and defined and named them (Braun & Clarke, 2006).

The primary aim of this study was to explore the social representations of alcohol use amongst women who drank while pregnant. Accordingly the interview transcripts were thematically coded first, and the focus group transcripts were then examined in light of this coding frame. The data from the focus groups was therefore used to add another layer to the analysis.

After identifying the social representations of alcohol use in the data I explored what discursive frameworks these representations fell into as well as the subject positions made available to the participants through these discourses (Stenner, 1993; Ussher et al., 2013). In exploring the subject positions I paid attention to where the participants were positioned in their stories as well as where others were positioned, the amount of power and control that was afforded to the participants and others through these positions, and what the consequences were for the participants' subjectivity in taking up these positions (Stenner, 1993; Willig, 2008). The final step of the analysis involved examining the implications of the social representations of alcohol use for the participants' actions and choices, as well as for society in general (Ussher et al., 2013).

Reflexivity

In qualitative research the researcher is considered an important part of the research – her values and beliefs are seen as playing a role in both the type of research that is performed as well as the results found. Her subjectivity should therefore be acknowledged throughout

the research process (Willig, 2008). When she describes how her interpretations were produced and makes visible exactly what was done, this helps others determine the validity of the research (Riessman, 1993). The researcher influences the research process both as a person, which is called personal reflexivity, and as a theorist, which is called epistemological reflexivity (Willig, 2008).

Epistemological reflexivity involves reflecting on how the researcher's assumptions shape the research process and the implications this has for the research and its findings (Willig, 2008). What I expected to find in this research as well as the position from which I made sense of it ultimately affected my final findings (Parker, 2010). The ways in which I framed my research questions, the theoretical framework within which I worked, and the ways in which I decided to collect and analyse my data would all have had an impact on the research process. While a qualitative research design privileges the perspective of the participants (Babbie & Mouton, 2008), it is impossible for a researcher to simply ignore his/her own knowledge and perceptions when collecting and analysing data (Flick & Foster, 2008; Joffe & Yardley, 2004). For instance, my perception of prenatal alcohol use as a critical problem in need of intervention in the Western Cape, along with my hope that this research project could make a valuable contribution in this regard, would have played a role in the sorts of questions I asked of the study participants as well as how I chose to analyse my data. This study therefore offers one possible interpretation of the data – other researchers may have interpreted it differently and emphasised different aspects of it (Willig, 2008).

In terms of personal reflexivity, applicable here is acknowledging the fact that I occupy a position within a particular institution (the University of Cape Town, UCT). My position within UCT would have had an effect on how I related to the participants of this study and how they related to me (Parker, 2010). Coming from UCT I have an academic background and also an interest in performing my research in a particular way. This would have influenced the way in which I perceived the participants and the way in which I talked and related to them. Relatedly, the participants were bound to have viewed me in a particular light as a researcher and this could have affected what stories they chose to tell me and how they chose to tell them. Indeed some participants through their dialogue seemed to demonstrate their awareness of my academic background. Participant 1, for example, discussed wanting to stop drinking but feeling unable to do so - she seemed to want advice from me in this regard as in her interview she said, about her reasons for participating in the study:

> Participant[3] 1: […][4] Ek het net gevoel ek moet met iemand praat; iemand wat geleer het vir die goed, want ek weet nie meer nie *[(...) I just felt that I must talk to someone; someone that has learnt about these things, because I do not know anymore]*.

And a bit further on she noted: "En wat dink u moet ek doen?" *[And what do you think I must do?]*. This demonstrates that she perceived me as being in a position of authority when it came to stopping drinking, and perhaps because I was educated in the field of psychology she felt I would be able to assist her. In Participant 1's case, her perception of me in this way seemed to encourage more openness and honesty, but in the case of other participants it may have had the opposite effect – some may have been hesitant to speak to me about their alcohol use precisely because of my academic background. Participant 12, while fairly forthcoming in her interview, seemed to perceive the psychology discipline in a more negative light than Participant 1. During her teen years she experienced a miscarriage and when talking about the incident to me she said:

> Participant 12: Ek het daarna 'n sielkundige gaat sien en so aan. Maar ek het myself daar uit getrek onder die sielkundige uit. Want hoekom? Hulle praat dieselfde ding oor en oor, oor en oor. En ek het nie lus gehad moet dit wat hulle praat *[I went to see a psychologist and so on. But I took myself away for the psychologist. Because why? They speak about the same thing over and over, over and over. And I did not like what they spoke about]*.

Participant 12's negative experience with a psychologist after her miscarriage may have influenced how she saw me, coming from a psychology background, and what information she therefore chose to share with me in her interview. My academic position therefore played a role in the data collection process.

Acknowledging that I am from a different race and class group to my participants is important too. These differences could have affected how the participants perceived me, how they interacted with me, what stories they chose to tell me and how they chose to tell them. Indeed there were some participants who seemed to implicitly demonstrate their awareness of my race and class: in Focus Group 2 the participants were discussing what they felt contributed to alcohol use in their community and one of the female participants said:

> Female Participant 3: Want baie keer met die wit mense, as jy agtien jaar is gaan jy uit die huis uit. Jy gaan bly in 'n woonstelletjie. Ons kan nie. Ons kry drie of vier kinders

[3] When referring to the interview participants I use "Participant" and when referring to the focus group participants I use "Male/Female Participant".
[4] […] and (…) indicate omitted words or sentences.

> by die huis. Dan het jy nie eens 'n man nie *[Because many times with the white people, if you are eighteen years old you can leave the home. You can go live in a flat. We cannot. We have three or four children at home. Then you do not even have a husband]*.
>
> (Focus Group 2)

While Female Participant 3 does not talk about coloured people directly, she herself is coloured (as are most people from her community) and her use of the word "ons" *[we]* strongly suggests that she is referring to coloured people as a group. Through her dialogue she constructs a clear boundary between white and coloured people and the different opportunities they have access to in South Africa as a result of their race. She therefore seems to be demonstrating her awareness of my white race and the privileges I have because of it. These unequal power relations between myself and the participants are bound to have had an effect on how the participants interacted with me, which will also be explored in the analysis and discussion section.

While my race and class position may have served to inhibit some participants, the fact that I am a woman may have made other interview participants feel more comfortable in confiding with me, given that I have the ability to fall pregnant and therefore possibly understand their situations. For instance, in her interview Participant 6 was particularly open with me with regards to her fears of getting a pap smear and contraceptive injection, and she may have felt more at ease disclosing this sort of information to me because of my gender.

Ethical Considerations

This study was granted ethical approval by the Research Ethics Committee of the Faculty of Humanities at the University of Cape Town. Ethics were carefully considered in this research and this section outlines the principles and procedures of informed consent, confidentiality, and risks and benefits for the participants in taking part in this research (Willig, 2008).

Permission to interview the women who drank while pregnant was gained from the Chief Executive Officer of FARR. The HMHB© fieldworkers arranged for me to meet with the group 3 (binge drinkers) and 4 (addicted to/dependent on alcohol) HMHB© participants in order to determine whether they would be willing to take part in this research (see Appendices B and C). In terms of the focus group participants, one of the fieldworkers approached residents of the community to determine if they were willing to participate in the group discussions (see Appendices D and E).

Signed consent forms were obtained from the pregnant women and the community members before the interviews/focus groups began (see Appendices F, G, H and I). They were made aware of the purposes of the research study, the procedure and potential consequences of the research, that their participation was voluntary and that they could withdraw from the research at any point. They were also informed that the interviews/focus groups would be tape recorded (with their consent), that all the information collected from them would remain strictly confidential, that their names would be kept separate from the interview/focus group information and that when the information was reported on, a pseudonym would be used. A pseudonym was also used for the name of the study community in order to ensure anonymity and avoid stigmatisation.

In terms of the risks to the participants in participating in this research: the things they discussed may have evoked feelings of anger, sadness or anxiety. They may also have become embarrassed or uncomfortable when talking about certain aspects of their lives, particularly given the sensitive nature of this research. The interview participants were accordingly made aware of the counsellor at FARR, as well as the CEO, who they could contact, should these risks have arisen, and the focus group participants were given the contact details for the South African National Council of Alcoholism and Lifeline.

In terms of the benefits to the participants, the process of being asked to share their stories may well have been therapeutic. Indeed some participants at the end of their interviews/focus group discussions were positive about the experience. For example, at the end of her interview Participant 6 noted: "Nou het ek my hart uit gepraat, en nou voel ek weer vry" *[Now I spoke my heart out, and now I feel free again]*. In terms of more general benefits, the information gained from this research could inform aspects of the HMHB© programme which the interview participants are members of. Indeed this research project, along with a summary of the findings and implications, will be submitted to the CEO of FARR as well as presented at their annual general meeting in 2015.

Summary

In summary, this study made use of a qualitative design in which 14 women who drank while pregnant were interviewed individually using an episodic interview, and 13 members of the pregnant women's community took part in two focus group discussions. The data from these interviews and focus groups was analysed using thematic decomposition analysis. In the following chapter, I turn to the results of this analysis.

CHAPTER 3: ANALYSIS AND DISCUSSION

From both the focus group discussions and most of the individual interviews it was clear that there is an awareness in the Madison community of the potential harm that can be done to the fetus when drinking alcohol during pregnancy. With regards to the interview participants, their understanding of the possible consequences of prenatal alcohol use varied, but they all showed at least some knowledge in the area, often obtained through attending the HMHB© programme run by FARR. Participant 5 for example noted:

> Participant 5: Ek het hier na FARR toe gekom, en hulle het vir my baie dinge geleer, films gekyk wat drank aan die baba kan doen *[I came here to FARR, and they taught me a lot of things, watched films on what drinking can do to the baby]*.

Similarly, Participant 7 noted that "hier by FARR […] ek het baie dinge geleer wat ek nie geweet het nie" *[Here at FARR (...) I learnt a lot of things that I did not know]*. Further on in their interviews when I asked Participants 5 and 7 for their thoughts on drinking while pregnant they both responded in a way which illustrated they had a good understanding of the potential harms of prenatal drinking:

> Participant 5: Hy [my kind] kan 'n alkohol sindroom kind wees. Hy presteer nie op die skool nie *[He (my child) can be an alcohol syndrome child. He does not do well at school]*.
>
> Participant 7: Miskien sy [my kind] kan breinskade opdoen, of sy kan gestremd wees *[Maybe she (my child) can be brain damaged, or she can be disabled]*.

This demonstrates that FARR played an important role in educating these women about the possible outcomes of drinking while pregnant, and helped them to consider the health and well-being of their babies – through FARR these participants were able to integrate new knowledge of the effects of prenatal alcohol use into their existing world view of drinking. In terms of the focus groups, participants from both groups showed an understanding of the possible harms of drinking during pregnancy. Focus Group 1 when discussing the effects drinking during pregnancy can have on the unborn baby said:

> Male Participant 7: Dit kan 'n Mongooltjie wees *[It can be disabled]*.
>
> Female Participant 2: Ja, 'n alkohol baba *[Yes, an alcohol baby]*.
>
> Male Participant 7: Alkoholis baba wees *[An alcohol baby]*.
>
> Female Participant 5: Hy is ondergewig *[He is underweight]*.
>
> Male Participant 7: Mmm, ondergewig ja *[Mmm, underweight, yes]*.
>
> Female Participant 2: Kan nie dink in die skool nie *[Cannot think in school]*.
>
> Male Participant 6: Breinskade *[Brain damaged]*.

(Focus Group 1)

Similarly, the participants from the second focus group appeared to have quite a comprehensive understanding of the harms of prenatal alcohol use:

> Female Participant 3: Sy [ń swanger vrou] moet nie eers dink aan drink nie want daai lewetjie is te klein. Daai ogies, daai mondjie – daai allerste word vernietig as gevolg van die alkohol *[She (a pregnant woman) must not think about drinking because that life is too small. Those little eyes, that little mouth – all those would be destroyed as a result of alcohol]*.
>
> Male Participant 5: En dis hoekom daar baie misvormde kinders gebore word, of die kind is ń - *[And that's why there are lots of deformed children born, or the child is a-]*
>
> Female Participant 4: Alkoholsindroom kind. *[Alcohol syndrome child]*.
>
> Male Participant 5: Ja *[Yes]*.
>
> […]
>
> Female Participant 1: Ja, want daai kindertjies se breins kry seer. Daai kind is nog in die baarmoeder, dan is sy brein al siek *[Yes, because those children's brains get hurt. That child is still in the womb, then his brain is damaged]*.

(Focus Group 2)

Yet despite the general understanding of the harms of prenatal alcohol held by these participants, drinking during pregnancy appeared to be a significant problem in this community, illustrating that knowledge alone is insufficient for changing drinking behaviour (Ajzen, Joyce, Sheikh, & Cote, 2011). When I asked the participants from Focus Group 1 if there were pregnant women who drank in their community they responded:

> Male Participant 7: Ja *[Yes]*.
>
> Male Participant 7 and Female Participant 4: Baie *[A lot]*.
>
> Female Participant 7: Ja, daar is baie van hulle *[Yes there are a lot of them]*.

(Focus Group 1)

In this same focus group, two of the female participants admitted that they themselves had consumed alcohol while they were pregnant. In terms of the 14 interview participants, 20 weeks or under into their pregnancy, they had all been identified as either binge drinkers or addicted to/dependent on alcohol. However, their drinking behaviour during their pregnancy varied: there were some who reported drinking only in the first few months of their pregnancy, others who drank for longer and then stopped, and others who drank for most of or throughout their pregnancy. Seven out of the 14 participants reported drinking because they were at first unaware of their pregnancy. Out of these seven, there were five who noted

that they stopped drinking upon discovering they were pregnant. Participant 9 for example said: “Vandat ek uitgevind het ek is swanger, het ek nie meer gedrink nie” *[When I found out I was pregnant, I did not drink anymore]*.

The implication with these five participants is that if they *had* been aware of their pregnancy from the beginning, there is a possibility that they would not have consumed any alcohol during the first trimester of their pregnancy, thereby preventing any potential damage to the fetus (Bateman, 2012). Importantly, the first trimester of pregnancy is a critical stage for embryonic and fetal development (Lester et al., 2009). During the embryonic period (third to the eighth week of the pregnancy), the neural tube - the precursor to the central nervous system – as well as all major organs starts to take shape. By the end of the first trimester the fetus is able to move about, swallow, digest food and urinate (Sigelman & Rider, 2009). Notably, alcohol consumption (versus no alcohol consumption) during the first trimester increases the likelihood of an FASD diagnosis by 12 times (May et al., 2013), pointing to the importance of early detection of pregnancy so as to avoid this risk (Rendall-Mkosi et al., 2013).

It is important to note, however, that out of the five participants who reported ceasing drinking upon finding out they were pregnant, there were two participants whose accounts I doubted because of inconsistencies in the discussion of their drinking behaviour. These inconsistencies made me wonder whether they were being entirely truthful with me when it came to their drinking, particularly given that they were aware of the possible harms of prenatal alcohol use, which might have made them hesitant to be completely forthcoming. A possible reason for this could be that they did not want to be judged (by me) for their actions. This ties in with the stigma attached to drinking during pregnancy, which will be discussed further on in this analysis. The fact that I am white and middle class, and they were coloured and working class, could have played a role in this. In South Africa, inequalities across racial categories are still in existence. For example, white-headed households on average earn more than 3 times that of coloured-headed households (Statistics South Africa, 2012). Because of my socioeconomic standing and the inequality that exists between our racial categories, the participants may have assumed that I would have been judgemental of their drinking behaviour, and therefore choose not to be entirely forthcoming with me.

Social Representations of Alcohol Use

Despite the differences in drinking behaviour during pregnancy across the interview participants, there were many areas in which their construction and understanding of alcohol

use overlapped. Furthermore, both the interview participants and the focus group participants described alcohol use in similar ways. This analysis will explore the social representations of alcohol use held by these pregnant women as well as members of their community. It will also highlight the discursive frameworks within which these representations fall, the subject positions that are made available through these discourses, and the implications of the social representations for the participants' choices and actions. Together, these analyses will also shed light on possible reasons as to why some pregnant women were able to stop drinking, while others were not – analyses that will add to understandings of the shortcomings of current prevention and treatment approaches.

The study participants held multiple social representations of alcohol use: they represented it as both a social and individualised activity, they constructed it as a solution to the stressors they faced as well as causing problems in their lives, they connected it to changes they experienced in their behaviour, they constructed it as a stigmatised activity while pregnant, and they related it to their experiences of motherhood. Importantly, these social representations reflect both the drinking behaviour of the participants on an individual level, but also the social context that influences this behaviour. For example, an individual's social network plays a pivotal role in shaping and regulating drinking behaviour (Mulvaney-Day & Womack, 2009; Sun, 2014) which will be explored in the following section on the social and individualised nature of drinking.

The Social and Individualised Nature of Alcohol Use

Within the majority of the individual interviews, and also within the focus group discussions, the social nature of alcohol consumption within this community came through strongly: it was evident in the participants' discussion of their first encounters with alcohol as well as their alcohol use before, during and after their pregnancies. Consistently, drinking was represented as a social activity that was heavily influenced by peers. At the same time, however, there were also participants who represented drinking as an individualised activity, where their drinking behaviour was clearly distinguished from the drinking of their social group or community.

The influence of peers

One area in which the social nature of alcohol use was evident was in the interview participants' introduction to alcohol. Although not all could recall the specifics of their first

encounters with drinking, most of them noted that it took place during either their teen years or early twenties. For some it involved a social event with their friends or family members:

> Participant 4: Die heel eerste keer wat ek beginne drink het, toe was ek by ń vriend se verjaarsdag. Toe het ons haar party gevier *[The very first time that I began drinking, I was at a friend's birthday. We celebrated her party]*.

Participant 13 noted a similar experience when discussing her introduction to alcohol:

> Participant 13: Ons het ń party gevier, my nefie se 21st gevier en daardie dag toe vind ek uit dis mos lekker om te drink *[We celebrated a party, my cousin's 21st and that day I found out that it is nice to drink]*.

Both Participant 4's and 13's first encounters with alcohol involved the celebration of a birthday party. Similarly, for other participants, their first time drinking was linked to celebrating Christmas. These participants therefore anchored their first experiences with drinking into the pre-existing category of pleasurable and celebratory occasions. Typically, young people use and abuse alcohol because it brings about a positive mood and because they obtain positive social rewards from it (Hides et al., 2008). When young adults discuss drinking they often emphasise the pleasure, fun and celebration that are linked to drinking together as friends - drinking is seen as a way to bond and have fun with one's peers (Niland, Lyons, Goodwin, & Hutton, 2013; Szmigin, Bengry-Howell, Griffin, Hackley, & Mistral, 2011).

The peers of a number of the participants in the present study played a pivotal role in their decision to first try alcohol. For example, when Participant 11 explored her reasons for first drinking she noted: "Ek wil nie vir [my vriende] teleurstel nie" *[I did not want to disappoint (my friends)]*. Similarly, Participant 12 said:

> Participant 12: Want al my vrinne het dit gedoen. Ek was nog al een in die groep in wat nog nie gedrink het nie. So ń mens kan sê dis groepsdruk […] en hulle almal het gedrink, en toe het ek uit gevoel. Toe begin drink ek ook nou saam met hulle *[Because all my friends had done it. I was the only one in the group who had not drunk yet. So a person can say its group pressure (...) and all of them had drunk, and then I felt left out. Then I also began to drink together with them]*.

In order to feel included in her peer group Participant 12 began drinking. Participant 8, who was 16 years old at the time of her interview, noted a related experience: when she was sober and her friends were drunk, "dan voel ek uit. Ek voel nie […] in by hulle nie" *[then I feel left out. I do not feel (...) in with them]*. This demonstrates that for these participants one of the motivations for their first encounters with alcohol was a desire to feel

accepted and included by their friends, a finding evident in other alcohol use literature too: a key factor in young people's introduction to alcohol use is the influence of their peer network (Homish & Leonard, 2008). Offers of alcohol as well as increased peer alcohol use are both associated with youths' intention to drink (Schwinn & Schinke, 2014).

Importantly, the participants' peers played an influential role not only in their first encounters with drinking, but in later drinking experiences too. Participant 4 in her interview told me that in recent years she had spent time in Cape Town and that when she was there she did not drink. When I asked why she said: "Omdat ek niemand geken het daar nie" *[Because I did not know anyone there]*. Further on in her interview she noted that when she returned to Madison she began drinking again and was still currently drinking at the time of her interview. When I asked her for possible reasons as to why she drinks in Madison but not in Cape Town she responded: "My maatijies is hier" *[My friends are here]*. For Participant 4, then, a pivotal factor in her motivation to drink is whether or not she has friends or people that she knows with her.

With Participant 3, her peers also played a significant role in her drinking. She noted in her interview that from the age of 19 until quite recently (she was 29 at the time of her interview) she drank nearly every weekend. When I asked her why she thought this was the case she said: "Because at that time I didn't have a boyfriend, no children. I was just with my friends. I didn't think - I drank all the time and go out to places". At the time of her interview, Participant 3 did have a boyfriend and a baby and saw these factors as playing a role in her current non-drinking, a notion that will explored in the section on drinking and motherhood. But before having a partner and child Participant 3 only spent time with friends, and with them, she would go out and drink on a regular basis. Participants 3 and 4 therefore clearly felt that their peers played an influential role in their drinking. Indeed peer alcohol use is a strong predictor of drinking amongst young people, including heavy episodic drinking and problem drinking (Andrews, Tildesley, Hops, & Li, 2002; Homish & Leonard, 2008). Furthermore, pregnant women who are surrounded by peers who use alcohol are at an increased risk for drinking themselves, and may in actual fact feel pressure to continue drinking because of their social group (Branco & Kaskutas, 2001; Deshpande et al., 2006; Leonardson et al., 2007; May & Gossage, 2001; McKinstry, 2005; A. Salmon, 2007).

With some participants the influential role of peers on alcohol use came through in their discussion about *stopping* drinking. In her interview Participant 5 noted that she no longer drinks and when probed for reasons as to how she managed to abstain she said:

Participant 5: Ek is nie tussen vrinne wat drink nie. Ek is by die huis. Ek sal ook nie na mense toe loop wat drink nie *[I am not amongst friends that drink. I am at the house. I will also not walk to people that drink]*.

