Discourses of Motherhood and Stigma Production: FASD Public Awareness-Raising in British Columbia, 1979–2015

by

Alexa Norton
Bachelor of Arts, University of British Columbia, 2013

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of the Requirements for the Degree of

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Supervisory Committee

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Abstract

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This study traces the evolution of motherhood discourses in 41 fetal alcohol spectrum disorder (FASD) public awareness documents produced in British Columbia from 1979–2015. These documents offer a window for understanding how dominant cultural values and motherhood norms are upheld and promoted via FASD prevention, with special implications for women marginalized by race, culture, and socioeconomic status. In order to deconstruct dominant discourses, this project is rooted in feminist post-structuralism and uses a Foucauldian-inspired discourse analysis as its method. Drawing on Carol Bacchi's (2009) problematization framework, I analyzed the documents using two questions: 1) What is 'the problem' represented to be? and 2) What presuppositions or assumptions underlie this representation of 'the problem'? Findings indicate that FASD public awareness-raising overwhelmingly positions maternal substance use as a woman's individual choice. Alcohol abstention is framed as a duty to the fetus, although it is framed differently depending on the targeted audience. Findings show that documents present maternal substance use as a gauge of fitness for motherhood and unfairly focus on women who are racialized, low-income, and young. Uniquely, documents produced by and for Indigenous populations differed thematically than for the general population. In conclusion, this study highlights how FASD public awareness-raising promotes dominant cultural values and adheres to a neoliberal health promotion tradition.

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Chapter 1: Introduction and Research Questions

This research project seeks to explore discourses of motherhood and their evolution in fetal alcohol spectrum disorder (FASD) public awareness campaigns produced in British Columbia, Canada, from 1979–2015. Discourse, according to Foucault, refers to "ways of constituting knowledge, together with the social practices, forms of subjectivity and power relations which inhere in such knowledges and relations between them" (Weedon, 1987, p. 108). Discourse permeates the conscious and unconscious minds of the subjects it seeks to govern (Weedon, 1987), and motherhood is one of the foremost sites in which discourse circulates; it is an institution upon which rules and regulations are imposed by social and political systems (Rich, 1986). The purpose of this research project is to better understand how discourse functions to reproduce and re-inscribe dominant cultural values of motherhood by disciplining women who consume alcohol while pregnant, particularly those who are marginalized by intersections of race, culture, and socioeconomic status.

In order to better understand the dominant cultural values and mainstream norms that are upheld and promoted in FASD public awareness campaigns, as well as recognize, resist, and deconstruct dominant discourses, this project is rooted in feminist post-structuralist methodology and uses a Foucauldian-inspired discourse analysis as its research method. With a changing social, political, and economic landscape as its backdrop, beginning with the labelling of fetal alcohol syndrome (FAS) in 1973, I will highlight how discourses of motherhood have shaped FASD public awareness campaigns with adverse implications for populations of women, particularly those marginalized through social constructions of race, culture, and socioeconomic status. In doing so, I

hope to highlight how FASD public awareness campaigns hinder health promotion efforts and reproduce stigma, as well as open possibilities for how they might be transformed to become less discriminatory, stigmatizing, and more informative and effective.

The sections to follow will guide the reader through the research process. Within the literature review I strategically summarize histories (including historical inconsistencies) as well as research and commentary on motherhood, women who use substances, and FASD. As well, I briefly contextualize FASD public awareness campaigns as a tool of health promotion. Following the literature review, in Chapter Three, I outline my theoretical framework and methodological approach, sample selection process, and methods of data collection. In Chapter Four, I detail my findings and analyze the collected data using Carol Bacchi's (2009) problematization framework. Finally, in Chapter Five, I elaborate on the significance or the findings and work to 'make meaning' of the project.

Researcher Location

As I step into the role of researcher for the first time, it is important to me and in the field of feminist research that I self-locate: that I am upfront about my investments and what has led me to pursue research in the field of FASD prevention. As both separate and inextricable entities, motherhood and FASD are influenced by sociocultural forces, historical context, moral preoccupation, and concerns about women's social roles (Poole, 2008a). Despite an increasing amount of research that is critical of the aetiology and moral production of FASD (Armstrong, 2003; Golden, 2005; Schellenberg, 2012; Tait, 2003a), mainstream research and FASD discourses continue to perpetuate particular

constructions of maternal alcohol use that are individualistic, stigmatizing, and racialized (Bourassa, McKay-McNabb, & Hampton, 2004; Fiske & Browne, 2006). As someone who is neither a mother nor used substances while pregnant, and who is a middle-class woman of Euro-settler descent doing research in an area that has unfairly focused on women who are poor, racialized, and Indigenous (Boyd, 2015), I come to this topic as an outsider with a responsibility to explain how I arrived here and what I intend to do.

I am a straight, cisgender, middle-class, able-bodied, woman of Euro-settler descent, born and raised in Grande Prairie, northern Alberta. I grew up in a cohesive family unit by Western standards: one mother, one father, one brother, and one sister. My maternal great-grandparents were Scottish immigrants; my paternal great-grandparents came from Britain and Belgium seeking refuge after the Second World War. I currently live as a fourth-generation settler on the unceded territory of the Coast Salish peoples, including the territories of the xʷməθkwəy̓əm (Musqueam), Skwxwú7mesh (Squamish), Stó:lō and Sḵwx̱wú7mesh/Selilwitulh (Tsleil-Waututh) Nations, otherwise known as Vancouver, BC. I was the first person in my family to obtain a bachelor's degree and am the first to seek a master's degree. I grew up in a tight-knit, resource-rich community that is known, somewhat ironically, for its high-income earnings and disparate distribution of wealth; high rates of violence, crime, and substance use; and its multiculturalism, xenophobia, and racism. The questions I have asked in this study have been shaped by this background.