Similarly, Participant 14 decided to stop drinking during her pregnancy and in her interview she said:

Participant 14: Dit was nie vir my swaar gewees nie want elke keer het ek my vrinne vermy. Ek het nie geworry oor hulle nie. Ek het net by die huis gesit. Worry nie oor mense nie *[It was not difficult for me, because every time I avoided my friends. I didn't worry about them. I just sat at my house. Not worrying about people]*.

What is implied in the way in which Participants 5 and 14 talk about their non-drinking is that if they were around their friends then they would feel tempted to drink. Indeed when I asked Participant 5 what she would do if she was amongst drinking friends she responded: "Dan sal ek ook mos nou wil saam drink*" [Then I would also want to drink with them]*. This was also discussed in one of the focus groups:

Female Participant 5: […] die moment as jy besluit, ek gaan nie die naweek drink nie, dan kom 'n maatjie wat nooit by jou gekom het nie, dan kom hy om vir jou te sê, "hier is vir jou ń dop". *[(...) the moment you decide, I am not going to drink this weekend, then a friend comes that had never come to you, then he comes and says, "here is a drink for you"]*.

Female Participant 2: Jy drink dit! *[You drink it!]*.

(Focus Group 1).

Some of the interview participants' solution was to therefore avoid friends that drink, in order to avoid being tempted into drinking themselves. Encouraging pregnant women to associate with non-drinking peers may well be advantageous given the strong influence peers had on drinking in this community. Indeed when I questioned one of the interview participants as to what people in her community could do if they do not want to drink she responded:

Participant 7: As jy nie wil drink nie […] Jy kan na vriende of familie toe gaan – iemand wat nie drink nie *[If you do not want to drink (...) You can go to friends and family – someone that does not drink]*.

Similarly, in the second focus group discussion one of the participants suggested that those who are trying to give up alcohol could "miskien net jou vrinnekring ń bietjie verander" *[maybe just change your friendship circle a bit]* (Female Participant 4, Focus Group 2). This is, however, a potentially problematic suggestion to make given the apparent pervasiveness of

drinking in this community – a woman's decision to abstain from alcohol use while pregnant may well be a lonely choice (Branco & Kaskutas, 2001).

Alcohol use is framed by the social norms of a peer group: an individual's perception of how other members of their social group think and act heavily influences their own drinking behaviour (Perkins, 2002; Perkins & Berkowitz, 1986; Phua, 2013). Those who believe that many of their peers are drinking heavily are likely to drink more themselves in order to conform to their social group (Halim et al., 2012). The interviews and the focus group discussions in the present study made it clear that the participants viewed drinking alcohol as a way of life in Madison. For example, when I asked Participant 14 to talk about what happens in her community she said: "Daar's baie mense wat drink" *[There are a lot of people that drink]*. Similarly, Participant 2's response to this question was: "dan drink hulle van Vrydag tot Maandag toe" *[then they drink from Friday to Monday]*. The participants in Focus Group 1 also discussed community members drinking over the weekend, and when I asked why they thought this happened they said:

> Male Participant 7: Omdat hulle voel dis nou naweek en hulle wil drink *[Because they feel it's now the weekend and they want to drink]*.
>
> Female Participant 3: Ons is moeg. Dis vir ontspanning *[We are tired. It's for relaxation]*.
>
> Male Participant 7: Ja, hulle wil ontspan *[Yes, they want to relax]*.
>
> (Focus Group 1)

This clearly constructs drinking over the weekend as a norm in this community - the weekend is seen as a time to relax and unwind, and drinking is integral to this (Demers et al., 1996). Furthermore, it seems that for many in the community, heavy and continuous drinking is the norm. For example, when I asked Participant 4 about her drinking she noted that when she drank with her friends she "sit by die kan. [Die wyn] moet opraak" *[sits by the can. (The wine) must be finished]*. Similarly, Participant 5 when discussing drinking with friends over the weekend noted "Ons drink aanmekaar. Daar's nie ń stop nie" *[We drink continuously. There isn't a stop]*. And Participant 13 stated: "dan drink ons mos nou tot ons nie meer kan nie" *[then we drink until we cannot anymore]*.

In South Africa, the proportion of the population who drink is low when compared to other countries; however, our per capita consumption of alcohol is 11 litres (compared to 6 litres across the African region), and those who do drink tend to do so regularly and at risky levels (Peltzer & Ramlagan, 2009; World Health Organisation, 2014). Eleven percent of the South African population engage in heavy episodic drinking which is the highest percentage

across the African continent (World Health Organisation, 2014). Importantly, FASDs are associated with this sort of drinking – heavy episodic (binge) drinking by pregnant women is the pattern of drinking that is most likely to lead to a FASD (May et al., 2007; May et al., 2008).

The norm of heavy episodic drinking, both during pregnancy and generally, is partly rooted in the legacy of the "dop system" (Horn, 2013; Russell et al., 2013). Although now outlawed, dependence on alcohol in agricultural towns and communities, like Madison, still persists (London, 1999). This is in part due to the establishment of illegal or unregistered shebeens in impoverished areas which make alcohol readily accessible (Cloete, 2012; Russell et al., 2013). In the present study, some focus group participants made it clear that shebeens are a significant problem in their community and felt the shebeens were one of the reasons why such heavy and continuous drinking took place:

> Male Participant 6: From Friday, the shebeens, you understand […] on Friday they are opening, they close Sunday. It's 24 hours. That's why I'm telling you, there are too many shebeens in [Madison] that are selling alcohol, [il]legal alcohol to us. That's why we've got a problem.
>
> (Focus Group 1)

Clearly, individuals have easy access to alcohol through the shebeens, and in communities such as Madison, they are often one of the only social and recreational outlets for residents (Watt et al., 2014). Indeed one participant noted that Madison is in need of more "ontspannings geriewe" *[recreational facilities]* (Participant 5) so that they have alternative places at which to socialise where alcohol is not served. Importantly, then, while the majority of the interview participants engaged in heavy episodic drinking at least at some point during their pregnancy, often their friends, family members and partners did so too, highlighting the fact that the participants' drinking behaviour cannot be understood in isolation – it is clearly influenced by their social network and the social norms of heavy drinking in their community

Drinking as a social and pleasurable activity

Alcohol use was consistently represented by many of the study participants as a social and pleasure-filled activity that is done amongst peers. Within this representation drinking was described as fuelling social interactions, a finding evident in other research studies too (Cloete, 2012; Demers et al., 1996; Guise & Gill, 2007; Niland et al., 2013; Watt et al., 2014). For example, Participant 6 noted: "want as ons almal dronk is, dan verstaan ons mekaar" *[because if we are all drunk, then we understand each other]*. This representation

draws on a discourse that Niland et al. (2013) call the "friendship fun discourse" (p. 532) where drinking is constructed as a social pleasure, rather than an individual experience or activity - it is something that is done for sociability and enjoyment (Lyons & Willott, 2008; Niland et al., 2013). In the present study the interview and focus group data made it clear that in this community, friendship and drinking were heavily intertwined and together facilitated having a good time. Participant 10 noted that when she went out drinking: "Dan wil ek net dans so, by vriende wees en my enjoy" *[Then I just want to dance, be with friends and enjoy myself]*. Similarly, when Participant 3 discussed going out drinking with friends she said: "we are dancing, smoking and laughing". Likewise, when I asked Participant 2 to discuss a recent experience she had with alcohol she said: "Elke naweek dan drink ons. Later dan sit ons die groot musiek, en dan geniet ons nou vir ons lekker" *[Every weekend we drink. Later we switch on the big music, and then we enjoy ourselves]*.

Participant 2's, 3's and 10's accounts illustrate the friendship fun discourse – these participants saw alcohol use as a way of socialising and having an enjoyable time with their friends. Importantly, within this discourse drinking is constructed as a *group* activity. One of the ways in which this is illustrated is through the use of the personal pronoun, "we". In my interview with Participant 2, I worded my question to her (about a recent experience with alcohol) along the lines of, "Can you tell me about a time when *you* drank alcohol?", and interestingly, she responded to this question not with the personal pronoun "I" but instead with "we", thereby constructing this drinking experience as a collective activity. Indeed in many of the interviews drinking was described by the participants as something which a social group does together, rather than something an individual does alone (Guise & Gill, 2007). When participants spoke about their drinking behaviour they often situated it within the context of their social group. Participant 9, for example, described what happened when she and her friends decided to drink together:

> Participant 9: Ons gooi ons geldjies bymekaar. Ons stuur iemand dorp toe om vir ons nou die goedjies te gaan koop. Die een bring dit vir ons, en dan drink ons *[We put our money together. We send someone to town to buy the goodies for us. That person brings it back for us, and then we drink]*.

Again this emphasises the social nature of the participants' drinking activities, including the planning of a night of drinking. This opens up a collective subject position in which alcohol use is linked to the identity of the social group, rather than the identity of an individual. Frequently, participants spoke about how they "drink saam met [vriende]" *[drink together with (friends)]* (Participant 11). One implication of the "friendship fun" discourse, in

which alcohol is represented as a social rather than an individual activity is that serves to normalise and legitimate alcohol use within a social setting. This is because when the participants discuss drinking they refer to others in their social circle as doing the same, and they stress the frivolous and fun nature of a night out drinking with friends, which could lead them to infer that they are not problem or dysfunctional drinkers (Guise & Gill, 2007; Niland et al., 2013). Relatedly, this could also serve to lessen the participants' individual responsibility for their drinking (Guise & Gill, 2007) – it constructs alcohol use as something which social groups do together and not something that is done alone, thereby shifting responsibility for giving up alcohol use from the individual to the social group. For one participant in the present study her alcohol use appeared to be so connected with one of her friendships that she felt unable to resist the social pressure to drink, emphasising the strong influence her social network had on her drinking:

> Participant 2: Ek kan dit los, maar dan kom [my vriend] na my toe en dan drink ons saam. Sy kan nie allenig drink nie *[I can stop it, but then (my friend) comes to me and we drink together. She cannot drink alone]*.

Another implication of representing alcohol use as a social and group-based activity is that it can serve to defend drinking behaviour against stigmatisation (Echabe et al., 1992; Echabe et al., 1994). The interview participants in the present study fall within a group who are heavily stigmatised because of their drinking (which will be explored in more detail further on in this analysis), and so they may have felt the need to justify or defend their use of alcohol because of this stigma - members of stigmatised or discriminated against groups can use representations to defend their actions or behaviour (Echabe et al., 1994). By representing alcohol use as an activity which is done as a group rather than done alone the participants' drinking behaviour is normalised because it is presented as part of the normal, social activities of their peer group (Guise & Gill, 2007; Niland et al., 2013).

The individualisation of alcohol use

While the social nature of alcohol use was clearly a prominent feature of the participants' accounts, there were some instances in which participants, to varying degrees, individualised their drinking. Notably, alcohol use was often simultaneously represented as both a social and individualised activity by the participants, depending on the context in which they anchored their drinking. One of the ways in which drinking was individualised was in the participants' distancing of themselves from the drinking activities of their social group. For example, when I asked Participant 8 to discuss her drinking in the early months of her pregnancy she said:

> Participant 8: Ons, hulle nou besluit het maar hulle gaan drink, dan gaan ons na my een vriend se huis toe en dan drink ons daar. Daarvanaf gaan ek weer huis toe. Ek raak nie dronk nie *[We, they decide to go drink, then we go to my one friend's house and we drink there. Thereafter I go back to my house. I do not get drunk]*.

Participant 8, similar to Participant 2, when talking about drinking used the plural personal pronouns "ons" [we] and "hulle" [they], thereby constructing alcohol use as an activity that is done by the group, and not one that she does on her own. However, she then went on to separate herself from the rest of the group in the second sentence through her use of the personal pronoun "ek" [I]: when she has had enough to drink she returns home. In other words, the rest of her social group may have carried on drinking and becoming inebriated, but she removed herself from this situation and did not allow herself to get drunk, thereby individualising her drinking behaviour. This was also evident in Participant 10's interview - when she discussed drinking during her pregnancy she noted: "Ek drink by my huis saam met my maatjies" *[I drink at my house together with my friends],* which clearly constructs her drinking as a social activity. However, she also noted:

> Participant 10: Ek het gedrink, maar ek het nooit dronk geraak van die alkohol nie. As ek drink, dan gooi ek op van die alkohol *[I drank, but I never became drunk from the alcohol. If I drank, then I would throw up from the alcohol]*.

The way in which Participants 8 and 10 discuss their drinking – that it is a social activity done with friends, but that they themselves do not become drunk – could be an attempt to represent themselves as more responsible drinkers: they linked their drinking to their peer groups (thereby indicating that it is a group activity), while at the same time also *distancing* themselves from the group when it came to heavy drinking. Similar to other social representation research on alcohol and substance use, they constructed a clear boundary for their drinking behaviour between drinking with friends, and drinking to become inebriated (Drabble & Trocki, 2013; Trocki et al., 2013). Both participants made it clear in their interviews that they chose to *not* become drunk with their friends, thereby stressing that even though they did drink during their pregnancy, they did not do so at risky levels – they took some personal responsibility for their drinking behaviour (Baxter et al., 2004; Hunting & Browne, 2012). For some participants, this responsibility-taking helped them in their decision to stop drinking during their pregnancy, which will be discussed in the section on the stigma attached to prenatal alcohol use in this study community.

The individualisation of alcohol use was also apparent in the participants' discussion of drinking places in their community. For example, although Participant 2 represented her

drinking behaviour as a social activity that was done with her close friend, when it came to *where* she and her friend drank, she individualised her alcohol use: "[Ek drink] by die huis. Ek drink, en dan lê ek. Dan loop ek nie rond nie" *[(I drink) at the house. I drink, and then I lie down. I do not walk around]*. When I asked her where other people in the community drink she said "hulle drink daar by die yard" *[they drink there by the yard],* which I discovered after my interviews meant the areas in front of and between the participants' homes. The participants who spoke about it saw drinking "on the yard" as a negative thing. For example, when I asked Participant 14 to tell me a bit about what happens when she would drink she said:

> Participant 14: Daar gebeur somtyds baie dinge. As jy baie dronk is, baklei baie met die mense. En jy sit sommer op die yard. Jy hou sommer 24 hours op die yard *[Sometimes a lot of things happen. If you are very drunk, then you fight with people. And you sit on the yard. You stay for 24 hours on the yard]*.

Clearly, drinking and spending all your time "on the yard" is something that was frowned upon. Interestingly, even though I asked Participant 14 for a personal experience with drinking, she responded to the question using the second person, and not the first person. The function of this is to distinguish herself from those who spend most of their time "on the yard", getting drunk and getting into fights – Participant 14 did not position herself, personally, as engaging in these sorts of activities, but rather represented it as a generalised activity that others in the community engage in (Guise & Gill, 2007). In Participant 2's case she individualised her drinking by positioning herself as someone who drank at home, and not someone who drank "on the yard" like other members of her community. Although she did not say so directly, based on what other participants (like Participant 14) said in their interviews about "the yard", a possible function of Participant 2's individualising her drinking could be to ensure that I do not associate her with the negative on-goings of drinking "on the yard". Similar to Participants 8 and 10, she positioned herself as taking a bit more responsibility for her drinking – even though she did drink while pregnant, she did so at home, away from the unbecoming behaviour of those who drink "on the yard".

The individualisation of drinking came through most strongly in Participant 1's and 7's interviews. When I asked Participant 1 about her experiences with alcohol she said: "Ek drink alleen. Ek maak die deur toe en dan drink ek alleen" *[(...) I drink alone. I close the door and I drink alone]*. Similarly Participant 7 in her interview stated:

> Participant 7: As ek drink, ek is nie een wat praat nie. Ek loop ook nie rond nie. Ek sit net by my huis. En as dit is dat iemand lelik is by my huis, dan gaan ek altyd in my kamer in

[If I drink, I am not one who talks. I also don't walk around. I just sit at my house. And if it comes that someone is ugly in my house, then I always go into my room].

Participants 1 and 7 clearly construct their drinking as an individual activity as opposed to a social one. They described shutting themselves away from the rest of the community and drinking alone in their homes. However, they appeared to have different motives for individualising their drinking. For Participant 7, her motivation appeared to be similar to those of Participants 2, 8, 10 and 14 – she wished to distance and distinguish herself from the stigma that can be associated with using alcohol in public (Rolfe et al., 2006). She did not drink and walk around in her community talking to others; rather, she sat at home, making sure to avoid any nastiness. While she admitted to drinking, she was careful to position herself as taking some responsibility when it comes to what she *does* when she drinks.

Participant 1 had a very different motive for individualising her drinking - she wanted help with her alcohol abuse problem. During her interview when I asked her how much she presently drinks she said:

Participant 1: As ek die bottels tel op ń Sondag, dan kom daar seker so 18 bier bottels uit daai plek uit […] 18 bier bottels vir ń naweek. En dis groot bier bottels – nie dumpies nie. Ek gaan nie lieg nie want ek wil gehelp wees *[If I count the bottles up on a Sunday, then about 18 beer bottles comes out of that place (…) 18 beer bottles for a weekend. And it's big beer bottles – not little ones. I will not lie because I want help]*.

Furthermore, after she had told me that she drinks alone at home she said: "[…] hulle sê mos ń mens moenie alleen drink nie, dan's jy mos 'n alkoholis" *[(…) they say that a person mustn't drink alone, then you are an alcoholic]*. It was clear that Participant 1 felt that if she individualised her drinking (in other words, constructed it as something which she did alone at home) and emphasised to me how much she drank, it would illustrate how much she wanted and needed assistance. The representation of someone who drinks alone as an alcoholic did not come up in any of the other interviews, but it was present in the second focus group discussion, where a few group members seemed to hold the same belief as Participant 1:

Female Participant 3: Maar ek het nou gelees in 'n boek in. Om 'n alkoholis te wees of een te word of jy's alreeds een, 'n alkoholis is iemand wat alleen drink. Hy verkies om alleen te drink. Dan sê hulle jy's 'n alkoholis. *[But I read in a book. To be an alcoholic, or to become one, or if you already one, an alcoholic is someone who drinks alone. He chooses to drink alone. Then they say you are an alcoholic]*.

(Focus Group 2).

In response to this I asked Female Participant 3 what she thought about people who drink as much as someone who drinks alone, but who do so in the company of others:

Female Participant 3: Ek dink as mens met ander mense drink is jy nie 'n alkoholis nie. As jy alleen drink is jy 'n alkoholis. Dink jy nie so nie? *[I think that if a person drinks with other people then you are not an alcoholic. If you drink alone you are an alcoholic. Don't you think so?]*

Female Participant 1: Ja *[Yes]*.

Notably, the National Institute of Health in the United States do list drinking alone as one of the possible warning signs of alcoholism (MedlinePlus, 2013). In the present study, because the belief that an alcoholic is someone who drinks alone was only discussed by a few study participants, it appears that it was not necessarily a common belief held in this community. However, it does indicate that there are *some* individuals who think about drinking in this way, a finding evident in other research too: Niland et al. (2013) noted that participants in their study constructed drinking alone as problematic, while drinking with friends was seen as a legitimate and fun activity. This is a potentially dangerous belief to hold: if drinking alone is seen as problematic while drinking socially is not, heavy drinking in social situations becomes legitimised which may result in social drinkers who are dependent on or addicted to alcohol in not seeking treatment because they do not see themselves as having a problem with alcohol.

The Relationship Between Alcohol Use and Problems

Despite the strong emphasis the majority of participants placed on the social and fun nature of drinking, there was also much discussion of alcohol use and problems they experienced in their lives. For some, drinking was represented as a way in which to *cope* with the problems they faced, while for others alcohol use, and in some cases non-alcohol use, was represented as the *cause* of their problems. A few participants discussed problems they experienced before and after their pregnancy, but most noted the problems they experienced while they were pregnant. Pregnancy can be a psychologically stressful life transition for women which may interact with other stressors to influence drinking behaviour (Choi et al., 2014a; A. Jackson & Shannon, 2013).

Drinking as a way of coping with problems

The participants experienced a range of stressors throughout their lives including unemployment, infidelity, domestic arguments and fights, jealous and sometimes abusive

partners, rape, miscarriages and the deaths of children or romantic partners. Interestingly, there were some participants who did *not* make a link between the experience of a severely traumatic event (for example, rape or the loss of a child) and their drinking behaviour. Women – including those who are pregnant - with a history of trauma are more likely to drink at hazardous levels (Choi et al., 2014b; Ethen et al., 2009; Skagerström et al., 2011; Watt et al., 2014). While the present study appears to confirm this – 10 out of 14 participants had experienced a traumatic event (with some experiencing more than one) and they were all identified as heavy drinkers via the AUDIT – what is surprising is that there were a few participants who did not connect their traumatic experience to their drinking. They did not note that they drank in response to or as a way of coping with the event, which stands in contrast to other research (Choi et al., 2014a; Choi et al., 2014b; Cloete, 2012). While drinking may have assisted them in dealing with the event, they were not conscious of this. One could speculate that perhaps these particular participants were in some sort of denial of the seriousness of these traumas, or that the traumas were in some way normalised given the extreme oppression experienced by members of marginalised communities like Madison (Cloete, 2012).

There were, however, a number of other participants who represented their alcohol use as a way of coping with the relational and domestic problems they faced. Alcohol use has oftentimes been described as a coping strategy, whereby drinking is used as a way to regulate and reduce unwanted internal experiences (Choi et al., 2014b; Demers et al., 1996; Hides et al., 2008; Kuntsche, Knibbe, Gmel, & Engels, 2005). In the present study, Participant 4 noted that during her pregnancy:

> Participant 4: Ek het baie probleme gehad. As die probleem so erg raak, dan besluit ek, 'hey, gaan steek 'n doppie' *[I had a lot of problems. If the problem became too much for me to handle I would decide, 'hey, go have a drink']*.

When I asked her for examples of the sorts of problems she experienced she said that her teenage stepson was "stout" *[naughty]* and "baie gruwelik" *[very creepy and cruel]* in her home which angered her and made her feel stressed. Because of these negative feelings she would drink: "Dis maar net die stress wat vir my baie laat drink" *[It was just the stress that made me drink so much]*. Another problem which Participant 4 experienced while pregnant was her partner's infidelity. When talking about this she said:

> Participant 4: Dit het baie seer gevoel. Dis hoekom ek so gedrink het […]. Dan tiep ek en dan vergeet ek daai oomblik *[It hurt a lot. That's why I drank. (...). Then I pass out and forget for that moment]*.

In order to deal with and forget about the hurt and pain associated with her partner's unfaithfulness Participant 4 drank heavily. Problem drinking is associated with a host of marital problems including infidelity (DiBello, Neighbors, Rodriguez, & Lindgren, 2014). Participant 1's partner was also unfaithful to her while she was pregnant with their child. She noted that there were some weekends when her partner would stay with his other girlfriend and when this happened "dan drink ek maar net" *[then all I would do is drink]*. The affair that he was having made Participant 1 wonder whether she should continue with her pregnancy – she did not want to have a child with someone who did not care about her:

> Participant 1: Want as [hy] vir my omgee, dan sou [hy] mos nou nie elke week weg gewees het of nie geld gebring het nie *[Because if (he) cared about me, then (he) wouldn't be away every weekend or not bring any money home]*.

Not only did Participant 1 feel emotionally unsupported by her partner, she was also not being financially supported by him - at this stage she did not work and was reliant on his income. The financial insecurity that she felt as a result of this was one of the reasons why she drank, a finding evident in other research performed with pregnant women presenting with alcohol problems (A. E. Anderson et al., 2014; Powers et al., 2013; Watt et al., 2014). Participant 7 also connected her drinking to problems in her life: during her pregnancy she experienced a lot of difficulty with her partner's previous girlfriend who would come to their home and emotionally abuse her. When she attempted to involve the police in the matter, her partner would prevent her from talking to them. She therefore turned to alcohol:

> Participant 7: Ek het altyd net gedink, die beste is vir my, ek drink my probleme weg. As die probleme begin, dan besluit ek ek drink maar net, miskien kan dit verminder. Want dan hoor en sien ek nie die goed nie, want ek is net in my huis en ek loop nie rond nie *[I always thought, the best for me is, I drink my problems away. If the problems start, then I decide I will just drink, maybe it can be reduced. Because then I do not hear and see what is happening, because I am just in my house and I am not out and about]*.

Participant 7 saw alcohol use as a way of diminishing the stress she experienced and also as a way of blocking her sensory awareness of the problem, a finding evident in another study performed with South African women who reported that they drank in order to numb their senses to distressing stimuli (Choi et al., 2014b). Similar to Participant 7, Participant 12 also noted that she experienced problems in her home. She did not wish to discuss these in the interview but acknowledged that: "Drank laat voel vir my ek vergeet van alle probleme wat ek het" *[Drinking made me feel like I was forgetting all the problems I had]*. Drinking

therefore offered Participant 12 a way of escaping or avoiding the problems she was facing at home (Jacobs & Jacobs, 2014; Watt et al., 2014).

The representation of alcohol use as a strategy for coping alludes to a wider discourse of self-medication in which alcohol is used by individuals in order to manage inner tensions, emotional pain and stressful life circumstances. Within this discourse alcohol is seen as a strategy for self-care in which symptoms associated with stressful experiences can be medicated (Drabble & Trocki, 2013; Gueta & Addad, 2013; Rolfe et al., 2009). In the present study, Participants 1, 4, 7 and 12 anchored their experiences with drinking into a context of coping with their problems – they represented drinking as a means to regulate and manage the negative feelings they experienced as a result of the stressors they faced. Furthermore, alcohol offered them a way to forget about, avoid or escape from their problems. This finding was also evident in the first focus group discussion, in particular amongst the female participants. For example, Female Participant 4 in Focus Group 1 discussed how she drank when her daughter was placed in foster care:

> Female Participant 4: En toe daai kind van my af weggeneem is, toe begin my…drinkery […]. Ek was elke dag dronk. Elke dag, saans as ek by die huis kom, ek is dronk *[And when that child was taken away from me, then my drinking began (...). I was drunk every day. Every day, when I came home in the evening, I was drunk]*.
>
> (Focus Group 1).

Although Female Participant 4 did not say so directly, she clearly saw drinking as a way for her to deal with the negative experience of her daughter being placed in foster care. In the same focus group discussion, Female Participant 5 also discussed drinking because of the stress she experienced. For her, this stress took place during her pregnancy:

> Female Participant 5: […] My partner flankeer met 'n ander meisie […] dan gaan drink ek om daai stres af te kry *[(...)My partner flirted with another girl (...) then I would drink to get rid of the stress]*.
>
> (Focus Group 1).

Like Participants 1 and 4, Female Participant 5 saw alcohol as a way of coping with her partner's unfaithfulness – she drank in order to reduce the impact of this stressor in her life. Within this discourse of self-medication, the subject position that the participants take up is one in which they are dependent on something (i.e., alcohol) to cope with their problems (Rolfe et al., 2009). They turned to alcohol because they felt as though it was a viable way of dealing with the stressors they faced. A consequence of taking up this subject position is that

it can serve to disempower these participants by making them feel as though they are unable to deal with their stressors without the support of alcohol.

However, it is important not to individualise these women's problems (Rolfe et al., 2009) without addressing the social context - as already established, individual drinking behaviour cannot be understood in isolation. South Africa is a particularly challenging environment with a number of stressors and in many parts of the country, poverty and unemployment levels are amongst some of the highest in the world (Choi et al., 2014b; Chopra et al., 2009). In the present study it was made clear in both the focus group discussions that there were limited opportunities in this particular community. For example, Female Participant 3 in the second focus group, when discussing education and employment opportunities, noted: "daar is niks vir ons nie" *[there is nothing for us]*. Similarly, the FARR fieldworker in the first focus group discussion said: "hier is niks wat jou besig hou nie" *[here there is nothing to keep you busy]*. Given the low resource setting within which the participants reside, they may have felt that drinking was the *only* way in which to cope with their problems. Furthermore, the social environment in which these women live may have supported and maintained their drinking given that heavy alcohol use appears to be the norm in this community (Cloete, 2012; Watt et al., 2014). It seems likely that the domestic and relational problems faced by the participants during their pregnancy coupled with the social nature and strong influence of peers on drinking in the study community, contributed to some of the participants being unable to cease drinking while pregnant.

There was however, some acknowledgement that alcohol does not offer a long term solution, and that drinking can in fact exacerbate stressors (Choi et al., 2014b). For example, when Participant 4 discussed drinking in order to cope with her partner's infidelity, she noted, "maar die pyn bly tog maar nog altyd daar" *[But that pain always stays there]*. Similarly, in the second focus group discussion the participants discussed the limits of alcohol as a solution to problems:

> Female Participant 1: […] Maar, die wyn vererger dit net, want môre as jy nugter is, dan is daai probleem nog altyd daar. [Dit] is nog nie opgelos nie. *[(...) But the wine just makes it worse, because tomorrow when you are sober, then that problem is still always there. (It) is still not solved]*.
>
> Female Participant 2: Presies. *[Precisely]*.
>
> (Focus Group 2).

Accordingly, a few of the interview and focus group participants were aware of the limitations of drinking in order to cope with one's problems – that it does not get rid of the problem, and in actual fact can sometimes make it worse.

Drinking as causing problems

The consumption of alcohol was not only seen as a way of coping with problems, but also as *causing* problems. In this regard, most participants discussed personal problems they faced as a result of alcohol use, but some also acknowledged that drinking contributed to social problems affecting the whole community. For example, Participant 12 noted that when people have been drinking over the weekend:

> Participant 12: Daar's mense wat mekaar seermaak. Ja, verkragting vind plaas en so aan. Meeste van die naweke moord en so aan *[There are people that hurt each other. Yes, rape takes place and so on. Most of the weekends there is murder and so on]*.

She therefore felt that "dis nie 'n goeie ding om te drink nie, want daar's altyd sulke goed wat gebeur" *[it's not a good thing to drink, because such things always happen]*. Indeed alcohol use has been identified as a causal factor for injuries and harm including interpersonal violence and homicide (P. Anderson, Chisholm, & Fuhr, 2009; Gil-Gonzalez, Vives-Cases, Alvarez-Dardet, & Latour-Perez, 2006; Rehm, Patra, & Popova, 2006). Other participants noted that alcohol use caused problems in their homes - Participant 14 stated: "elke keer as ek drink, dan is daar probleme in die huis" *[Every time that I drink, then there are problems in the house]*.

These problems tended to be of a domestic nature where drinking would cause arguments and fights between the participants and their intimate partners. Alcohol use is said to increase the likelihood of interpersonal conflict, and heavy drinkers report that their alcohol use often causes them to become argumentative (Choi et al., 2014b; Orford et al., 2002; Rolfe et al., 2006). Most participants acknowledged that their own alcohol use as well as the alcohol use of their partners played a role in the conflict they experienced. In her interview Participant 10 noted: "Ek en my kêrel het baie gebaklei, as ons so gedrink het" *[My boyfriend and I fought a lot, if we drank]*. Likewise, Participant 3 said that when she and her boyfriend drank, "het [ons] baie gestry en baklei" *[we argued and fought a lot]*.

For most participants these fights were non-physical, but for a few their fights would become violent. Indeed alcohol use, by both men and women, is a risk factor for domestic violence (Jewkes, 2002; Jewkes, Levin, & Penn-Kekana, 2002). Participant 2 noted that when she and her partner would drink together he would become physically abusive towards her.

When I asked what happened when they fought she said: “Dan moet ek maar weghol” *[Then I have to run away]*. I asked her how she felt about this and she responded “Nee, dan vra hy verskoning agterna” *[No, then he apologises afterwards]*. Thereafter, she returns home, but his abusiveness continues; she noted that they fought like this “elke naweek” *[every weekend]*. Like Participant 2, Participant 11 also linked drinking to violence committed by her partner. She and her partner no longer drink, but she described what used to happen when they did:

> Participant 11: As ek vir [my kêrel] sê maar ek gaan nie drink nie, ek worry nie om te drink nie […] hy […] wil my slaat as ek nie wil drink nie *[If I tell (my boyfriend) that I will not drink, I do not worry with drinking (...) he (...) wants to hit me if I do not want to drink]*.

Participant 11’s partner would become violent towards her if she did not want to drink with him – she described how he would “force my en hy slaat my as ek nie wil drink nie” *[force me and hit me if I do not want to drink]*. When he became like this she would say to him:

> Participant 11: […] om die vrede te bewaar en nie nou moeilikheid te maak nie**,** gaat koop die bier en dan drink ek saam met jou *[(...) to keep the peace and not to cause trouble, go buy the beer and then I will drink with you]*.

Interestingly, when Participant 11 spoke about this situation she did not appear to see it as problematic – before describing to me what would happen if she refused to drink with her partner she said, “dis nie eintlik probleme nie” *[it’s not actually problems]*. In her interview Participant 14 also discussed a link between her drinking and her partner’s violence. However, while Participant 11 drank with her partner in order to *prevent* him from becoming violent, Participant 4’s drinking sometimes c*aused* her partner to become violent:

> Participant 4: Ja, hy raak kwaad. Somkeer dan besluit hy, hy loop, en somkeer dan gee hy vir my so twee of drie klappe want ek wil nie hoor nie (The participant laughs a bit when talking about this) *[Yes, he gets angry. Sometimes he decides he will walk away, and sometimes he will hit me two or three times because I did not listen]*.
>
> JK: So hy raak kwaad? *[So he gets angry?]*.
>
> Participant 4: Ja, dan voel ek maar skuldig want ek was nou verkeerd *[Yes, then I feel guilty because I was wrong]*.

Interestingly, Participant 4 seemed to consider her partner’s violence as justified – her dialogue suggests that she sees her drunken behaviour as deserving of punishment from her

partner. Furthermore, she also laughed a bit when discussing her partner becoming violent towards her, which could imply that she sees this sort of behaviour as normal.

What is evident within Participants 2's, 4's and 11's stories is that their partners appear to hold the dominance and control in their relationships: In the case of Participant 2, even though her partner's violence towards her was continuous, when he apologised, she would return to him, which enabled him to continue with this violent behaviour. Participant 11, in order to avoid the violence of her partner, agreed to drink with him thereby further enabling his threats of violence. In the case of Participant 4, she seemed to think that her partner must exert some sort of authority over her, through violence, if she became drunk and argumentative. In this way Participants 2, 4 and 11 all occupy a submissive and powerless subject position, while their partners occupy a dominant and controlling one, which alludes to both the discourse of patriarchy and the related notion of hegemonic masculinity.

The patriarchal discourse asserts that men hold more power in society than women (Kiguwa, 2004). Hegemonic masculinity, an essential element of this discourse, refers to the dominant position of manhood that is idealised in society. In South Africa, it is commonly associated with the oppression and subordination of women (Jewkes & Morrell, 2010): "In a highly gender-inequitable country like South Africa, hegemonic masculinity mobilises and legitimates the subordination and control of women by men" (Jewkes & Morrell, 2010, p. 3). The domestic violence experienced by Participants 2, 4 and 11 falls within this discursive framework through its illustration of the violent control and authority their male partners have over them. Indeed patriarchal beliefs and practices are prevalent in this country and have fostered an environment in which women face high rates of abuse and violence (Choi et al., 2014b; Jewkes & Morrell, 2010).

The discourse of patriarchy and related notion of hegemonic masculinity is also apparent in the participants' discussion of drinking as a result of their partner's infidelity. As already established, Participant 1 reported that she drank in an attempt to cope with her partner's unfaithfulness, and in her interview, she suggested wanting to leave her partner but said: "As ek daai man los, dan het ek nie 'n blyplek nie" *[If I leave that man, then I do not have a place to live]*. What this demonstrates is Participant 1's financial dependence on her partner – like most of the other participants she did not have full time employment and was therefore dependent on him in supporting herself and her child. In this way, her partner held the control in their relationship: he was unfaithful towards her and was able to get away with this infidelity because Participant 1 was financially unable to leave him. And because of this, she turned to alcohol as a way of coping.

For some participants their drinking, or not drinking, resulted in their partners becoming violent towards them. For others, their drinking was a way of dealing with their partner's infidelity, and their related inability to take action against this. Accordingly, the participants' drinking behaviour and its relationship to their domestic partnerships is rooted in the patriarchal discourse and related notion of hegemonic masculinity. In both scenarios the participants occupy a powerless and subordinate position, while their male partners occupy a position of dominance and control. Elsewhere it has been argued that some women may drink to assert themselves and to challenge these unequal interpersonal dynamics (Choi et al., 2014b; Lyons & Willott, 2008), but this was not found in the present study. Rather, it seems that some of them drank as a way of coping with the subordinate position they occupied in their relationships, while others drank because they felt unable to stand up to their partners.

It is important to note that while patriarchal beliefs and practices appeared to be prominent in this particular community, discussion by some of the interview and focus group participants suggested that there is some resistance to this discourse. For example, Participant 12 noted that she hopes to move to Cape Town in the future as she feels that there will be more opportunities for her there. When I asked her if she thought her boyfriend would come with her she responded that she was unsure and said that if he decided not to, "dan moet ons twee net mekaar los, of ons moet maar net skei van mekaar af" *[then the two of us must break up or we must just separate from each other]*. Regardless of whether or not Participant 12's partner chooses to go with her to Cape Town, she would still go, which demonstrates that she did not feel as though she needed to be reliant or dependent on him – she had her own ambitions and wanted to follow them, even if this meant losing her boyfriend. In this way, she is, albeit subtly, challenging the subordinate position that women often occupy in patriarchal societies.

Related to the representation of drinking causing problems in the participants' lives, alcohol use was also represented as causing changes in their behaviour, which will be explored in the following section.

Alcohol-related Changes in Behaviour

Many of the interview participants discussed drinking heavily before they fell pregnant. Participant 5, for example, said: "Voor ek swanger was het ek baie gedrink" *[Before I was pregnant I drank a lot]*. Oftentimes the participants' discussion of their heavy drinking was centred on the physical and psychological effects they felt alcohol had on them – a finding evident in other research on heavy alcohol use too (Guise & Gill, 2007; Trocki et

al., 2013). This could be a reflection of alcohol expectancies; an individual's learned beliefs with regards to the effects of alcohol. Alcohol expectancies have been thought to have a direct impact on the psychological and behavioural outcomes of drinking (Borders, Barnwell, & Earleywine, 2007; Pabst, Kraus, Piontek, Mueller, & Demmel, 2014). For example, individuals who are expecting alcohol to increase their aggression are more likely to report aggressive behaviour or hostile acts, irrespective of the amount of alcohol consumed (Borders et al., 2007).

The participants in the present study discussed a loss of control they experienced when they became inebriated. Participant 4, for example, admitted to being a heavy drinker, and when I asked her to explore how she felt when she drank she responded:

> Participant 4: My kop voel dronk. Ek voel bewusteloos. Somkeers is ek so dronk, dan weet ek nie eers wat ek praat nie *[My head feels drunk. I feel unconscious. Sometimes I am so drunk, that I do not know what I am talking about]*.

Participant 6 discussed a similar experience: when she drank heavily, "dan weet ek niks wat rondom my aan gaan nie" *[then I do not know what is going on around me]*. Both Participants 4 and 6 therefore link their heavy drinking experiences to a diminished sensory awareness. Other participants explored this loss of control in a bit more detail, and noted that alcohol use would sometimes cause them to engage in behaviour that they would not normally engage in. In her interview Participant 8 noted that when a person drinks, "jy doen goed wat jy nie verwag het van jouself nie" *[you do things that you do not expect of yourself]*. Similarly, in Focus Group 2 one of the participants said: *"*drank verander eintlik maar 'n mens" *[alcohol actually changes a person]* (Female Participant 3). Alcohol use is represented by these participants as causing changes in a person's behaviour. The subject position made available here is one in which the individual does not have control over his/her actions – *alcohol* is in control and makes a person behave in ways which are uncharacteristic of him/her.

When I asked Participant 3 during her interview how she felt when she drank she responded: "Ek voel ek praat enige ding - goeters wat nie reg is nie - en ek baklei ook sommer" *[I feel I talk about anything – things that are not right – and I also get into fights easily]*. Participant 3 linked drinking to a shift in her personality – she felt as though drinking led her to lose control over her actions and her speech. Similarly, Participant 10 noted that: "Wanneer ek alkohol gebruik het, dan was ek lief vir baklei met other people" *[When I drank alcohol, I loved fighting with other people]*. As noted in the previous section, for some participants this resulted in arguments and fights with their intimate partners. Heavy alcohol

use can result in a range of negative physiological and psychological effects including, but not limited to, impaired judgement and poor insight (Sullivan, Harris, & Pfefferbaum, 2010). A drawback of alcohol use which heavy drinkers identify is that it can cause a person to become argumentative, belligerent and aggressive (Orford et al., 2002).

Heavy drinking and unsafe sex

The participants' discussion of alcohol use and changes and behaviour was extended by some to include engaging in potentially unsafe behaviour. In her interview Participant 14 discussed feeling nervous about how she might behave in front of men when she had been drinking - she worried that she may become too flirtatious and that men would get the wrong idea:

> Participant 14: As jy nou drink […] jy is altyd showerig rondom die mansmense. Miskien as jy by 'n party of so is, jy voel altyd showerig as jy dronk is *[If you drink (...) you always show off in front of the men. Maybe if you are at a party or something, you always feel like showing off if you are drunk]*.

A bit further on in her interview she said: "Sê nou maar jy's rondom 'n klomp mansmense en jy drink, mense kry altyd ander gedagte" *[Say for example you are around a group of men and you drink, people always get the wrong idea]*. It appears that Participant 14 was concerned that some men may interpret her flirtatious behaviour as an opportunity for them to engage sexually with her. While she did not explore this scenario any further, one could speculate that it is these sorts of drinking situations that may give rise to unsafe sex practices, and in some cases, unintentional pregnancies. Indeed Participant 8 in her interview noted that drinking can cause people to engage in "onveilige seks" *[unsafe sex]*. Similarly, in the second focus group discussion, Female Participant 4 noted that when people drink they may engage in unprotected sex and, as Male Participant 5 stated: "dis waar swangerskappe inkom" *[this is where pregnancy comes in]* (Focus Group 2). In South Africa, hazardous alcohol use is strongly related to sexual risk behaviours, including not using a condom during sexual intercourse (Avalos et al., 2010).

Although not discussed directly by the participants, one could speculate that their high levels of alcohol use before their pregnancies - and perhaps the high levels of alcohol use by their partners - may have contributed to their engaging in unsafe sex, resulting in their unplanned pregnancies. Indeed some of the participants noted in their interviews that their partners drank heavily too. It is possible that if these participants' risky alcohol use had been detected and stopped (for example, at a primary health care facility – see Mertens, Ward,

Bresick, Broder, & Weisner, 2014; Sorsdahl et al., 2010) *prior* to their falling pregnant, their unintended pregnancies could have been avoided, thereby preventing not only the occurrence of FASDs but the birth of a possibly unwanted child. Prevention of FASDs could benefit from turning attention towards reducing alcohol use not only amongst pregnant women but also amongst women of child-bearing age (Rosenthal et al., 2005), and perhaps their partners too.

Another way in which unintended pregnancies and also the occurrence of FASDs can be prevented is through educating couples about effective birth control measures (Jansen Van Vuuren & Learmonth, 2013; May et al., 2005; Rosenthal et al., 2005). In the present study, all of the participants continued drinking when they fell pregnant, but, as already established, for seven out of 14 participants, this was because they were at first *unaware* of their pregnancy; a finding common in other research too – a number of women drink post-conception before recognising they are pregnant (Lester et al., 2009; O'Connor et al., 2011; Tough, Tofflemire, Clarke, & Newburn-Cook, 2006). In this study, Participant 5 in her interview noted: "Ek het […] nie geweet ek is swanger nie. Toe het ek […] baie gedrink. [*I did (...) not know I was pregnant. And I (...) drank a lot*].

This strongly suggests that for these participants, their pregnancies were unplanned. Indeed Participant 3 noted in her interview that when she found out she was pregnant she "het geskrik" *[got a shock]*. There could be a number of reasons as to why these participants did not take contraceptive measures, but this was not a question directly explored in this particular study. One participant did, however, briefly discuss her feelings against birth control measures: She spoke about a nursing sister who wanted her to get the contraceptive injection (this particular participant had 5 children, 3 of whom were in foster care at the time of the interview), and said: "Ek gaan dit nie doen nie. Dis te seer" *[I will not do it. It's too sore]* (Participant 6). She noted that the nursing sister assured her that it was not painful but her response was: "Ek is te bang want die mense sê dis [seer]" *[I am too scared because the people say it's (sore)]* (Participant 6). What this illustrates is that there may well be a myth in this community surrounding the contraceptive injection, which might be influencing women to avoid getting the injection.

This is an area which is deserving of further study: understanding women's reasoning behind their contraceptive decision-making is critical to explore if we wish to reduce the rates of unintended pregnancies (Yee & Simon, 2010). Importantly, unplanned pregnancies, and therefore alcohol consumption during pregnancy, could potentially be avoided through attempting to dispel any myths that surround birth control measures – data from this study

thus suggest that preventing FASDs is not only about preventing alcohol use during pregnancy or amongst women of child-bearing age, it is also about preventing unintended pregnancies from happening in the first place.

Gendered representations of alcohol use

As noted above, Participant 14 worried that if she were to become drunk, she may behave provocatively in front of men, and they may misinterpret this as meaning that they can make sexual advances towards her. Female drinking as leading to sexual attention from men alludes to the discourse of vulnerability in which women are positioned as being in danger if they become intoxicated – if they drink too much they are vulnerable to being sexually or physically attacked by men (De Visser & McDonnell, 2012; Lyons & Willott, 2008). This, like the discourse of patriarchy, establishes a power imbalance between men and women where men occupy a dominant and controlling position, while women occupy a vulnerable and passive one. The vulnerability discourse also reflects the reality that alcohol use is in fact associated with an increased risk of all forms of interpersonal violence (Jewkes, 2002), including sexual assault: heavy drinking by women is predictive of sexual assault victimisation (Mouilso & Fischer, 2012).

In the present study, although Participant 14 did not say so directly, what is implied in her account of female drinking is that if a woman is to drink she is positioned as someone who is vulnerable to the sexual advances of men - inherent in her fear of "showing off" in front of men when she drinks is that she would be at risk for unwanted sexual attention. This discourse of vulnerability comes across most strongly in Participant 11's interview who discussed placing herself in potentially dangerous situations when she consumed alcohol, thereby putting herself at risk for harm:

> Participant 11: Ek loop taverns en ek soek alkohol ook. Dan kry ek seer, maar ek hoor nie. Ek loop dorp toe, ek alleen. Ek koop vir my wyn. Die mense is rof, hulle maak my seer, maar ek hoor nie *[I walk to taverns and I look for alcohol. Then I get hurt, but I do not listen. I walk to town, alone. I buy wine for myself. The people are rough, they hurt me, but I do not listen]*.

Participant 11 painted a picture in which her drinking caused her to have a reduced awareness of her personal safety which resulted in her vulnerability to being hurt by others. Further on in her interview she noted: "alkohol het my altyd baie gebruik" *[alcohol always used me a lot]*. Indeed when Participant 11 was 15 years old, she was gang-raped. At the time of the incident, she was inebriated and when discussing it she said "Ek was gerape, deur

alkohol" *[I was raped, because of alcohol],* which illustrates that she viewed drinking as causing the rape. On the night that it happened she said that because she had been drinking "dan loop ek saans alleen, en dan word ek so gerape" *[then I walk alone in the evening, and then get raped]*. Participant 11 therefore represented alcohol use as causing her to put herself in a potentially dangerous situation (walking home alone at night), thereby making herself vulnerable to being raped. The problem with this way of thinking is that it can serve to absolve perpetrators of violence of responsibility for their actions, as it places all the responsibility for violent behaviour on alcohol use by the victim. Relatedly, victims of violence, like Participant 11, who are inebriated when attacked may be made to feel as though they caused the violence through their drinking (Everitt-Penhale, 2013). While alcohol use *is* a risk factor for violent victimisation, this is not a justification for victim-blaming.

Partly as a result of her past negative experiences with alcohol use, Participant 11 felt that women should not drink. In her interview she said: "alkohol is nie bedoel vir 'n vroumens nie" *[alcohol is not meant for a woman]* and "['n man] kan maar alkohol gebruik as hy wil, maar 'n vrou moet nie alkohol gebruik nie" *[(a man) can drink alcohol if he wants to, but a woman must not drink alcohol]*. While she is the only one who voiced this particular opinion, some of the other interview participants as well as participants from one of the focus groups constructed alcohol use as a predominantly male activity. Traditionally, heavy alcohol use has been considered a masculine behaviour with being able to drink excessively and hold one's liquor as important elements of masculinity (Conroy & De Visser, 2013; De Visser & Smith, 2007; De Visser & McDonnell, 2012). Conversely, women who drink heavily tend to be positioned as unfeminine because their alcohol use can lead to unwomanly conduct such as sexual disinhibition and impaired maternal behaviour - traditional discourses of femininity expect women to remain in control and responsible (De Visser & McDonnell, 2012).

In the present study Participant 11 clearly represented alcohol use as a masculine activity. In her discussion of the drinking patterns of her mother and father Participant 6 did the same. In her interview she said that her father did not drink very much and that because of this "hy was soos 'n vrou gewees" *[he was like a woman]*. The implication here is that drinking very little is what women do, while drinking heavily is what men do. In the first focus group discussion alcohol use was also linked to masculinity. One of the female participants spoke about a male friend of hers who drank and said:

> Female Participant 4: […] toe [hy] nou gewerk het en gedrink het, toe het [hy] hope vriende. Want hy was mos 'n mannetjie - as hy geld het, hy koop mos [alcohol] net

[(…) when (he) worked and drank, then (he) had lots of friends. Because he was a real man – if he had money, then he would buy (alcohol)].

For Female Participant 4, the ability of this male friend of hers to buy and consume alcohol means that he is a "real man". Like Participants 6 and 11, alcohol use is represented by her as a masculine activity. This representation was also illustrated through the language that participants used when describing alcohol use. Several of the interview participants as well as some of the focus group members referred to alcohol as "hom" *[him]* which ultimately serves not only to personify alcohol use, but to masculinise it.

This is not to say that in this community drinking was done more by men than it was by women – it was clear from the interviews and focus groups that *both* men and women drank alcohol in the community. In fact, some participants reported that their male partners did not drink at all, or drank very little, which will be explored in more detail in the following analysis section. However, there were still some members of this community who constructed alcohol use as a predominantly masculine activity and something which was not suited to women. In this way these participants anchored their understanding of alcohol use within the context of traditional discourses of masculinity and femininity. The danger with this is that it may make men feel as though they *need* to drink in order to prove their masculinity (De Visser & Smith, 2007), while it positions women who drink as not feminine enough (Lyons & Willott, 2008) - drinking causes them to lose control and engage in traditionally unfeminine behaviours such as fighting or arguing, or putting themselves in potentially risky situations. Alcohol use as violating traditional gender roles may be particularly pertinent for mothers who drink, which will be discussed in the final section of this analysis.

In some cases the interview participants' partners appeared to disapprove of the participants' drinking because they viewed it as unfeminine. Participant 9 noted that her boyfriend: "wil mos nie hê ek moet drink nie" *[does not want me to drink],* because he felt that she became "onbeskof" *[unmannered]* when she had been drinking. A bit further on in her interview she said: "[My kêrel] het vir my gesê ek moet nie drink nie want ek is mos nou swanger" *[(My boyfriend) said to me that I must not drink because I am pregnant]*. Indeed for those participants who, like Participant 9, ceased alcohol use during their pregnancy, a commonality that emerged across some of their interviews is that their partners played an influential role in their non-drinking. Participant 12's partner, like Participant 9, also wanted her to stop drinking when he found out she was pregnant, as he did not want their child to be damaged from alcohol use:

> Participant 12: My outjie het my baie gesê ek sal die drank moet los want hy wil nie 'n kind hê wat se kop nie lekker is of so nie *[My boyfriend told me a lot that I must stop drinking because he did not want to have a child who was not right in the head]*.

Interestingly the participants' partners speaking to them about ending their drinking draws on the patriarchal discourse (Kiguwa, 2004). It is subtly alluded to in Participant 9's and 12's word choice when they talk about their boyfriends saying to them that they "moet nie drink nie" *[must not drink]* (Participant 9) and that they "die drank moet los" *[must stop drinking]* (Participant 12). Rather than their partners *asking* them to stop drinking, they clearly *told* them to do so, almost as though they were issuing a command that they felt the participants must obey. Participant 6 noted that she did not drink during her first two pregnancies, and when exploring possible reasons as to why, she said that her partner at that time:

> Participant 6: […] wou mos nie gehad het ek moet drink nie. Ek mag nie eers tussen mense geloop het nie, of vrinne of so nie *[(...) did not want me to drink. I must not walk amongst people or even friends]*.

Participant 6's partner through this extract is constructed as controlling Participant 6's actions – he had authority over her drinking and also over with whom she could associate. Participant 3, who stopped drinking upon discovering she was pregnant, also discussed her partner's role in this:

> JK: […] so till the end of your pregnancy in Augustus het jy nie gedrink nie? *[(...) so till the end of your pregnancy in August you did not drink?]*.
>
> Participant 3: Nooit. My boyfriend was streng. Hy is baie streng op drank *[Never. My boyfriend was strict. He is very strict about alcohol]*.
>
> JK: So he didn't want you to drink?
>
> Participant 3: No.

Again we see a partner of the participants who is constructed in a controlling and authoritative role – one of the reasons why Participant 3 did not drink in her pregnancy is because her partners' strictness disallowed her from doing so. In this way Participants 3, 6, 9 and 12 are constructed in a submissive position in which they are under the control of their dominant partners.

While it is no doubt of immense benefit to have partners who support their pregnant wives or girlfriends in not consuming alcohol during their pregnancy, the *way* in which this support is given amongst these interview participants is potentially problematic because of the way that it draws on the discourse of patriarchy. The male partners are positioned as

having control over the participants drinking and because of their submissive position the female participants submit to this control and therefore do not drink. It is the male partner who has the authority in this decision, and not the pregnant woman herself. Rather, these women should be empowered to make this decision themselves, and their partners should be encouraged to play a more encouraging and compassionate role in this, as opposed to a restrictive and controlling one.

For other participants who did not drink prenatally restrictions placed on them by their parents appeared to support non-drinking. For example, some participants who reported not drinking during their first pregnancies (when they were teenagers and living at home with their parents) emphasised the role that structure and rules enforced by their parents played in this. When discussing why she thought she did not drink in her first pregnancy, Participant 4 said:

> Participant 4: Daai tyd was ek nog in die huis. My ma-hulle […] was 'n bietjie hard gewees. Jy mag nie sulke dinge gedoen het nie *[That time I was still in the house. My mom and them (...) were a bit strict. You could not do certain things]*.

Similarly, Participant 1 noted that she did not drink during her first pregnancy when living with her parents:

> Participant 1: In my parents' house there's rules […] My ma het nie toegelaat laat ek met mans worry nie […] Ek mag nooit geloop het nie. Ek moet skool gaan en jy moet leer *[In my parents' house there were rules (...). My mom did not want me to worry with men (...) I must never walk around. I must go to school and I must learn]*.

For Participants 1 and 4 growing up in an environment in which their parents enforced certain rules and also placed restrictions on their behaviour played a significant role in their non-drinking during pregnancy. Notably, more encouraging and compassionate social support for non-drinking was also evident in some of the participants' accounts, which will be discussed in the following section on the stigma attached to alcohol use during pregnancy.

The Stigma Attached to Drinking Alcohol During Pregnancy

Stigmatisation refers to negatively labelling a certain behaviour or personality characteristic which deviates from the social norms of a particular society or community and often results in discrimination (Gaebel, Zäske, & Baumann, 2006; Link & Phelan, 2001). Substance misuse is a highly stigmatised behaviour - individuals in need of help with addiction or dependency problems often hide or deny that they have a problem for fear of being negatively labelled by others (Myers, Fakier, & Louw, 2009; Sorsdahl, Stein, & Myers,

2012). Although men are stigmatised for substance abuse, women with substance misuse problems tend to experience much higher levels of stigma (Myers et al., 2009; Radcliffe, 2011; J. M. Sanders, 2012). A possible reason for this could be that female substance abuse is generally associated with sexual availability and promiscuity as well as an inability to fulfil traditional gender roles (Myers et al., 2009), such as pregnancy and motherhood.

Increasingly, motherhood is seen to begin with pregnancy: A pregnant woman is expected to place the needs of her fetus as primary and to protect her fetus from any potential harm (Baxter, Hirokawa, Lowe, Nathan, & Pearce, 2004; D. Lupton, 2011). The responsibility to ensure the optimum health and development of the fetus is oftentimes placed solely on the pregnant individual (D. Lupton, 2011). Accordingly, a woman who fails to live up to this expectation that is placed on her - by, for example, consuming alcohol - is seen as an irresponsible, selfish and poor mother (Baxter et al., 2004). Women who drink during pregnancy are seen to deviate from societal norms and are stigmatised on the basis of their failure to properly fulfil their gendered reproductive role as mothers (J. M. Sanders, 2012; Stengel, 2014).

Consequently, pregnant women who use and abuse substances are often publicly shamed and punished for their actions. Furthermore, the stigma that they experience may prevent them from seeking help because of a fear of being judged and persecuted by others (Greaves & Poole, 2005) - stigma has been found to be a major barrier to pregnant women who use legal or illegal substances seeking effective treatment (Finnegan, 2013). In some extreme cases, in particular in the United States, punitive measures have been taken against pregnant addicts, including criminal prosecution (Young, 1994). This undoubtedly increases stigma and the reluctance of women to seek help with decreasing their substance use. In the present study, it was clear that in Madison alcohol use during pregnancy was represented as a stigmatised behaviour.

Inconsistencies, lack of detail and defensive behaviour

This was illustrated in several ways within the interviews and focus groups. For instance, it was demonstrated indirectly in *how* some of the interview participants discussed their drinking and their pregnancy. For example, some of participants stated that they had stopped drinking upon finding out they were pregnant, but there were parts of their interviews which seemed to indicate otherwise. When I asked Participant 5, for example, if she had continued to drink alcohol upon finding out she was pregnant her response was that she had

not. But further on in the interview when I asked her to explore her drinking in the early months of her pregnancy she said:

> Participant 5: Dit was nie vir my lekker nie. Mense het baie met my gepraat ek moet ophou as ek wil 'n gesonde kind hê *[It was not nice for me. People spoke to me a lot about stopping if I wanted to have a healthy baby]*.

This reveals an inconsistency in her story - it indicates that there *was* a time that she drank alcohol while being aware of her pregnancy, which stands in contrast to her response that she had stopped drinking upon finding out she was pregnant. There were a few other participants with similar inconsistencies in their stories, and also others who were not always very forthcoming with regards to their drinking behaviour during their pregnancy. Participant 2, for example, was 7 months along in her pregnancy when she was interviewed and she admitted to drinking every weekend throughout those 7 months. But when I attempted to elicit more detail on her drinking behaviour during these months the answers she gave were very short and clipped. For instance, when I asked her what sort of thoughts she had when drinking her response was "uh, niks nie" *[no, nothing]*. Indeed throughout the interview she appeared defensive about her alcohol consumption. Her evasiveness, when I probed for more specific details on her drinking, could indicate a social desirability bias – she may have wished to avoid answering my questions on her drinking so as to create a good impression (Grimm, 2010). Indeed social desirability bias has been known to decrease reports of prenatal alcohol use, particularly in face-to-face interviews (Skagerström et al., 2011). Through the inconsistencies and lack of detail in their stories, these participants indirectly demonstrated their awareness that their alcohol use would potentially harm their unborn babies, and that they do not want to be judged, by me, for this. In this way, they represented prenatal alcohol use as a stigmatised and frowned upon activity.

The defensiveness apparent in Participant 2's interview was also discussed by another interview participant who described witnessing this sort of defensive behaviour amongst other pregnant women in her community who drank:

> Participant 5: […] hier is party vrouens [wat drink tydens swangerskap], en mens praat met hulle, maar hulle steur hulle nie aan jou nie. Dis net, "jy sê nie vir my nie, dis my kind" *[(…) here there are some women (that drink during pregnancy), and people speak to them, but they do not pay any attention. They say "Don't tell me what to do, it's my child"]*.

While some people in the community attempted to speak to pregnant women about their drinking, these women would become indignant and defensive, and did not want to

listen to what others might have to say. In the second focus group discussion I asked the participants how they would respond if they were to see a pregnant women drinking in their community and they said:

> Female Participant 4: Mens kan hulle aanspreek, maar- *[A person can speak to them, but-]*
>
> Male Participant 5: Dan skel hulle vir jou uit *[Then they will scold you]*.
>
> Female Participant 4: Dan skel hulle vir jou uit. Hulle sê "Dis niks met jou te doen nie, dis my lewe en ek drink. Ek vra nie vir jou nie" *[Then they will yell at you. They say, "It's nothing to do with you, it's my life and I drink. I am not asking you"]*.
>
> (Focus Group 2)

Like Participant 5, the two participants in the second focus group discussion felt that pregnant women who drink in their community would become defensive if someone were to approach them about their drinking. This illustrates another way in which alcohol use during pregnancy is represented as a stigmatised behaviour: the focus group members' concern with the defensiveness of pregnant women who drink indicates that they were disapproving of and frowned upon drinking during pregnancy, thereby stigmatising their actions.

Personal responsibility and individualism

Another way in which alcohol use during pregnancy was represented as a stigmatised behaviour was through the discussion by two of the participants of the deaths of their babies which they felt was as a result of their drinking: Alcohol exposure during the prenatal period is associated with stillbirth, preterm delivery and sudden infant death syndrome (Bailey & Sokol, 2011). Participant 1 when talking about the death of her baby said, "Dis my skuld" *[It's my fault]* and "Ek verwyt my elke dag" *[I blame myself every day]*. Similarly, Participant 11 noted:

> Participant 11: Ek het die mistake gemaak, ek moes nie alkohol gebruik het nie, want dit het die baba aangetas. En baie dae dan dink ek, ja, dit hang van my af, ek is die oorsaak. Ek is die probleem, en ek verwyt self vir my *[I made the mistake, I should not have used alcohol, because it damaged the baby. And many days I think, yes, it is because of me, I am the cause. I am the problem, and I blame myself]*.

What is clear is that Participants 1 and 11 both felt a tremendous amount of guilt and as though they were to blame for what happened. Relatedly, mothers of children with an FASD diagnosis often express feeling guilty over their prenatal alcohol use (Campbell, 2007; Zabotka, 2012). Participant 1's and 11's discussion of feelings of guilt and blame illustrates

that they "took on" the stigma and shame associated with drinking during pregnancy in their community. For Participant 11, taking on this shame and stigma was in some way reduced when she decided to stop drinking – she saw the death of her baby as a motivating factor to give up alcohol use: "Toe ek nou besef ek het my babatjie verloor, toe los ek nou alles […] toe besluit ek, nee, nie nou meer nie" *[When I realised I had lost my baby, then I left everything (…) then I decided, no, not anymore]*.

Participant 1, on the other hand reported that she still drinks; she expressed a strong desire to stop but felt unable to do so. Her feelings of shame and guilt over what happened seemed to be all consuming. She felt that her teenage son was ashamed of her and that her partner blamed her for what happened to their baby. She was also fearful as to how other pregnant women who were part of the HMHB© programme would react to her if she was around them. In her interview she noted: "Hoe gaat ek nou voel, hier sit al die mommies nou, en nou sit ek nou" *[How will I feel now, here sit all the mommies now, and here I sit]*. Participant 1 therefore worried about how other expectant mothers would react to her and treat her given what happened to her baby - it appears that she may have feared being discriminated against because of her prenatal alcohol use. Indeed before my interview with her began, she wanted to ensure that there would be no one else present. What this suggests is that she internalised the shame and stigma that is associated with drinking during pregnancy in her community.

Participant 1's and 11's discussion of the guilt they felt for their prenatal alcohol use and the subsequent death of their babies draws upon two related discourses of personal responsibility and individualism. With the discourse of personal responsibility the onus is put on the individual engaging in a health risk behaviour (like smoking or drinking) as being solely responsible for any negative health-related outcomes (Mejia et al., 2014). This discourse resonates well with ways of thinking that Westernised societies endorse - namely, self-governance, self-sufficiency, free choice and independence (Sun, 2014). It reflects the ideology of liberal individualism in which individuals are positioned as having the choice as to how they should think or act. Individuals, rather than social structures, are seen as being responsible for managing individual harms and risks to their bodies, which includes a pregnant woman's decision on whether or not to drink (Baxter et al., 2004; Hunting & Browne, 2012; Lindsay, 2010; D. Lupton, 2012). In line with both of these discourses, the pregnant individual is seen as being responsible for making the right choice - in other words, she should choose not to drink, and those who do not make this choice are seen to be in

breach of their responsibility to take care of their fetus (Benoit et al., 2014; Hunting & Browne, 2012; Young, 1994).

In the present study, Participant 1 noted in her interview: "Nou ek sê aanmekaar, dis my skuld" *[Now I say over and again, it's my fault],* and Participant 11 said: "Dit hang van my af" *[It is because of me]* when they discussed the loss of their babies. These excerpts and the ones noted above clearly illustrate the immense personal responsibility they both felt for the death of their babies. Through the way in which they spoke about their feelings of guilt and shame over what happened, they positioned themselves as having made the wrong choice (i.e., to drink while pregnant) and thereby failing to take responsibility for their fetuses. In her interview Participant 11 also said:

> Participant 11: Swangerskap is mos vir jou om jou gelukkig te maak, want hier's mos nou 'n mens in jou. Jy het mos nou 'n baba in jou maag […] Maar […] ek het dit nie kop toe gevat nie *[Pregnancy is meant to make you happy, because there is a person inside you. You have a baby in your stomach (...). But (...) I did not take it seriously.*

It is not only Participant 1's and 11's accounts of the loss of their babies which fall within the discourses of individualism and personal responsibility - the stigmatisation of drinking during pregnancy draws on these discourses too. When a pregnant woman is stigmatised and shamed for her drinking, she is indirectly positioned as the one who is solely responsible for the health and well-being of her unborn baby; and her "choice" to neglect this responsibility by, for example, consuming alcohol, positions her as a poor mother (Baxter et al., 2004; D. Lupton, 2011). The discourses of personal responsibility and individualism are therefore potentially problematic when it comes to the way in which we frame and understand alcohol use during pregnancy. Not only could they be harmful to individuals like Participants 1 and 11 (in the case of Participant 1, the immense guilt and shame she felt has actually driven her to contemplate suicide), but they also decontextualise alcohol use during pregnancy by failing to take into account the social and structural issues that contribute to substance misuse amongst pregnant women (Hammer & Inglin, 2014; Hunting & Browne, 2012). Women who abuse alcohol while pregnant often come from a low socioeconomic background (May & Gossage, 2011b; Skagerström et al., 2011) in which they experience various forms of marginalisation and social inequity including low education, unemployment and inadequate access to housing, material resources and substance abuse treatment (Benoit et al., 2014; Myers, Louw, & Fakier, 2008; Myers et al., 2010; Watt et al., 2014).

In the present study, only one participant had completed high school (and one was presently in high school when she was interviewed), one had not finished primary school, and

two had received no schooling. Furthermore, they were all dependent on either their parents or partners for income, with three of the participants also receiving social grants (in South Africa, these are means-tested grants only available to the very poor). These social and structural factors play a pivotal role in the ability of pregnant women to make positive lifestyle changes (Leppo, 2012), such as reducing their alcohol intake.

The subject position that is opened up through the stigmatisation of drinking during pregnancy – and which falls within the discourses of individualism and personal responsibility - is one in which the pregnant individual is made to feel solely responsible for adopting behaviours that will optimise the health and well-being of her unborn baby. As one female participant in the second focus group discussion noted:

> Female Participant 3: Ek dink nie ’n swanger vrou moet drink nie omdat jy verantwoordelik is vir daai lewe binne-in jou *[I do not think a pregnant woman should drink because you are responsible for that life inside of you]*
> (Focus Group 2).

And if a pregnant woman fails to take responsibility for her unborn baby by consuming alcohol, she could be shamed and seen as a bad mother by other community members. Female Participant 3 noted later on in the group discussion:

> Female Participant 3: Maar as ’n mens gedrink is en jy is swanger, dan dink ek nie die mens is ’n goeie ma in jou huis nie *[But if a person is drunk and she is pregnant, then I don’t think that person is a good mother in her house]*
> (Focus Group 2).

But the point of critiquing the discourses of individualism and personal responsibility is not to deny the importance and value of an individual taking responsibility for his/her actions when it comes to health risk behaviours like alcohol misuse during pregnancy (Sun, 2014). Indeed in the present study there were several participants who seemed to embrace individualistic thinking and personal responsibility-taking when it came to making a decision to stop drinking during their pregnancy. For example, Participant 13 noted that she decided to stop drinking a few months into her pregnancy and when talking about it she said: “dit was maar net my eie wil” *[it was just my own will]*. Similarly, Participant 5, who also stopped drinking a few months into her pregnancy, noted: “En later toe besluit ek, nee, dis nie die moeite werd om so aan te gaan nie, ek wil ’n ander paadjie stap” *[And later I decided, no, it’s not worth the effort to carry on like this, I want to walk a different path]*. Participant 12, who also decided to stop drinking a few weeks after finding out she was pregnant felt that stopping drinking “was vir my maklik gewees, want ek het net vir myself gesê ek moet dit

los" *[was easy for me, because I just told myself that I must stop it]*. For these participants it is clear that having a personal sense of control and choice, and taking responsibility for their actions, was an important element in their decision to stop drinking. It is likely that this decision-making process is partly a reflection of the approach taken by FARR in their HMHB© programme: the fieldworkers who work with the programme participants are taught to encourage the pregnant women to start valuing themselves in a hope that this will improve their self-esteem (Jaco Louw, personal communication, June 23, 2014).

The discourses of personal responsibility and individualism open up a much more positive subject position for those participants who chose to stop drinking during their pregnancy as it offers them a position in which they are able to feel empowered and confident to make positive life changes. But perhaps these participants were able to stop drinking not *only* because of the personal responsibility they took in this decision, but because they also had access to some form of social support. While not all of the participants directly acknowledged the role support systems played in their non-drinking, it was still evident from their interviews that they had contact with some form of social support (a more restrictive form of social support was discussed in the previous section). For example, even though Participant 13 in her interview when talking about her decision to stop drinking said that it was "net my eie wil" *[just my own will],* she also noted that one of the fieldworkers from FARR was supportive in her non-drinking too: "Sy het baie met my gepraat - ek moenie so nie, ek moet dink aan my babatjie se lewens" *[She spoke to me a lot - I mustn't do that, I must think about my baby's life]*. It appears that the support offered by the FARR fieldworker through her ongoing discussions with Participant 13, helped her in her decision to stop drinking.

For other participants who ceased drinking during their pregnancy, their social support seemed to come from the non-drinking of their partners. Participant 10, for example reported that when she and her partner found out she was pregnant "toe los ons die drank" *[then we stopped drinking]*. She was the only one to directly link her partner's non-drinking to her own decision to stop drinking - In her interview she said: "[…] hy wil by my staan. Ons doen dit eintlik vir ons baba" *[(...) He wanted to stand by me. We actually did it for our baby],* clearly showing the supportive role her partner played in her pregnancy. While none of the other participants explored the role their partners' non-drinking played in their own decision not to drink, it is bound to have had a positive influence. Intimate partners may be able to play an important role when it comes to pregnant women wanting to stop using or abusing substances. For example, partners of pregnant smokers who are also trying to quit

smoking are perceived as more supportive by pregnant women than non-smoking partners (McBride et al., 2004). When it comes to prenatal alcohol use, the effects of a brief intervention with pregnant women using alcohol are significantly enhanced when their partners participate in the intervention (Chang et al., 2005). In the present study, it appears that for those who stopped drinking during their pregnancy, both social support along with personal responsibility and individualistic thinking played an important role in their non-drinking.

However, it is important to note that the discourses of personal responsibility and individualism did not resonate positively with all the participants: Participants 1 and 11 appeared to internalise them in a negative way, and several other participants who drank for most of or throughout their pregnancies did not draw on these discourses in their interviews, which could indicate that they require an alternative way in which to understand and frame their drinking, in order for them to consider stopping. For some participants their desire to be a good mother to their children was a motivating factor for ceasing alcohol use, which will be discussed in the following section.

Alcohol Use and Motherhood

Maternal and child health was a top priority of the South African government post-apartheid (Chopra, Daviaud, Pattinson, Fonn, & Lawn, 2009), and currently over 90% of pregnant women in South Africa attend antenatal care and have a skilled attendant when giving birth (Silal, Penn-Kekana, Harris, Birch, & McIntyre, 2012). But despite this, mortality rates for mothers and children in the country are high (Chopra et al., 2009). It is estimated that each year 2,500 mothers die, 20,000 babies are stillborn, and nearly 22,000 babies will die before reaching 1 month of age (Pattinson & Maternal, 2008). These high mortality rates are in part due to the deficiencies in access to maternal health care services that still exist. For example, in rural areas of South Africa, pregnant women have the lowest coverage of antenatal care and face considerable barriers in accessing health care services including long and expensive travel times and high costs associated with delivery (Silal et al., 2012; Wabiri et al., 2013).

In an effort to improve maternal and child health and well-being - and ultimately to lower the rates of FASDs - FARR, through their HMHB© programme, wish to improve pregnant women's knowledge of the prenatal period, to educate these women about how to best look after themselves and their unborn babies, and to support them throughout their pregnancies. One way in which these women are supported is through encouraging them to

value their pregnancy and emphasising the positive side of the experience. FARR's programme theory is that if the participants are able to see their pregnancies in a positive light, they will focus on ensuring that they adopt healthy lifestyle choices, which will obviously be of benefit to both their own health and the health of their unborn babies (Jaco Louw, personal communication, June 23, 2014).

Pregnancy is a significant life event during which positive decisions to do with health-related behaviour can be made, and pregnant women often express a strong desire to create healthy conditions for the growth and development of their fetus (April et al., 2010; Greaves & Poole, 2005). In studies that include pregnant women and mothers in treatment for substance abuse problems, participants report that the discovery of their pregnancy was a "moment of change" (Söderström, 2012, p. 462) or a "turning point" (Radcliffe, 2011, p. 986) which made them re-evaluate their substance use and engage with treatment services (Radcliffe, 2011). One particular approach to alcohol abuse treatment is to use brief interventions in emergency departments of health care facilities where substance abuse related injuries are seen to provide a "teachable moment" in which patients may be contemplating a change in their behaviour and are therefore more receptive to an alcohol intervention (Nilsen et al., 2008; Walton et al., 2008). Similarly, pregnancy could also be seen as a "teachable moment" to capitalise on in the provision of substance abuse services.

It was clear from the interviews in this study that many of the participants identified with the emphasis that was placed, in the HMHB© programme, on pregnancy as a positive experience. Those participants who stopped drinking during their pregnancy stressed that their desire to have a healthy baby was a strong motivating factor in this decision, a finding evident in other research on prenatal alcohol use (Chang, Goetz, Wilkins-Haug, & Berman, 2000). Indirectly alcohol use was represented by these participants as a behaviour that would impede their desire to have a healthy baby. When I asked Participant 3 what made her decide to stop drinking upon discovering she was pregnant she said:

> Participant 3: Ek het besluit die baba is meer belangrik as die drank […] en ek kan nie so aan gaan nie. Want as ek aanmekaar gedrink het, dan sal hy gestremd of gebreklik gewees het *[I decided the baby is more important than the drinking (...) and I could not carry on like that. Because if I had carried on drinking, then he would have been disabled or retarded*[5]*]*.

[5] This is a direct translation from Afrikaans.

Participant 3 weighed up the health and well-being of her unborn baby against alcohol use, and chose to put her unborn baby's needs first. Participant 12 made the same decision - upon finding out she was pregnant (three months into her pregnancy) she continued to drink for another two weeks and then decided to stop:

> Participant 12: Toe besluit ek maar ek moet die drank los. Want die drank is 'n bad influence op my kind. As ek 'n gesonde kind wil hê, dan moet ek die drank los *[Then I decided that I must stop drinking. Because the drinking is a bad influence on my child. If I want to have a healthy child, then I must stop drinking]*.

Similar to Participant 3, Participant 12 valued the health of her unborn baby more than her alcohol use and decided that it was imperative for her to stop drinking in order to ensure that she could give birth to a healthy child. Importantly, even though drinking during the first trimester increases the odds of an FASD diagnosis by 12, if the pregnant individual ceases drinking after the first trimester the odds of having an FASD child decrease by 5 times (May et al., 2013). Participant 12's decision to discontinue drinking when she did therefore improved her chances of having a healthy baby.

Responsible mothering and competing rights

The decision of Participants 3 and 12 (and also other participants who stopped drinking during their pregnancy) to put the health of their unborn babies first draws on the discourse of responsible mothering, which is closely linked to the related discourses of personal responsibility and liberal individualism. According to the discourse of responsible mothering mothers are positioned as being morally obligated to protect and optimise the health and well-being of their unborn babies and infants, and to place the needs of their offspring before their own (Baxter et al., 2004; Benoit et al., 2014; D. Lupton, 2011; Radcliffe, 2011).

In the present study the accounts of Participants 3 and 12 reveal that they view the health and well-being of their fetuses as vitally important, and they feel they must protect their fetuses from any potential harm. This illustrates their wish to conform to the responsible motherhood ideal, a finding present in other research on substance use during pregnancy too (Baxter et al., 2004; Radcliffe, 2011; Watt et al., 2014). Pregnancy seemed to open up an opportunity for some of the interview participants to cease their alcohol use – their desire to prioritise the health of their unborn babies motivated them to stop drinking. In Participant 12's account she used the words "ek moet die drank los" *[I must stop drinking],* emphasising that she sees non-drinking during pregnancy as an imperative or a moral obligation. When I

asked Participant 9 for her thoughts on alcohol use during pregnancy she responded in a similar way:

> Participant 9: Ek dink net dis verkeerd. Ons moet nie drink as ons swanger is nie want dit kan die baba ook aanraak, as jy alkohol gebruik tydens swangerskap *[I just think it's wrong. We must not drink if we are pregnant because it can also harm the baby, if you use alcohol during pregnancy]*.

Noteworthy is Participant 9's use of the word "ons" *[we]* – she applied this imperative of non-drinking while pregnant to not only herself, but all pregnant women. The consumption of alcohol is therefore anchored by these participants into the context of responsible mothering: it is represented as something which would prevent them from fulfilling their obligation as responsible mothers to ensure the health and well-being of their fetuses. Relatedly, they position themselves as personally responsible for protecting their fetuses from any potential harm.

There can be no doubt that the decision of some of the participants to prioritise the health of their unborn babies - and therefore not consume alcohol - results in a positive outcome: not drinking during pregnancy helps to ensure the health and well-being of both the pregnant woman and her unborn baby. And for those participants who stopped drinking, their desire to be a responsible mother and put the health of their fetuses first appeared to resonate positively with them. However, what of those pregnant women who do not embrace this way of thinking? In particular, what of those women who feel uncertain about their pregnancies - particularly if they are unplanned - which in the present study appeared from the interviews to be the case for all the participants. One study of pregnant and post-partum women in a township in the Western Cape found that those women who did not express a strong attachment to their pregnancy or unborn babies, or were resistant to becoming mothers, continued drinking heavily during their pregnancies. This lack of attachment was bound up in the fact that their pregnancies were not planned. In fact some women reported that they drank heavily in the early stages of their pregnancy in an attempt to abort the fetus (Watt et al., 2014).

In the present study, none of the participants spoke directly about a lack of attachment to their pregnancy or unborn babies, but there were a few participants who experienced some doubts over their pregnancy. Participant 1 in her interview noted: "Partykeer het dit vir my gevoel ek moet sommer […] val laat ek 'n miskraam kan kry" *[Sometimes it felt like I must just (...) fall so that I can have a miscarriage]*. For Participant 1, the reservations she held about her pregnancy were connected to feeling unsupported and unloved by her partner who

was having an affair with another woman while she was pregnant with his child. When Participant 12 found out she was pregnant she expressed similar reservations:

> Participant 12: In die eerste plek was dit vir my ’n skok gewees want ek wil nie weer swanger gewees het nie. Want […] ek wil nog verder gaan met my lewe, verder gaan studeer. Ek wil nog my eie ding gedoen het *[In the first place it was a shock for me, because I did not want to be pregnant again. Because (…) I want to go further in my life, study further. I still want to do my own thing]*.

A bit further on in Participant 12’s interview she spoke about taking a few weeks to think about the pregnancy and “of ek verder gaan met die swangerskap en of ek dit gaan beëindig” *[If I wanted to go further with the pregnancy or if I wanted to terminate it]*. As already established, Participant 12 did decide to see her pregnancy to full term (as did Participant 1), and once she had made this decision she seemed to embrace being a responsible mother and putting the health of her unborn baby first. However, it is still important to note that for those women who, like Participants 1 and 12, are having reservations about carrying on with their pregnancy to full-term, the discourse of responsible mothering may not necessarily resonate with them: If they feel obligated to put the needs of their unborn baby before their own, they may well feel pressured to continue with a pregnancy which they do not want, or are unprepared for. Relatedly, they may feel shame or guilt if they feel unable to conform to the responsible motherhood ideal (D. Lupton, 2011). Indeed Participants 1 and 11 both felt a tremendous amount of guilt over their alcohol use and the resultant loss of their babies.

The prioritisation of the health and well-being of the fetus alludes to another potentially problematic discourse, namely, the discourse of competing rights (Greaves & Poole, 2005). Major developments in the sphere of biomedical technology have made it possible to view the developing fetus in the womb and have also greatly improved our understanding of its developmental needs (Logan, 1999; D. Lupton, 2012). One outcome of these advancements is that they have “legitimated a vision of the fetus as a ‘second patient’ ” as well as revived the “notion of the mother as ‘vessel’ who merely provides a host environment for the growing embryo” (Logan, 1999 p. 131). Increasingly, therefore, it is being argued that fetuses have “rights” that need to be protected, and often these rights are seen as superior to those of pregnant women (Flavin & Paltrow, 2010). As a result, the focus of the media, the public and the law is oftentimes on the health and welfare of the fetus, and seldom on the health and welfare of the pregnant woman herself (Benoit et al., 2014; Greaves & Poole, 2005). In the case of pregnant women who have substance misuse problems, their

rights are often put second to the rights of their fetus (Flavin & Paltrow, 2010) which serves to position the health and well-being of pregnant women as less important than the health and well-being of their unborn children (Benoit et al., 2014)

A problem with this discourse is that it draws attention away from significant social problems such as limited access to health care (Flavin & Paltrow, 2010) which, as already noted, is a considerable problem for some pregnant women in South Africa (Silal et al., 2012; Wabiri et al., 2013). Furthermore, it fails to contextualise pregnant women's lives, health and experiences: Pregnant women with substance misuse problems often face other difficulties including poverty, poor mental health and trauma (Greaves & Poole, 2005). Indeed the pregnant women in the present study faced a variety of psychosocial stressors including unemployment, physical and sexual abuse, and infidelity of partners, and - as has already been discussed - some of them linked these problems to their decision to drink.

An inherent danger with the competing rights discourse and the responsible mothering discourse is that if we focus too much attention on the "rights" and needs of the fetus it will detract attention away from the health and welfare of the pregnant woman, as well as the social context within which her decisions and behaviour need to be understood (Greaves & Poole, 2005; Sun, 2014). Furthermore, these discourses can become a barrier for pregnant women seeking substance abuse treatment who may fear prejudicial treatment on the basis of their substance use (Poole & Isaac, 2001). If pregnant women using and abusing alcohol are made to feel as though they have failed to protect the interests of their fetus, they may not want to come forward and admit they have a problem. In addition, poor South African communities like Madison already face significant barriers in accessing substance misuse treatment services (Myers et al., 2010).

An alternative approach to substance misuse treatment for those pregnant women with whom the responsible mothering ideal does not resonate could be brief motivational interviewing, which FARR make use of for both their group and one-on-one sessions in the HMHB© programme (Jaco Louw, personal communication, June 23, 2014). This is a directive and client-centred counselling approach that aims to both instigate an individual's motivation to change their health risk behaviour as well as to minimise their resistance to change (Floyd et al., 2007; Jansen Van Vuuren & Learmonth, 2013; Miller & Rollnick, 1991). Women who have reservations about their pregnancy may well benefit from this approach because of its emphasis on empathetic and non-judgemental respect for the individual's autonomy as well as supporting their self-efficiacy when it comes to making decisions about their behaviour (Floyd et al., 2007; Jansen Van Vuuren & Learmonth, 2013).

Additionally, motivational interviewing has been shown to be effective in reducing prenatal alcohol use in two rural South African communities (Marais et al., 2011; Rendall-Mkosi et al., 2013).

Bad mother versus good mother

The participants' discussion of alcohol use and motherhood was not only focused on their pregnancy, but also on the mothering of their babies and young children. The importance of the mother-infant relationship when it comes to children's development is well-established (Parfitt, Pike, & Ayers, 2014; Snyder, Shapiro, & Treleaven, 2012) and the ability of a mother to attune to and regulate the needs of her infant and respond appropriately has significant implications for the overall and relational development of the child. Secure attachment between a mother and her infant results in beneficial results for the child, while insecure attachment can put them at risk for developmental difficulties (Snyder et al., 2012). Mothers who present with alcohol or other drug abuse problems may not be able to meet all the needs of their children, which places these children at an increased risk for physical, academic and social-emotional problems (Conners et al., 2004). As a result of this, mothers who abuse alcohol are often labelled as bad or unfit mothers to their children (Jacobs & Jacobs, 2014). This "bad mother" discourse dominates public discourses on substance-using pregnant women and mothers, who are positioned as posing threats to both their children and their communities (Bell, McNaughton, & Salmon, 2009; Reid, Greaves, & Poole, 2008; A. Salmon, 2004).

In the present study some of the participants drew on this bad mother discourse in that they represented their alcohol use as causing bad mothering of their children. When Participant 13 discussed her experiences with alcohol she noted that when she drank she became:

> Participant 13: […] ongeduldig met my kinders. Ek is snaaks met my kinders. Dis amper soos ek het 'n wreedheid in my siel as ek wyn gedrink het" *[(….) impatient with my children. I am strange with my children. It's as though I have a cruelty in my soul if I drink wine]*.

Similarly, Participant 4 noted that she became argumentative when she had been drinking and that sometimes this resulted in her taking out her frustrations on her children: "haal ek dit sommer op die kinders uit" *[I take it out on the children]*. In the case of Participant 10 she felt that when she drank she became a negligent mother:

> Participant 10: Ek het nie omgegee vir my twee kinders nie. Baie gedrink, dan worry ek nie van my kinders nie. Want as ek dronk is, dan wil ek net lê *[I did not care for my two children. Drank a lot, then I do not worry about my children. Because if I am drunk, then I just want to lie down]*.

Similarly, Participant 11 in her interview noted that when she drank she did as she pleased:

> Participant 11: Kom huis toe wanneer ek wil. Maar ek vergeet ek het 'n kind by die huis […] dan loop ek rond en ek kom wanneer ek wil. Of ek maak nie kos nie en hulle moet self kos maak want ek is op die dronk *[Come home when I want to. But I forget I have a child at home. (...) Then I walk around and come home when I want to. Or I do not make food and they must make food themselves because I am on a binge]*.

Through these representations Participants 4, 10, 11 and 13 position themselves as bad or unfit mothers when they are under the influence of alcohol. They felt that when they had been drinking they were unable to fulfil their motherly duties of taking care of their children and attending to their needs; a finding evident in other South African research performed with mothers with heavy drinking problems (Jacobs & Jacobs, 2014).

A problem with the bad mother discourse is that not only is it potentially harmful to women who are given this label and as a result could be at risk for being poorly treated by governmental services (Reid et al., 2008), or in the case of this study, women who appear to internalise this label, but it – like the discourses of responsible mothering and personal responsibility - also fails to adequately take into account the structural and contextual factors that contribute to "bad mothering" (i.e., substance misuse): it frames the behaviour as an individual choice without locating it within its broader context (Bell et al., 2009; A. Salmon, 2004).

Through Participant 10's and 11's accounts above a mother is given a very clearly defined role: she is seen as someone who needs to be at home with her children, caring for and looking after them. And for these participants a woman who drinks cannot be those things. Accordingly, alcohol use is not only represented as causing bad mothering, but also as *preventing* good mothering. In the second focus group discussion this was also explored. One participant in particular felt that a pregnant woman who drinks is not a good mother to her children:

> Female Participant 3: Want jy het snaakse maniere, en as jy dronk is maak jy nie jou huis skoon nie [...] Jy bly in die vuil huis *[Because you have strange manners, and if you are drunk then you do not clean your house (...) You live in that dirty house]*. (Focus Group 2)

For those participants who stopped drinking during their pregnancy, along with their desire to have a healthy baby and therefore prioritise the needs of their fetus, another motivating factor for their decision to stop drinking was their desire to be a good mother to their children. Participant 7, for example, said:

> Participant 7: Ek kan nie my kind grootmaak met drank nie. Dis nie reg nie. My kind kan miskien siek raak of so, dan is ek dronk. Dan weet ek nie wat fout is met my kind nie *[I cannot raise my child with alcohol. It's not right. My child could become sick or something, then I am drunk. Then I do not know what is wrong with my child]*.

Similarly, Participant 3 noted that she chose to stop drinking so that her baby would be healthy, and so that she herself would be healthy and therefore able to look after him:

> Participant 3: Die rede hoekom ek besluit het ek gaan die drank los met hom is […] ek wil 'n gesonde baba hê, en myself ook gesond wees. Ek wil vir hom sorg *[The reason why I decided I will stop drinking is (...) I want to have a healthy baby, and also be healthy myself. I want to care for him]*.

Similar to Participants 10 and 11, both Participants 3 and 7 represented alcohol use as a behaviour which would prevent them from being good mothers to their children. They both felt that if they were drinkers, they would be unable to care for and look after their children properly, which motivated them to stop drinking. It was clear from the interviews that most of the participants who had ceased drinking during their pregnancies wanted to emphasise this to me, and to represent themselves to me in a positive, rather than a negative light. For example, in Participant 5's interview I asked her about the alcohol use in her community and what happens to the children when their parents drink and she said: "Die kinders word in die huise toe gemaak. Die ouers loop en kom wanneer hulle wil" *[The children are locked at home. The parents come and go when they want to]*. When I asked her what she wanted to do with her *own* children she said:

> Participant 5: Ek wil alles vir my kind doen. Ek wil nie my kind in die huis toe sluit en loop en dan kom wanneer ek wil nie. Ek wil saam met hom in die bed klim en saam met hom op staan, en alles doen vir hom wat mooi is *[I want to do everything for my child. I do not want to lock my child in the house and go and then come back whenever I want to. I want to get into the bed with him, and get up with him, and do everything that is nice for him]*.

Through this description, Participant 5 represented drinking parents in a negative light by describing them as neglectful of their children. Simultaneously she represented herself, as a non-drinker, in a much more positive light by describing herself as a caring and attentive

parent to her child. In this way she is resisting the "bad mother" discourse by emphasising that she would never be a negligent or inattentive parent; in fact, she would be the exact opposite of this. This is similar to a study of pregnant and post-partum women in substance abuse treatment, where the author noted that in her interviews the participants were often seeking to persuade her of their worth as mothers (Radcliffe, 2011).

Alcohol use as preventing good mothering, and the related desire of some participants to be good mothers to their children, falls within a broader gendered discourse in which the natural and instinctual position of a woman is seen to be that of a mother (Gueta & Addad, 2013). Particularly since the 19th Century, womanhood has been seen as synonymous with motherhood. Being a mother or desiring to be a mother is viewed as a dominant influence in women's lives and is presumed to be the primary identity of most adult women (Arendell, 2000; Jacques & Radtke, 2012). Within this motherhood framework, the "good mother" is characterised as someone who is protective, instinctual and self-sacrificing. She is firmly dedicated and devoted to caring for her children, and meeting their physical and emotional needs (Arendell, 2000; Gueta & Addad, 2013; Reid et al., 2008; A. Salmon, 2004; A. Salmon, 2011).

Like the responsible mothering discourse, the good mother discourse is drawn upon in a positive way by some of the participants – their desire to be good mothers to their children has motivated them to stop drinking (A. Jackson & Shannon, 2013). Participant 5, like Participants 3 and 7, also gave up drinking during her pregnancy and discussed her desire to not only care for her baby, but to set a good example for him:

> Participant 5: […] ek wil na my baba mooi kyk. Ek wil mos nie hê hy moet in my voetspore volg as ek die drank wil drink nie, sien jy. Ek wil hê hy moet mooi loop, reguit *[(…) I want to look after my baby well. I do not want him to follow in my footsteps if I drink, you see. I want him to grow up well and walk straight]*.

Participant 5 was therefore concerned with her child's well-being – she wanted him to follow a positive and healthy life path, and felt that if she were to drink, she would not be setting a good enough example for him to do that. While the good mother discourse, like the responsible mothering discourse, results in a positive outcome for both the participants and their children, it is important to make note of the shortcomings of this discourse, and of the ideal of motherhood in general. Because motherhood is conceptualised as something which is meant to be natural and instinctual, women are expected to have a maternal instinct to love and care for their children, and to find this experience naturally rewarding. This makes it very difficult for women to express any feelings of dissatisfaction, disappointment, anger or

frustration they may have over their mothering experience (Gueta & Addad, 2013; Kruger, 2006; Mamabolo, Langa, & Kiguwa, 2009). Furthermore, if they do not find the mothering experience rewarding and fulfilling, they run the risk of being pathologised (Kruger, 2006).

The ideology of the "good mother" sets a high standard for mothers as it expects them to be selflessly devoted to their children and meet all their needs. Women who do not live up to this ideal (by, for example, drinking alcohol) may be made to feel as though they are unfit mothers (Bell et al., 2009). While those participants in the present study who stopped drinking felt inspired and motivated to take care of their children, not all pregnant women are going to have these sorts of positive feelings. For example, factors such as depression may hinder these feelings. In South Africa, rates of maternal depression are high, with one study performed in townships in Cape Town demonstrating that over a third of 1,145 pregnant women were depressed (Tomlinson et al., 2014). Furthermore, depression is a predictor of drinking during pregnancy (May & Gossage, 2001; May et al., 2009; Meschke et al., 2008; Skagerström et al., 2011; Tomlinson et al., 2014).

In the present study the participants were not asked directly about depression, but through the interviews it was evident that two of them appeared to suffer from suicidal ideation, a strong indicator of depression, which may very well have prevented them from feeling positive about their pregnancy and becoming a (good) mother. It is possible that the good mother discourse, as well as the notion of responsible mothering, may not have resonated positively with all the participants, which may have contributed to the continued prenatal alcohol use of some of the participants.

Another danger with the good mother discourse is that it perpetuates the notion that women should be the primary caregivers of children, while conversely men are expected to be the financial providers (Eddy, Thomson-de Boor, & Mphaka, 2013; Williams, 2014). In the present study, the female participants clearly felt that it was their responsibility as women to look after and care for the children and they did not see this as a role for their partners. While not directly discussed, the assumption is that their male partners need to generate an income in order to support their families. One problem with this is that it places pressure on men to find employment in an environment with very limited employment opportunities (see, for example, (Chopra et al., 2009). Furthermore, the good mother discourse may prevent men from occupying more of a caregiving role in their children's lives, if they are made to feel as though their only role is to be a financial provider.

Summary of Social Representations

This chapter has demonstrated that the interview and focus group participants represented alcohol use in the following ways: as both a social and individualised activity; as a way in which to cope with problems, but also as causing problems; as contributing to undesired changes in their behaviour; as a stigmatised activity when done during pregnancy, and as connected to their experiences with motherhood. The following chapter will summarise these findings, explicate the methodological and theoretical contributions and practical implications of the findings, and explore the limitations of this study as well as suggestions for future research.

CHAPTER 4: CONCLUSION

This study has identified and explored the social representations of alcohol use held by women who drank while pregnant, as well as by members of their community. It has further elucidated what broader discourses these representations draw upon as well as explored the subject positions made available to the participants through these representations and discourses. Through these analyses this study has also highlighted why some interview participants were able to stop drinking during their pregnancy, while others were not.

Summary of Findings

The social representations of alcohol use held by the study participants were multiple and varied. They were also rooted within particular contexts that influenced drinking behaviour on an individual level. The first social representation fell within a social context where the social network of the participants played a pivotal role in their individual drinking. Alcohol use was represented by these participants as a social activity that was heavily influenced by their peers. Implicit in this representation was the notion that heavy drinking was a norm within this study community and that it offered one of the only ways in which to socialise, making it all the more difficult for pregnant women to resist social pressures to drink. This representation drew on the "friendship fun" discourse which links drinking to the collective subject position of a social group rather than an individual subject position. This normalises and legitimates drinking in a social setting, which may lead heavy social drinkers to believe that their alcohol use is not problematic or dysfunctional, as others in their social group are engaging in the same drinking behaviour. This makes it all the more difficult for an individual to give up alcohol use, and may predispose them to binge drinking in the first place.

But despite the strong emphasis on the social nature of drinking in this community there were participants who also represented their drinking as an individualised activity by constructing a clear boundary between drinking socially with friends, and drinking to become inebriated - some participants positioned themselves as taking a certain amount of responsibility for their drinking behaviour when it came to, for example, the unbecoming behaviour that can be associated with drinking heavily. Conversely, the individualisation of drinking was also constructed by other participants as problematic, where drinking alone was seen as dysfunctional. Indirectly, this de-problematises drinking in a social setting, which may result in heavy drinkers who drink socially not seeking treatment.

The second representation of alcohol use held by the study participants involved the relationship between drinking and problems: some participants represented their alcohol use as a way in which to cope with the relational and domestic problems they faced, while others represented it as causing problems in their lives. The representation of alcohol use as a coping mechanism drew on the discourse of self-medication which positioned the participants as being dependent on drinking to medicate the symptoms associated with stressful life experiences. Given the low resource setting within which they reside, they may well have felt that drinking was one of the *only* viable ways in which to cope with their problems. This, along with the strong social influence of drinking in the community, may have contributed to some participants being unable to cease drinking during their pregnancy.

For other participants drinking was represented as causing interpersonal conflict with their partners, and for some this resulted in their partners becoming violent towards them. This fell within a particular gendered context in which men and women were positioned unequally: the male partners had violent control and authority over the female participants who occupied a subordinate and passive subject position. In some cases participants drank in order to cope with this position of subordination or because they felt unable to stand up to their partners, while for others, their drinking, or non-drinking, resulted in violence from their partners. Resistance to this patriarchal way of thinking was limited; rather, it seemed to be quite a prominent feature of the domestic relationships of the participants.

Indeed the non-drinking of some interview participants during their pregnancy was in actual fact partly rooted in the patriarchal discourse – the participants' partners appeared to have authority over the participants' non-drinking in that they told, rather than asked, them to cease drinking. Relatedly, there were other participants whose non-drinking while pregnant was partly due to restrictions placed on them by their parents. However, there were a few participants who did receive more encouraging and compassionate support – rather than restrictive and controlling support - either from one of the FARR fieldworkers, or from a partner.

The third social representation of alcohol use centred on uncharacteristic changes in behaviour the participants experienced as a result of their heavy drinking. This also drew on a particular gendered framework where again men and women were positioned unequally: while heavy drinking by men was constructed by some participants as an important element of masculinity, heavy drinking by women was seen as contributing to sexual disinhibition - which may lead to unplanned pregnancies - or even risk for *unwanted* sexual attention from men. This relates to the discourse of vulnerability where women who drink are seen as being

at risk for sexual or physical attack by men. A danger with this is that it can make victims of violence who have been drinking at the time of being attacked feel as though they are to blame for the incident. Relatedly, it serves to lessen or absolve perpetrators of violence of responsibility for their actions.

The fourth social representation of alcohol use held by the participants was that drinking while pregnant was constructed as a stigmatised behaviour. This stigma was evident in the inconsistencies and lack of detail in some of the interview participants' stories, which illustrated that they did not want to feel judged (by me) for their drinking. It was also evident in the defensive behaviour of some pregnant women when it came to their drinking which many focus group participants disapproved of. A couple of interview participants appeared to have internalised the shame and stigma associated with prenatal alcohol use when they lost their babies, which they felt was as a result of their drinking. This stigma drew on the related discourses of personal responsibility and individualism in which a pregnant woman is positioned as being solely responsible for the health and well-being of her fetus. The problem with this is that it fails to take into account the social and structural issues that contribute to drinking during pregnancy, such as low education or unemployment. However, this is not to discredit the value in taking responsibility for health-risk behaviours – indeed a level of responsibility-taking coupled with access to some form of social support seemed to contribute to some interview participants being able to stop drinking during their pregnancy.

The fifth and final social representation of alcohol use rooted drinking within the context of motherhood. Some participants felt that their alcohol use contributed to poor mothering of their children. This drew on the "bad mother" discourse in which women who drink are seen as poor or unfit mothers to their children. But like the discourse of personal responsibility, this frames bad mothering as an individual choice, rather than locating it within its broader context. Furthermore, it can be damaging for women who are given this label, or who internalise it, which seemed to be the case for some of the participants of this study.

For other interview participants, their desire to prioritise the health of their unborn babies as well as to care for and look after their children appeared to be strong motivating factors in their decision to cease drinking during their pregnancy. The prioritisation of the health of the fetus drew on the responsible mothering and competing rights discourses in which - similar to the discourse of personal responsibility - women are positioned as being morally obligated to protect and optimise the health and well-being of the fetus. While some interview participants appeared to embrace this line of thinking, there were others who expressed reservations over their pregnancy with whom this way of thinking may not have resonated.

The desire of some participants to care for and look after their children fell within the discourse of good mothering where a good mother is characterised as someone who is protective, instinctual and self-sacrificing when it comes to her children. But this discourse, like the responsible mothering discourse, may not resonate positively with all women, which might have been another contributory factor to the continued alcohol use of some participants during their pregnancy, who may not have felt ready or prepared to become mothers. Furthermore, psychosocial factors, such as depression or the experience of infidelity, may hinder their ability to stop drinking and care for their children.

Methodological and Theoretical Contributions

A valuable contribution that this study has made is that through employing the theory of social representations as well as the episodic interview, it has given voice to a marginalised and stigmatised group. Alcohol use during pregnancy is often studied quantitatively and tends implicitly to be carried out from the perspective of the fetus and prospective child development (Söderström, 2012). With this study the perspective of women who drank while pregnant was privileged – their understanding of alcohol use, as well as their interests and priorities, could be heard (A. Salmon, 2007). An in-depth look at the lived experiences of these women was generated, which - as will be discussed in the following section – can be used to inform the content and delivery of intervention initiatives (Watt et al., 2014).

In addition, alcohol use during pregnancy was not only explored on an individual level but also on a contextual level: social representation theory argues that representations need to be understood within their social, historical and cultural contexts. Accordingly, through this approach this study was able to highlight the influential role that different social structures had on individual drinking behaviour. Relatedly, the use of focus groups with community members also contributed to an understanding of drinking on a contextual level: it offered insight into how members of this study community collectively made sense of alcohol use, and the norms and values they associated with it.

Furthermore, this study was not limited to exploring social representations of alcohol use alone – through a discourse analytic approach it also situated these representations within broader discursive frameworks (for example, the discourse of patriarchy) and examined the implications these discourses had for the participants' subjectivity.

Practical Implications

Health risk behaviours, like prenatal alcohol use, have multiple levels of influence which occur on an intrapersonal, interpersonal, community and policy level. When intervening in these behaviours, ideally all of these levels should be used in order to develop a systematic and comprehensive intervention approach (Sallis, Owen, & Fisher, 2008). Drinking during pregnancy is a complex problem that stems from multiple social and structural issues and interventions should therefore not only focus on the individual, but also on social networks and communities (Hunting & Browne, 2012; Rosenthal et al., 2005). The findings of this study point to a number of practical implications that could be of great value here.

Firstly, the prevention of FASDs should not only focus on preventing drinking during pregnancy but also on preventing unplanned pregnancies. This could be done by reducing risky alcohol use amongst women of child-bearing age as well as their male partners, in order to reduce unsafe sex practices. Relatedly, couples engaging in sexual intercourse should be educated about effective contraceptive measures and any myths surrounding birth control should be dispelled. These interventions could potentially be combined with initiatives focusing on HIV and sexually transmitted diseases, and implemented by health care workers in a primary health care setting (Rosenthal et al., 2005).

Secondly, while encouraging a level of responsibility-taking is important when it comes to helping pregnant women to stop drinking, not *all* the responsibility for behaviour change should be put on the individual. Rather, intervention strategies should also be implemented on a community level. For example, alternative recreational opportunities that do not involve alcohol should be provided in isolated communities such as Madison. These would offer individuals a chance to de-stress and socialise, without having to turn to alcohol (Choi et al., 2014b). Community-level interventions should also focus on shifting the norms of heavy drinking in social settings through, for example, health communication and social marketing campaigns (Chersich et al., 2012; Rosenthal et al., 2005). These campaigns could also be used as a platform from which to challenge the negative discourses that surround alcohol use – for instance, the notion that heavy drinking is associated with being masculine could be challenged, and more responsible drinking practices could be advocated. These campaigns would benefit from using members of the community who are respected figures – shifting social norms should ideally be driven by ingroup members rather than outsiders (Neville, 2015).

Thirdly, psychosocial services should be provided to women facing difficulties during their pregnancy so that they do not feel they need to turn to alcohol in order to cope with their problems (Watt et al., 2014). This is particularly pertinent for women in isolated communities, like Madison, with limited access to mental health care and substance misuse services. Counselling and therapeutic services should be offered that focus on addressing stressful circumstances faced by pregnant women (for example, infidelity or domestic abuse) and helping these women to develop effective coping strategies (Choi et al., 2014b; Eaton et al., 2014; Watt et al., 2014). Relatedly, these services should also focus on empowering pregnant women so that they feel confident to make positive life choices (Choi et al., 2014b) and are able to stand up to their partners if they are being controlling or restrictive.

Equally, men should be encouraged to support their pregnant partners in a compassionate and caring manner, as they may be able to play a pivotal role in helping their partners not to drink while pregnant (Chang et al., 2005). Intervention programmes focusing on alcohol use during pregnancy may benefit from including a component that works with *both* the pregnant individual and her partner – they could both be educated about what to expect during the pregnancy, and how best to ensure the health of the fetus. Father involvement during pregnancy is an important predictor of maternal behaviours during the prenatal period (Martin, McNamara, Milot, Halle, & Hair, 2007). Furthermore, involving fathers in the pregnancy may also encourage both partners to take equal responsibility when it comes to caring for their child.

Fourthly, it may well be beneficial for substance abuse treatment services to capitalise on the moments of pregnancy and motherhood as opportunities during which alcohol dependent women can change their behaviour – the desire to protect the fetus and to be a caring and compassionate mother could be strong motivating factors for giving up alcohol. However, an alternative approach – such as brief motivational interviewing – may be needed when it comes to women who are uncertain about their pregnancy or becoming a mother. These women may even want to consider abortion or adoption if they feel as though they are not ready to take on the parenting role.

Importantly, these treatment services must ensure that they do not decontextualise or individualise drinking during pregnancy as this ultimately serves to stigmatise the behaviour. Rather, treatment services need to adopt a non-judgemental and supportive approach that prioritises the health of *both* the fetus and the pregnant woman (Flavin & Paltrow, 2010) and acknowledges that the pregnant woman's drinking behaviour is influenced by multiple factors. When it comes to (pregnant) women with alcohol dependency problems who have

been sexually or physically assaulted or who are experiencing domestic abuse, it is important that these treatment services ensure women are not made to feel as though they are responsible for the violence because of their drinking.

Lastly, treatment and prevention of prenatal alcohol use needs to be framed appropriately at a policy and legislative level in South Africa so as to guarantee that women who have problems with alcohol abuse are not punished for their actions. In the United States, one response to prenatal alcohol and drug use has been to arrest, detain and sometimes even prosecute pregnant women for their substance use (Flavin & Paltrow, 2010). In order to prevent this from happening in South Africa, it needs to be acknowledged that drinking during pregnancy does not occur in isolation: a pregnant woman does not simply "choose" to drink - her alcohol use is rooted in a particular context and is influenced by various social and structural issues (for example, limited access to mental health care services and the norm of heavy drinking in social situations) that need to be addressed.

Limitations and Suggestions for Future Research

While this study has a number of beneficial practical and methodological implications, it is not without its limitations. One limitation is that only one interview was held with each of the interview participants. In these interviews some of the participants were quite shy and reserved and not always willing to discuss their drinking behaviour and their thoughts on their own drinking. This is to be expected given the highly sensitive nature of the research topic, the general stigma surrounding drinking during pregnancy, as well as the inequalities that exist between the participants and myself in terms of our differing race and class. While I made every effort to put the participants at ease and to conduct the interviews in a non-threatening way, this cannot necessarily ensure complete transparency from the participants. Future research that explores alcohol use from the perspective of women who drank while pregnant would benefit from conducting two or more interviews in order to give more time for trust and rapport to develop between the researcher and participants.

Another limitation with regards to the data collection was the language barrier between myself and the participants. Given that I am not fluent in Afrikaans I was not always able to understand everything the participants were saying, and while the Afrikaans fieldworkers were able to assist me in this regard, there were still some parts of the interviews and focus groups that I could not make complete sense of at the time of data collection. Upon reading through the transcripts I came across some instances where a follow-up question would have been useful for further clarification, but because I did not entirely understand

what was said at the time, these questions were not asked. Future research needs to take these sorts of language barriers into account, and consider employing someone to conduct the data collection that is fluent in the first language of the participants. Alternatively, follow up interviews with participants for further clarification could also be conducted.

An obvious limitation of qualitative research is that it usually works with small sample sizes and as a result, findings of qualitative work are not necessarily generalisable to the wider population (Willig, 2008). Accordingly, the social representations of alcohol use held by these study participants may not be the same for other pregnant women and community members. Future research would benefit from not only studying alcohol use during pregnancy with larger samples, but also with individuals who come from different backgrounds. Of particular importance here is noting that the interview participants are all members of the HMHB© programme and some of the opinions they expressed in their interviews may therefore have been a reflection of what they learnt through the programme. It would therefore be useful to do research with pregnant women living who are not affilitated with a treatment programme. It would also be useful to include the romantic partners and social networks of these pregnant women in future research, given the pivotal role they appear to play in drinking, or non-drinking, during pregnancy.

Concluding Remarks

This study has demonstrated that alcohol use can be understood and made sense of in multiple and varied ways: the interview and focus group participants represented alcohol use as a social activity, but also as an individualised activity; they saw it as a method of coping with problems, yet also contributing to problems as well as unwanted changes in their behaviour; they represented it as a stigmatised activity when done during pregnancy, and they connected it to their experiences of motherhood. For some interview participants the social nature of drinking in their community, reservations about their pregnancy and becoming a mother, and psychosocial problems they faced may have inhibited their ability to stop drinking during their pregnancy. For other participants, access to some form of social support, a level of responsibility-taking and a desire to protect the fetus from harm as well as care for and look after their children seemed to contribute to their ability to give up drinking while pregnant.

This study has also shown that individual drinking behaviour is shaped by the context within which it takes place. For instance, the participants drinking patterns appeared to be influenced by their peers, as well as by the social norms of drinking in their community. The

way in which the participants made sense of alcohol use was also shaped by broader discursive frameworks; for example, traditional discourses of femininity and masculinity affected the ways in which the participants understood male and female drinking.

A number of intervention opportunities have also been highlighted in this study which could be of great value in the prevention and treatment of alcohol use during pregnancy – a critical problem in South Africa. Given the multiple influences on prenatal alcohol use, these interventions are targeted at both an individual and a contextual level, focusing not only on how we can assist pregnant women directly in not consuming alcohol, but also on what changes need to be made or which factors need to be promoted in the environments of pregnant women in order to ensure that alcohol use during pregnancy does not take place.

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APPENDICES

Appendix A: The Alcohol Use Disorders Identification Test (AUDIT)

Read questions as written. Record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about your use of alcoholic beverages during this past year." Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Code answers in terms of "standard drinks". Place the correct answer number in the box at the right.

1. How often do you have a drink containing alcohol? (0) Never [Skip to Qs 9-10] (1) Monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week ☐	6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily ☐
2. How many drinks containing alcohol do you have on a typical day when you are drinking? (0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7, 8, or 9 (4) 10 or more ☐	7. How often during the last year have you had a feeling of guilt or remorse after drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily ☐
3. How often do you have six or more drinks on one occasion? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily ☐ *Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0*	8. How often during the last year have you been unable to remember what happened the night before because you had been drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily ☐

4. How often during the last year have you found that you were not able to stop drinking once you had started? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily ☐	9. Have you or someone else been injured as a result of your drinking? (0) No (2) Yes, but not in the last year (4) Yes, during the last year ☐
5. How often during the last year have you failed to do what was normally expected from you because of drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily ☐	10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down? (0) No (2) Yes, but not in the last year (4) Yes, during the last year ☐
Record total of specific items here ☐ *If total is greater than recommended cut-off, consult User's Manual.*	

Appendix B: English Recruitment Advertisement for Interview Participants

Participation in a research study

University of Cape Town

Dear Prince Alfred Hamlet resident,

I am a student from the Psychology Department at the University of Cape Town doing research on alcohol use in Prince Alfred Hamlet, and I am interested in interviewing you for my research project.

The interview will take approximately an hour of your time, and will take place at a venue in your area of residence. All information obtained from you will be kept strictly confidential, and a pseudonym (made-up name) will be used so that the interview information is completely anonymous.

Taking part in this interview will give you an opportunity to share your experiences and your stories. In order to thank you for your time, you will be given a small gift pack containing two toiletry items.

If you are interested in taking part in this research study please provide your details below, and I will contact you to set up an interview time that is most convenient for you.

Best wishes,
Jane Kelly

***

I am interested in taking part in this research study and am willing to provide my name and contact details to the researcher.

_____ _____
Signature Date

_____ _____
Name (printed) HMHB© fieldworker name

_____
Contact number

Appendix C: Afrikaans Recruitment Advertisement for Interview Participants

<u>Deelname aan ’n navorsingstudie</u>

Universiteit van Kaapstad

Beste Prins Alfred Hamlet-inwoner,

Ek is ’n student aan die Departement van Sielkunde aan die Universiteit van Kaapstad. Ek doen navorsing oor alkohol gebruik in die Prins Alfred Hamlet-gebied, en wil graag ’n onderhoud met jou voer vir my navorsing.

Die onderhoud sal plus-minus een uur neem, en sal by ’n plek in jou area plaasvind. Die inligting van die onderhoud sal vertroulik bly, en jy sal nêrens geidentifiseer kan word as iemand wat aan die navorsing deelgeneem het nie.

Die onderhoud sal jou die geleentheid gee om jou persoonlike ondervindings en stories met my te deel. Om dankie te sê sal ek vir jou ’n klein geskenkpakkie van twee items toiletware gee.

As jy geïntereseerd is om deel te neem in die navorsing, gee asseblief jou persoonlike besonderhede hieronder, en ek sal jou kontak om ’n onderhoud te reël op ’n tyd en datum wat jou pas.

Groete,
Jane Kelly

***

Ek is bereid om deel to neem aan die navorsing en is bereid om my naam en kontakbesonderhede aan die navorser to verskaf.

_____ _____
Handtekening Datum

_____ _____
Naam (drukskrif) HMHB© gemeenskaapwerker se naam

_____
Kontaknommer

Appendix D: English Recruitment Advertisement for Focus Group Participants

Participation in a research study

University of Cape Town

Dear Prince Alfred Hamlet resident,

I am a student from the Psychology Department at the University of Cape Town. I am doing research on alcohol use in Prince Alfred Hamlet, and I would like to hold an informal group discussion which looks at your views and opinions on drinking in your community.

The discussion will take up approximately an hour and a half of your time, and will take place at a venue in your area of residence. The information from the discussion will remain confidential and you will never be identified as someone who has participated in the research. The discussion will give you the opportunity to share your personal experiences and stories. In order to thank you for your participation in this group discussion, you will be provided with a soft drink and a small meal.

If you are interested in taking part in this research, please give your name and contact details on the following page to Veronica, and she will give you the discussion date, time and place.

Best wishes,
Jane Kelly

***

I am interested in taking part in this research and am willing to give my name and contact details to the researcher.

_____
Signature

Group Discussion details:

Date:

Time:

Place:

Participation in a research study

University of Cape Town

Group Discussion 1
Date:
Time:

Name	Contact number	Signature

Group Discussion 2
Date:
Time:

Name	Contact number	Signature

Appendix E: Afrikaans Recruitment Advertisement for Focus Group Participants

<u>Deelname aan ’n navorsing studie</u>

Universiteit van Kaapstad

Geagte Prins Alfred Hamlet-inwoner,

Ek is ’n student aan die Departement van Sielkunde aan die Universiteit van Kaapstad. Ek doen navorsing oor alkohol gebruik in die Prins Alfred Hamlet-gebied, en wil graag ’n informele groep bespreking hou wat na jou mening en opinies op alkohol gebruik in jou gemeenskap kyk.

Die bespreking sal plus-minus een uur neem, en sal by ’n plek in jou area plaasvind. Die inligiting van die bespreking sal vetroulik bly, en jy sal nêrens geidentifiseer kan word as iemand wat aan die navorsing deelgeneem het nie.

Die bespreking sal jou die geleentheid gee om jou persoonlike ondervindings en stories te deel. Om dankie to sê sal ek vir jou ietsie om te eet en koeldrank verskaf. As jy geïntereseerd is om deel to neem in die navorsing, gee asseblief op die volgende bladsy jou naam en kontak nommer vir Veronica, en sy sal vir jou die bespreking datum, tyd en plek gee.

Groete,
Jane Kelly

***

Ek is bereid om deel te neem aan die navording en is beried om my naam en kontakbesonderhede aan die navorser te verskaf.

_____

Handtekening

***

<u>Groep bespreking besonderhede</u>

Datum:

Tyd:

Plek:

Deelname aan 'n navorsing studie

Universiteit van Kaapstad

Groep Bespreking Een
Datum:
Tyd:

Naam	Kontak nommer	Handtekening

Groep Bespreking Twee
Datum:
Tyd:

Naam	Kontak nommer	Handtekening

Appendix F: English Consent Form for Interview Participants

Consent to participate in a research study

University of Cape Town

Dear Prince Alfred Hamlet resident,

Study Purpose

You are being asked to participate in a research study being conducted by a student from the Department of Psychology, University of Cape Town. The purpose of this study is to determine how pregnant women and members of their community understand alcohol use.

Study Procedures

If you decide to participate in this study, you will be interviewed for approximately 60 minutes. The interview includes a few general questions about yourself, questions on your experiences with alcohol use and how you understand alcohol use. All information obtained from you will be kept strictly confidential.

What will you be asked to do: Participation will require that you meet with the researcher at a venue in your area of residence at a time set up by you and the researcher. The researcher will interview you for approximately 60 minutes. The interview will be tape recorded. Once the interview has been transcribed, the recording will be erased. Your real name will not be used in the transcript. Instead, we will use a made-up name. Only my supervisor and I will have access to the recording while it exists.

Possible Risks

Participating in the interview may bring on ideas or thoughts that make you upset, anxious or angry. You may also feel uncomfortable or embarrassed talking about some aspects of your life. If this happens you can contact Chanelle Le Roux (a registered counsellor at FARR) on 021 686 2646, or Leana Olivier on the same number. Participation in the study will also take away 60 minutes of your regular work/personal schedule.

Possible Benefits

There are no direct benefits to you in participating in this study, but my hope is that information gained from these interviews could be of use to the HMHB© programme. And that this information could be used to help pregnant women who are struggling with alcohol use problems.

Voluntary Participation

Participation in this study is completely voluntary. You are free to refuse to answer any question. If you decide to participate, you are free to change your mind and discontinue participation at any time. Whether you decide to participate or not, your decision will not affect your participation in the HMHB© programme, or any of FARR's other programmes, in any way.

Confidentiality
Information about you obtained for this study will be kept confidential. Your name will be kept separate from the interview information and when the interview is transcribed and reported on, a pseudonym (made up name) will be used. The interview information will only be made available to the supervisor of this research, Dr Catherine Ward. The study report will only present averaged information, so no-one will be able to link you to your interview information. The interview information will also be kept on a password protected computer.

Compensation
To thank you for taking part in this study, you will be given a small gift pack consisting of two toiletry items.

Questions
Any study-related questions, problems or emergencies should be directed to:
Jane Kelly 072 170 2105
Dr Catherine Ward 021 650 3422

Questions about your rights as a study participant, comments or complaints about the study also may be presented to the Research Ethics Committee, Department of Psychology, University of Cape Town, which can be reached on 021 650 3417.

* * *

I have read the above and am satisfied with my understanding of the study and its possible benefits and risks. My questions about the study have been answered. I hereby voluntarily consent to participation in the research study as described. I have been offered copies of this three-page consent form.

_____ _____
Signature of participant Date

_____ _____
Name of participant (printed) Witness

* * *

This interview will be recorded. This is so that the interview can be transcribed by the researcher. The only person who will listen to the recording is the researcher. Until they listen to it, it will be stored on a password-protected computer. After they have listened to it, it will be destroyed.

I agree that the interview can be recorded.

_____ _____
Signature of participant Date

_____ _____
Name of participant (printed) Witness

Appendix G: Afrikaans Consent Form for Interview Participants

Toestemming om deel to neem aan ’n navorsingstudie

Universiteit van Kaapstad

Beste Prins Alfred Hamlet-inwoner,

Doelwit van studie

Jy word genader om deel te neem aan ’n navorsingstudie wat deur ’n student van die Departement van Sielkunde aan die Universiteit van Kaapstad gedoen gaan word. Die doel van die studie is om uit te vind hoe swanger vroue en ander mense in hulle gemeenskap dink oor alkohol gebruik.

Prosedure van die studie

As jy gewillig is om deel te neem, sal ek ’n onderhoud van plus-minus een uur met jou voer. Gedurende die onderhoud sal ek vir jou ’n paar persoonlike vrae vra, vrae oor jou ondervindings met alkohol, en hoe jy alkoholgebruik verstaan. Alle inligting sal streng vertroulik wees.

Deelname aan hierdie studie sal beteken dat ons sal ontmoet by ’n plek in jou area op ’n tyd wat jou pas. Die onderhoud sal opgeneem word. Wanneer die opname van die onderhoud neer geskryf is, sal die opname vernietig word. Jou naam sal nooit gebruik word nie en net die onderhoudvoerder en haar bestuurder sal toegang tot die opname hê.

Moontlike risikos

Dit is moontlik dat gedurende die onderhoud dat idees of gedagtes jou kan onstel, angstig maak of kwaad maak. Jy mag dalk ook ongemaklik of skaam voel wanneer jy oor jouself praat. As jy voel dat jy met iemand wil praat oor hoe jy voel, kontak asseblief vir FARR se berader Chanelle Le Roux op 021 686 2646, of Leana Olivier by dieselfde nommer. Deelname aan die studie sal ’n uur van jou gewone werk skedule opneem.

Moontlike voordele

Daar is geen direkte voordeel om aan hierdie studie deel te neem nie, maar my hoop is dat die inligting van hierdie onderhoude voordelig vir die HMHB© program kan wees. Die inligting sal hopelik ook gebruik word om ander swanger vroue te help met hoe hulle alkoholgebruik verstaan en as hulle alkohol misbruik

Vrywilligge deelname

Deelname aan hierdie studie is totaal vrywillig. Jy hoef nie al die vrae te beantwoord as jy nie wil nie en jy kan enige tyd ophou met die onderhoud. As jy besluit om dit te doen, sal dit nie jou deelname in die HMHB© program, of enige ander FARR programme, affekteer nie.

Vertroulikheid
Inligting wat ons van jou kry sal totaal vertroulik bly. Jou naam sal apart gehou word van die onderhoud se inligting en wanneer die onderhoud opgeskryf en verslag gedoen word, sal jou naam nie genoem word nie. Die inligting van die onderhoud sal net beskikbaar wees vir die onderhoudvoerder en die bestuurder van die projek, Dr Catherine Ward. Die verslag sal so aangebied word dat niemand sal jou kan identifiseer met die inhoud van die onderhoud nie. Die onderhoud inhoud sal ook beskikbaar wees op ’n rekening met ’n wagwoord.

Vergoeding
Om vir jou dankie te sê vir jou deelname in die projek, sal jy ’n geskenkpakkie ontvang met twee items toiletware daarin.

Vrae
Vir enige vrae, probleme of noodgevalle in verband met die studie, bel:
Jane Kelly 072 170 2105
Dr Catherine Ward 021 650 3422

Vrae oor jou regte as ’n deelnemer van die studie, kommentaar, of klagtes oor die studie kan ook verwys word na die Navorsing-standarde Kommitee, Departement van Sielkunde, Universiteit van Kaapstad (021 650 3417).

* * *

Ek het die inligting hierbo gelees en ek verstaan dit. My vrae inverband met die studie is beantword. Ek gee vrywilig toestemming om deel te neem aan die studie. Die navorser het aan my afskrifte van hierdie vorm gegee.

_____ _____
Handtekening Datum

_____ _____
Naam (drukskrif) Getuie

_____
Kontak nommer

* * *

Die onderhoud sal opgeneem word omdat die onderhoud deur die navorser neergeskryf moet word. Tot dit neergeskryf word sal al jou informasie digitaal bewaar word met ’n wagwoord wat net ek ken. Daarna sal dit verwyder word
Ek gee toestemming dat die onderhoud opgeneem mag word.

_____ _____
Handtekening Datum

_____ _____
Naam (drukskrif) Getuie

Appendix H: English Consent Form for Focus Group Participants

Consent to participate in a research study

University of Cape Town

Dear Prince Alfred Hamlet resident,

Study Purpose

You are being asked to participate in a research study being conducted by a student from the Department of Psychology, University of Cape Town. The purpose of this study is to determine how pregnant women and members of their community understand alcohol use.

Study Procedures

If you decide to participate in this study, you will be part of an informal group discussion with approximately five other people. The discussion will be roughly an hour and a half in length. It will focus on your experiences with alcohol use in your community, and how you understand alcohol use. All information obtained from you in this group discussion will be kept strictly confidential.

What will you be asked to do: Participation will require that you meet with the researcher and other group members at a venue in your area of residence. The researcher will ask you and the other group members several broad questions on drinking in your community, and you will be asked to share your views and opinions in response to these questions. The discussion will be tape recorded. Once the discussion has been transcribed, the recording will be erased. Your real name will not be used in the transcript. Instead, we will use a made-up name. Only my supervisor and I will have access to the recording while it exists.

Possible Risks

Participating in the group discussion may bring on ideas or thoughts that make you upset, anxious or angry. You may also feel uncomfortable or embarrassed talking about some aspects of your life. If this happens you can contact the South African National Council on Alcoholism (SANCA) on 021 945 4080/1 or Lifeline on 086 132 2322. Participation in the study will also take away an hour and a half of your regular work/personal schedule.

Possible Benefits

There are no direct benefits to you in participating in this study, but my hope is that information gained from these group discussions could be of use to alcohol intervention and prevention programmes.

Voluntary Participation

Participation in this study is completely voluntary. You are free to refuse to answer any question. If you decide to participate, you are free to change your mind and discontinue participation at any time.

Confidentiality
Information about you obtained for this study will be kept confidential. Your name will be kept separate from the focus group information and when the group discussion is transcribed and reported on, a pseudonym (made-up name) will be used. The focus group information will only be made available to the supervisor of this research, Dr Catherine Ward. The study report will only present averaged information, so no-one will be able to link you to your focus group information. This information will also be kept on a password protected computer. Veronica and I will make sure that everything you talk about remains strictly confidential, and I would like to ask that you, and the rest of the group, do the same. I cannot, however, guarantee on behalf of the group members that this will be the case.

Compensation
To thank you for taking part in this study, you will be given a hot drink and small meal.

Questions
Any study-related questions, problems or emergencies should be directed to:
Jane Kelly 072 170 2105
Dr Catherine Ward 021 650 3422
Questions about your rights as a study participant, comments or complaints about the study also may be presented to the Research Ethics Committee, Department of Psychology, University of Cape Town, which can be reached on 021 650 3417.

I have read the above and am satisfied with my understanding of the study and its possible benefits and risks. My questions about the study have been answered. I hereby voluntarily consent to participation in the research study as described, and will keep all that is discussed in this group confidential. I have been offered copies of this three-page consent form.

_____	_____
Signature of participant	Date
_____	_____
Name of participant (printed)	Witness

* * *

This group discussion will be recorded. This is so that the discussion can be transcribed by the researcher. The only person who will listen to the recording is the researcher. Until they listen to it, it will be stored on a password-protected computer. After they have listened to it, it will be destroyed.
I agree that the group discussion can be recorded.

_____	_____
Signature of participant	Date
_____	_____
Name of participant (printed)	Witness

Appendix I: Afrikaans Consent Form for Focus Group Participants

Toestemming om deel te neem aan ’n navorsingstudie

Universiteit van Kaapstad

Beste Prins Alfred Hamlet-inwoner,

Doelwit van studie

Jy word genader om deel te neem aan ’n navorsingstudie wat deur ’n student van die Departement van Sielkunde aan die Universiteit van Kaapstad gedoen gaan word. Die doel van die studie is om uit te vind oor hoe swanger vroue en mense in hulle gemeenskap dink oor alkohol gebruik.

Prosedure van die studie

As jy gewillig is om deel te neem, sal ek ’n informeel groep bespreking van plus-minus een uur met jou en ander mense van jou gemeenskap voer. Gedurende die bespreking sal ek vir jou en die res van die groep vrae vra oor jou ondervinding met alkohol in jou gemeenskap, en hoe jy alkoholgebruik verstaan. Alle inligting sal streng vertoulik wees.

Deelname aan hierdie studie sal beteken dat ons sal ontmoet by ’n plek in jou area op ’n tyd wat jou pas. Die groep bespreking sal opgeneem word. Wanneer die opname van die bespreking neer geskryf is, sal die opname vernietig word. Jou naam sal nooit gebruik word nie en net die navorser en haar bestuurder sal toegang tot die opname hê.

Moontlike risikos

Dit is moontlik dat gedurende die bespreking dat idees of gedagtes jou kan onstel, angstig maak of kwaad maak. Jy mag dalk ook ongemaklik of skaam voel wanneer jy oor jouself praat. As jy voel dat jy met iemand wil praat oor hoe jy voel, kontak asseblief vir die South African National Council of Alcoholism op 021 945 4080/1 of Lifeline op 086 132 2322. Deelname aan die studie sal ’n uur van jou gewone werk skedule opneem.

Moontlike voordele

Daar is geen direkte voordeel om aan hierdie studie deel te neem nie, maar my hoop is dat die inligting van hierdie groep bespreking voordelig vir alkohol programme kan wees.

Vrywilligge deelname

Deelname aan hierdie studie is totaal vrywillig. Jy hoef nie al die vrae te beantwoord as jy nie wil nie en jy kan enige tyd ophou met die bespreking.

Vertroulikheid

Inligting wat ons van jou kry sal totaal vertroulik bly. Jou naam sal apart gehou word van die bespreking se inligting en wanneer die bespreking opgeskryf en verslag gedoen word, sal jou naam nie genoem word nie. Die inligting van die bespreking sal net beskikbaar wees vir die navorser en die bestuurder van die projek, Dr Catherine Ward. Die verslag sal so aangebied

word dat niemand sal jou kan identifiseer met die inhoud van die bespreking nie. Die bespreking inhoud sal ook beskikbaar wees op ’n rekening met ’n wagwoord. Ek en Veronica sal seker maak dat alles waaroor jy praat laat streng vertoulik, en ek wou vir jou vra dat jy en die res van die groep, dieselfde doen. Maar, ek kan nie waarborg dat die groep deelnemers dit nie vertroulik sal hou nie.

Vergoeding
Om vir jou dankie te sê vir jou deelname in die projek, gee ek vir jou iets klein om te eet en drink.

Vrae
Vir enige vrae, probleme of noodgevalle in verband met die studie, bel:
Jane Kelly 072 170 2105
Dr Catherine Ward 021 650 3422

Vrae oor jou regte as ’n deelnemer van die studie, kommentaar, of klagtes oor die studie kan ook verwys word na die Navorsing-standarde Kommitee, Departement van Sielkunde, Universiteit van Kaapstad (021 650 3417).

* * *

Ek het die inligting hierbo gelees en ek verstaan dit. My vrae inverband met die studie is beantword. Ek gee vrywilig toestemming om deel te neem aan die studie. Die navorser het aan my afskrifte van hierdie vorm gegee.

_____ _____
Handtekening Datum

_____ _____
Naam (drukskrif) Getuie

* * *

Die groep bespreking sal opgeneem word omdat die bespreking deur die navorser neergeskryf moet word. Tot dit neergeskryf word sal al jou informasie digitaal bewaar word met ’n wagwoord wat net ek ken. Daarna sal dit verwyder word
Ek gee toestemming dat die bespreking opgeneem mag word.

_____ _____
Handtekening Datum

_____ _____
Naam (drukskrif) Getuie

Appendix J: English Interview Schedule

I'd like to start off by saying thank you for giving up your time to do this interview, I really appreciate it. My name is Jane Kelly, and I'm a student from the Psychology Department at the University of Cape Town. I am here because I am interested in hearing about how people in Prince Alfred's Hamlet understand alcohol use.

Before we get started properly, I'd like to run through the details of my study and the consent form with you. I have two copies of the consent form, one which you can take away with you and one which I will take home with me once you have signed it. I also have the consent form in both English and Afrikaans.

What this interview entails is me asking you to tell me about your experiences with alcohol use, how you understand alcohol use, and a few general questions about yourself. There are no right or wrong answers here - I'm interested in hearing about your personal experiences. The interview will last for roughly an hour and it will be tape recorded. Only my supervisor and I will have access to this recording. Once I have written up the recording I will erase it. The write up will also be kept strictly confidential: only my supervisor and I will have access to it. I will also be using a made up name in the write up and the actual project, and not your real name – I will be keeping your name completely separate from my research project, so there will be no way of linking you to the interview. In other words, everything you talk about today will remain confidential and anonymous.

Your participation in this research is completely voluntary, and should you wish not to answer my questions, or withdraw from the research, please let me know because you can discontinue the interview at any time and it will in no way be held against you, nor will it affect your participation in any of FARR's programmes or activities

It is possible that the things you talk about today might make me you feel upset, angry or embarrassed. If this does happen, I have provided the contact details of Chanelle Le Roux, a registered counsellor who works for FARR, as well as Leana Olivier (the CEO of FARR).

There are not any direct benefits to you in participating in this study. However, the information that comes from these interviews could potentially be of use to the HMHB© programme. And it could be used in other ways (perhaps with other programmes) to help pregnant women who may have problems with alcohol use.

Would you like to take a few minutes to read through the consent form yourself and see if you have any questions?

Participant is given a few minutes to go through the consent form

Is everything clear to you? Do you have any questions you'd like to ask?

Participant is given an opportunity to ask questions

Ok. Well if you don't have any (other) questions, would you please sign the consent form? Signing the first part means that you voluntarily agree to take part in the study. Signing the second part means that you agree to this interview being tape-recorded.
Thank you. I'm going to switch the tape recorder on now and we can get started with the interview.

Episodic questions on alcohol use

Please remember that with these questions, there are no right or wrong answers. I'd like to encourage you to think of this as an opportunity to share your thoughts, views and personal experiences, in a safe space, remembering that whatever you tell me, will remain completely confidential.

I wonder if you can think about your pregnancy/ think back to when you were pregnant: round about when is it that you fell pregnant - could you show me on this calendar? *I will get out the 2012 and 2013 calendars. If the participant has already had the baby I will ask:*

And when was it that you had your baby - could you show me on the calendar?

Ok, so you were pregnant from _____ to _____. I wonder if you could think about a time, during these months in which you drank alcohol. Could you tell me about that time?

If the participant has difficulty relaying their story probe questions will be used such as:

- Could you tell me a bit about your pregnancy?
- Could you tell me how things went from there?
- Could you tell me what happened after that?
- Who else was with you, and what were they doing?
- How did you feel during this time?
- What were some of the thoughts running through your mind?

I wonder if you can think back to before your pregnancy *(if necessary I'll refer to the calendar here as a visual aid)*, and if you could tell me about an experience you had with alcohol before you fell pregnant?

If the participant has difficulty relaying their story probe questions, like the abovementioned ones, will be used.

Have you ever been pregnant before this most recent time?

If the participant's answer is yes I will ask:

Could you tell me a bit about the pregnancy/ies?

I wonder if you can now think back to the first time you drank alcohol. Could you tell me about that time?

If the participant has difficulty relaying their story probe questions, like the abovementioned ones, will be used.

Thank you for sharing your stories with me. I now have a few general questions on alcohol use:

Semantic questions on alcohol use

- What is related to the words "alcohol" or "drinking" for you?
- When you think about drinking, what are some of the things that come to mind?
- When you think about drinking while pregnant, what are some of the things that come to mind?

Demographic questions

Finally, I have a few general questions about yourself that I would like to ask:

- How old are you?
- How many children do you have?
- What is your marital status?
- Are you currently employed? And if you are, what is your occupation?
- What are your current sources of income?
- What is your completed level of schooling?

Thank you for sharing your thoughts and stories with me; I really appreciate it. Do you have any questions you would like to ask me? Or any comments you have?

The participant is given an opportunity to ask questions or give comments. If they don't have any, I will close the interview.

Appendix K: Afrikaans Interview Schedule

Ek wil begin deur jy te bedank vir jou tyd en gewilligheid om aan hierdie onderhoud deel te neem, ek waardeer dit opreg. My naam is Jane Kelly, en ek studeer aan die Universiteit van Kaapstad. Ek is hier omdat ek geïntereseerd is in hoe mense hier aan in Prins Alfred's Hamlet alkoholgebruik verstaan.

Voor ons behoorlik begin sal ek gou verduidelik hoe die studie werk en vir jou die toestemmingsbrief verduidelik. Ek het twee kopieë van die toestemmingsbrief – jy sal een huistoe neem en die ander een bly by my na jy dit geteken het. Die brief is in beide Afrikaans en Engels beskikbaar.

Hierdie onderhoud omskryf hoe jy alkoholgebruik verstaan en jou ondervindings daarmee. Daar is geen regte of verkeerde antwoorde nie - ek stel belang in jou persoonlike ondervindings. Die onderhoud sal ongeveer 'n uur duur en dit sal op band opgeneem word. Niemand behalwe ek en my toesighouer sal na hierdie opnames kan luister nie. Nadat ek die opnames neergeskryf het, sal die bande vernietig word. Die neergeskryfte onderhoude sal ook net deur my en my toesighouer gelees word en geen ander persoon sal dit sien nie. Ek gaan jou naam in die dokument verander en jou regte naam sal nooit gebruik word nie – so jy hoef jou glad nie te bekommer dat enige iemand ooit sal uitvind wat jy hier vir my vertel het nie.

Jou deelname aan hierdie projek is heeltemal vrywillig. Dit is heeltemal jou besluit of jy 'n vraag wil beantwoord of nie en jy kan ook heeltemal van die projek onttrek indien jy nie meer wil deelneem nie. Laat my asseblief weet indien jy wil onttrek – jy kan enige tyd gedurende die onderhoud onttrek en dit sal op geen manier teen jou gehou word nie. Dit sal ook nie jou deelname aan HMHB©-program affekteer nie.

Dit is moontlik dat van die goed waaroor ons gaan praat jou sal onstel, kwaad maak of vir jou in die verleentheid sal stel. Ek voorsien die kontaknommers van Chanelle Le Roux, 'n geregistreerde berader wat vir FARR werk asook die besonderhede van Leana Olivier (die grootbaas by FARR).

Daar is nie enige direkte voordele vir jou deelname by hierdie studie nie, maar die inligting wat ons inwin kan wel belangrik wees vir die HMHB©-program en dit mag dalk op ander maniere of met ander programme help om swanger vroue met alkoholprobleme te help.

Wil jy 'n paar minute neem om self deur die toestemmingsbrief te lees en te sien of jy enige vrae het?

Participant is given a few minutes to go through the consent form

Is alles duidelik? Het jy enige vrae?

Participant is given an opportunity to ask questions

Reg so. Indien jy nie enige (ander) vrae het nie kan ek jou asseblief vra om die toestemmingsbrief te teken? Die eertse deel van die brief gee toestemming dat jy deelneem aan die program. Die tweede deel gee my toestemming om die sessie op te neem.
Dankie. Ek gaan nou die bandopnemer aanskakel en ons begin dan met die onderhoud.

Episodic questions on alcohol use

Onthou dat daar geen regte of verkeerde antwoorde is nie. Dit sal vir my goed wees as jy aan hierdie onderhoud kan dink as ’n geleentheid om jou opinies, persoonlike ondervindings en gedagtes in ’n veilige omgewing kan deel. Onthou dat watokal jy vir my sê heeltemal vertroulik bly.

Kan jy asseblief terug dink en op die kalender vir my wys wanneer jy dink jy verwagtend geraak het? *I will get out the 2012 and 2013 calendars. If the participant has already had the baby I will ask:*

Kan jy vir my op die kalender wys wanneer die baba gebore was?

So jy was swanger van _____ tot _____. Ek wonder of jy kan terug dink oor ’n tyd, gedurende daardie maande, waarin jy alcohol gedrink het? Kan jy vir my vertel oor daardie tyd?

If the participant has difficulty relaying their story probe questions will be used such as:

- Kan jy my vertel ’n bietjie oor jou swangerskap?
- Hoe het dit toe verder gegaan?
- Kan jy vir my vertel wat toe daarna gebeur het?
- Wie was saam met jou en wat het hulle gedoen?
- Hoe het jy toe gevoel?
- Watter gedagtes het deur jou kop geloop?

Ek wonder of jy vir my kan vertel van ’n tyd onlangs, voor jy swanger geword het, wat jy ’n ondervinding met alkohol gehad het?

If the participant has difficulty relaying their story probe questions, like the abovementioned ones, will be used.

Behalwe hierdie swangerskap was jy van tevore swanger?

If the participant’s answer is yes I will ask:

Kan jy vir my ’n bietjie vertel oor jou swangerskap of swangerskappe.

Kan jy terug dink aan die eerste keer wat ek alkohol gebruik het? Kan jy my hiervan vertel?
If the participant has difficulty relaying their story probe questions, like the abovementioned ones, will be used.

Dankie dat jy jou stories met my gedeel het. Ek het nou ’n paar algemene vrae oor alkohol gebruik.

Semantic questions on alcohol use

- Waaraan dink jy as jy die woorde ‘alkoholgebruik’ of ‘drank’ hoor?
- Wanneer jy aan alkoholgebruik dink, watter gedagtes kom na vore?
- Wanneer jy dink aan alkoholgebruik tydens swangerskap, watter gedagtes kom na vore?

Demographic questions

Ek het nou ’n paar vrae oor jou.

- Hoe oud is jy?
- Hoeveel kinders het jy?
- Is jy getroud?
- Werk jy? Indien ja, watter werk doen jy?
- Het jy meer as een inkomste?
- Wat is jou opvoedingsvlak?

Dankie. Ek waardeer dat jy jou gedagtes so met my deel. Het jy enige vrae vir my of wil jy enige opmerkings maak?

The participant is given an opportunity to ask questions or give comments. If they don’t have any, I will close the interview.

Appendix L: 2012 and 2013 Calendars

2013

January

Sun	Mon	Tue	Wed	Thu	Fri	Sat
30	31	1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31	1	2
3	4	5	6	7	8	9

February

Sun	Mon	Tue	Wed	Thu	Fri	Sat
27	28	29	30	31	1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	1	2
3	4	5	6	7	8	9

March

Sun	Mon	Tue	Wed	Thu	Fri	Sat
24	25	26	27	28	1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1	2	3	4	5	6

April

Sun	Mon	Tue	Wed	Thu	Fri	Sat
31	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	1	2	3	4
5	6	7	8	9	10	11

May

Sun	Mon	Tue	Wed	Thu	Fri	Sat
28	29	30	1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	1
2	3	4	5	6	7	8

June

Sun	Mon	Tue	Wed	Thu	Fri	Sat
26	27	28	29	30	31	1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	1	2	3	4	5	6

July

Sun	Mon	Tue	Wed	Thu	Fri	Sat
30	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31	1	2	3
4	5	6	7	8	9	10

August

Sun	Mon	Tue	Wed	Thu	Fri	Sat
28	29	30	31	1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31
1	2	3	4	5	6	7

September

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	1	2	3	4	5
6	7	8	9	10	11	12

October

Sun	Mon	Tue	Wed	Thu	Fri	Sat
29	30	1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31	1	2
3	4	5	6	7	8	9

November

Sun	Mon	Tue	Wed	Thu	Fri	Sat
27	28	29	30	31	1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
1	2	3	4	5	6	7

December

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31	1	2	3	4
5	6	7	8	9	10	11

Appendix M: English Focus Group Schedule

Good morning/afternoon everyone. I'd like to start by saying thank you for giving up your time to take part in this group discussion, I really appreciate it. My name is Jane Kelly, and I'm a student from the psychology department of the University of Cape Town. This is my research assistant, Veronica. Before we get started properly, I'd like for everyone to introduce themselves. Perhaps we can go around the group and everyone can say their name?

The participants are all given an opportunity to introduce themselves, and I will note down their names.

Thank you – it's lovely to meet you all. Now, I'd like to run through the details of my study and the consent form with you.

Hand out the consent forms at this point.

I have given you two copies of the consent form, one which each of you can take home with you, and one which I will take home with me once you have signed it. I also have the consent form in both English and Afrikaans.

My first language is English and it would therefore be easiest for me if you speak in English. However, if you would like to speak in Afrikaans, that's fine, and then Veronica is here to translate the parts that I don't understand.

The purpose of my research is to hear about how pregnant women understand alcohol use, and also how community members such as yourselves understand it too. This group discussion will therefore focus on alcohol use in your community: I am interested in hearing about your experiences with drinking in the PAH community. There are no right or wrong answers here – I'd like to hear your thoughts and opinions as a group.

The discussion will last for roughly an hour and a half and it will be tape recorded. Only I and my research supervisor will have access to this recording. Once I have transcribed it I will erase the recording. The transcription will also be kept strictly confidential: only I and my supervisor will have access to it. I will be using made up names in the transcription, and not your real names – I will be keeping your name completely separate from the transcription, so there will be no way of linking you to the group discussion. Veronica and I will make sure to keep everything that is discussed here today strictly confidential. And I would like to ask you to do the same. However, I cannot guarantee that all the group members will do the same.

Your participation in this group discussion is completely voluntary, and if you wish not to answer my questions, or withdraw from the research, please let me know because you can leave the discussion at any time and it will in no way be held against you.
It is possible that the things you talk about today might make me you feel upset, angry or embarrassed. If this does happen, I have provided the contact details of the South African

National Council of Alcoholism (SANCA) as well as Lifeline, should you wish to talk to someone.

There are not any direct benefits to you in participating in this study. However, the information that comes from these group discussions could potentially be of use to alcohol prevention programmes.

To thank you for your time, I have provided you with something small to eat, and a hot/cool drink – please feel free to help yourself.

Would you all like to take a few minutes to read through the consent form yourselves and see if you have any questions? I have given you an Afrikaans copy, and if anyone wants an English copy please let me know.

Participants are given a few minutes to go through the consent form

Is everything clear to you? Do you have any questions you'd like to ask?

Participants are given an opportunity to ask questions, and if necessary Veronica will answer them in Afrikaans.

If you don't have any (other) questions, would you please all sign the consent form? Signing the first part means that you voluntarily agree to take part in the study, and that you will keep what we discuss today confidential. Signing the second part means that you agree to this group discussion being tape-recorded.

Participants are given a chance to sign the consent forms.

Thank you.

As I have mentioned already, in this group discussion I would like to hear about your thoughts and opinions on drinking in this community, and I'd like to encourage you to see this as an opportunity to share your personal points of view. I will be taking some notes during the discussion – these notes will help me when I'm writing up my project.

In your discussions, you may find that you have a similar response to someone else, or a different response – please remember that all your thoughts and opinions are welcome. I'm now going to switch the tape recorder on and we can get started with the discussion.

- The first question I'd like to ask of all of you is: Could you tell me about some of your experiences with drinking in your community?

- My second question is: When you think about drinking in your community, what are some of the things that come to mind?

- My third question is: If you had to describe the drinking that takes place in your community, what would you say?

- My final question is: when you think about drinking during pregnancy, what are some of the things that come to mind?

If the group members have difficulty discussing these questions probe questions will be used such as:

- Could you tell me how things went from there?
- Could you tell me what happened after that?
- Who else was with you, and what were they doing?
- How did you feel during this time? What were some of the thoughts running through your mind?

Thank you all very much for sharing your thoughts and opinions with me – I really appreciate it. Do any of you have any questions or comments that you would like to raise?

If there are no questions or comments I will close the group discussion.

Appendix N: Afrikaans Focus Group Schedule

Goeie more/middag almal. Ek wil begin deur julle te bedank vir julle tyd en gewilligheid om aan hierdie groepgesprek deel te neem, ek waardeer dit opreg. My naam is Jane Kelly, en ek studeer aan die Universiteit van Kaapstad. Hierdie is my assistant Veronica. Voor ons behoorlik begin, gaan ons net ’n ronde doen en elkeen kan net sy naam gee.

The participants are all given an opportunity to introduce themselves and I will note down their names.

Dankie – Dis lekker om almal te ontmoet. Nou, sal ek gou verduidelik hoe die studie werk en vir jou die toestemmingsbrief verduidelik. Ek het twee kopieë van die toestemmingsbrief – jy sal een huistoe neem en die ander een bly by my na jy dit geteken het. Die brief is in beide Afrikaans en Engels beskikbaar.

My eerste taal is Engels, so ek sal dit baie waardeer as julle bes kan probeer om Engels te praat, maar Veronica sal vir my tolk indien julle Afrikaans wil praat.

Die doelwit van my studie is om uit te vind oor hoe swanger vroue en ook mense van hulle gemeenskap alkohol gebruik verstaan. Hierdie groepgesprek gaan oor alkoholgebruik in julle gemeenskap: Ek stel belang om van julle persoonlike ondervindings met alkoholgebruik in die gemeenskap te hoor. Daar is geen regte of verkeerde antwoorde nie – ek stel belang in julle gedagtes en denkwyse as ’n groep.

Die gesprek sal ongeveer ’n uur en ’n half duur en dit sal op band opgeneem word. Niemand behalwe ek en my toesighouer sal na hierdie opnames kan luister nie. Nadat ek die opnames neergeskryf het, sal die bande vernietig word. Die neergeskryfte groepgesprek sal ook net deur my en my toesighouer gelees word en geen ander persoon sal dit sien nie. Ek gaan julle name in die dokument verander en julle regte name sal nooit gebruik word nie.

Ek en Veronica kan julle verseker dat alles wat hier gesê word streng vertroulik gehou, en ek vra dat julle dieselfde doen. Ek kan ongelukkig nie waarborg dat die ander lede van hierdie groep dieselfde sal doen nie.

Julle deelname aan hierdie projek is heeltemal vrywillig. Dit is heeltemal julle besluit of julle ’n vraag wil beantwoord of nie en julle kan ook heeltemal van die projek onttrek indien julle nie meer wil deelneem nie. Laat my asseblief weet indien julle wil onttrek – julle kan enige tyd gedurende die groepgesprek onttrek en dit sal op geen manier teen julle gehou word nie.

Dit is moontlik dat van die goed waaroor ons gaan praat julle sal onstel, kwaad maak of vir julle in die verleentheid sal stel. As enige van die bogenoemde gebeur, kan julle kontak maak met die South African National Council of Alcoholism (SANCA) of Lifeline

Daar is nie enige direkte voordele vir julle deelname by hierdie studie nie. Maar my hoop is dat die inligting wat ons inwin kan wel belangrik wees vir alkohol gebruik programme.

Om vir julle dankie te sê vir jou deelname in die projek, het ek vir julle iets klein om to eet en te drink.

Wil julle ’n paar minute neem om self deur die toestemmingsbrief te lees en te sien of julle enige vrae het? Ek het vir julle Engels en Afrikaans kopieë gee.

Participants are given a few minutes to go through the consent form

Is alles duidelik? Het julle enige vrae?

Participants are given an opportunity to ask questions, and if necessary Veronica will answer them in Afrikaans.

Indien julle nie enige ander vrae het nie kan ek julle asseblief vra om die toestemmingsbrief te teken? Die eertse deel van die brief gee toestemming dat julle deelneem aan die studie. Die tweede deel gee my toestemming om die sessie op band op te neem.

Participants are given an opportunity to sign the consent forms.

Dankie.

Soos ek vroeër genoem het gaan hierdie groepsgesprek oor julle gedagtes en opinies oor alkoholgebruik in julle gemeenskap, en ek wil julle aanraai om julle persoonlike gedagtes met my te deel. Ek sal notes neem gedurende to besprekeing – hierdie notes sal my help wanneer ek die projek opskryf.

Terwyl julle gesels sal julle dalk agter kom dat van julle dieselfde antwoorde het, of ’n heeltemalle ander antwoord – onthou almal se antwoorde is ewe belangrik.
Ek gaan nou die bandopnemer aanskakel en ons begin dan met die besprekings.

- Die eerste vraag wat ek vir julle wil vra is: Wat is van julle ondervindings met alkoholgebruik in julle gemeenskap?

- My tweede vraag is: Wanneer julle aan alkoholgebruik in julle gemeenskap dink, wat kom na gedagte?

- My derde vraag is: Hoe sou julle die alkoholgebruik in julle gemeenskap beskryf?

- My laaste vraag is: Watter gedagtes kom na vore wanneer julle aan alkoholgebruik tydens swangerskap dink?

If the group members have difficulty discussing these questions probe questions will be used such as:

- Hoe het dit toe verder gegaan?
- Kan julle vir my vertel wat toe daarna gebeur het?
- Wie was saam met julle en wat het hulle gedoen?
- Hoe het julle toe gevoel? Watter gedagtes het deur julle koppe gegaan?

Ek waardeer dat julle gedagtes so met my deel. Het julle enige vrae vir my of wil julle enige opmerkings maak?

If there are no questions or comments I will close the group discussion.