Until I entered university I had never explicitly considered the realities of race and oppression, of my own Whiteness and complicity in Canada's imperial and colonial project. My interest in this research project is the culmination of years spent navigating

and negotiating my own Euro-settler, female identity in a terrain where I am both privileged and marginalized because of my racialized identity and gender. It is the material embodiment of my participation in and accountability to the social justice movements and activities in which I take part—notably, feminism that is intersectional and anti-oppressive. Engaging in this research project has been a constant reminder to me of the knotty and complex ways in which social location, history, and experience coalesce, as well as a personal reminder to be conscious of my privilege and of preventing my research from reproducing the contradiction-filled, colonizing discourse of the "Other" (Fine, 1998) that permeates much of the FASD prevention literature.

When I began my master's degree I knew only that I wanted to focus on the ways in which the state interferes in the lives and bodies of women. After wading shallowly into the literature it fast became clear to me that health policy and public sentiment regarding FASD, and even FASD research itself, was divided and contested: full of contradiction, moral and racial overtones. A potential discourse analysis research project that implemented feminist, anti-racist, and decolonizing philosophies and methodologies seemed a perfect fit to me, but it also raised ethical questions about me as the researcher. Was I just another Euro-descended settler woman granting myself entrance to an area in which I had not been invited? How would I ensure that there was accountability on my part, given my outsider status? With the understanding that much of the FASD research and health policy in Canada has failed to account for historical, structural, and social context, further stigmatizing women who use substances while pregnant (Hunting & Browne, 2012), I endeavoured to create a project that both addressed these contexts and

kept me, the student and beginner researcher, dealing in discourse, where I could learn and contribute to possibilities for change from a distance.

Rationale for the Research Project

Public awareness campaigns have long been used as a tool of health promotion in FASD prevention and are intended to increase awareness about the effects of prenatal alcohol exposure, encourage information-seeking, indicate what services are available, and potentially change behaviour, although this is not agreed upon (Poole, Schmidt, Green, & Hemsing, 2016). Yet, there continues to be a lack of evidence about what specific elements contribute to campaign effectiveness (France et al., 2014). While some researchers credit public awareness campaigns with leading to significant decreases in alcohol use by most pregnant women, with an increasing number choosing complete abstinence, "the success of the public health message has been overshadowed by limited decreases in alcohol consumption levels by those women thought to be at highest risk for having an alcohol-affected child" (Tait, 2003a, p. 19). For example, in one Inuit community in Quebec, the prevalence of alcohol use during pregnancy was 60.5%, more than ten times higher than the estimate for Canada's general population (Popova, Lange, Probst, Gmel, & Rehm, 2017).

Some researchers contend that public awareness campaigns in their current format are not only ineffective for some populations, but inadvertently generate stigma that is directed at already marginalized groups (Bell et al., 2015a). This stigma is borne and reproduced vis-à-vis "centuries [of] discourses surrounding mothering and mothers [that] have idealized, scrutinized, and denigrated mothers' roles and behaviours" (Reid, Greaves, & Poole, 2008, p. 211). As Reid et al. (2008) describe:

> While mothers and mothering have, at times, been romanticized, there have also been many patterns of control over and judgment of mothers, exercised by patriarchal systems of law and custom. This tension has been particularly evident when considering women who are 'mothering under duress' such as those who are using substances or experiencing addiction. In these cases, the differences between ideal and real mothering behaviour creates clashes between women's and child rights, and conflicts between legal and social responses to mothers who behave 'badly.' (p. 211–212)

Behaving 'badly' in this case is simplified and characterized in "public health messaging that suggests that even one drink can be harmful and that any and all alcohol—or products containing alcohol—must be avoided." (Bell, McNaughton, & Salmon, 2009, p. 158). Put plainly, any woman who drinks any alcohol while pregnant is guilty of behaving 'badly.' The uniformity of this kind of messaging, what Armstrong and Abel (2000) label the "democratization" of FASD, sweeps the reality of risk of fetal alcohol exposure under the rug and ignores the social and structural determinants of health (Abel & Hannigan, 1995; George, 2001). Within this thesis, the social and structural determinants of health—as they impact the production of alcohol-affected infants—can be considered using Reading & Wien's (2009) conceptualization of proximal, intermediate, and distal determinants: distal determinants include poverty and economic inequality, misogyny and patriarchy, social exclusion and racism; intermediate determinants include inequitable systems like healthcare, education, and community infrastructure; and proximal determinants include health behaviours like smoking, compromised nutrition, alcohol use, and exposure to environmental toxins, stress, inadequate housing, and violence. For Indigenous women, these determinants also include systemic Indigenous racism, colonization, the Indian Act, diminished self-determination, and "loss of land, language and socio-cultural resources" (Reading & Wien, 2009, p. 8).

In Canada, dominant health discourses that focus on women's behaviour, choices, lifestyles, and personal responsibility obscure (or purposely make invisible) the structural and social determinants of health that are at the root of health inequities (Reid, Greaves, & Poole, 2008). For women who live in environments that generate higher risk of alcohol-affected births, and who are unable or choose not to fit within the narrow confines of dominant cultural concepts of 'good mothering,' the experience of fear, shame, and blame is commonplace (Bell et al., 2015a). As Hays (1996) notes, the Western cultural construction of motherhood is heavily invested in by dominant society and elicits powerful, value-laden responses when not conformed or subscribed to.

Strega, Callahan, Rutman, and Dominelli (2002) argue that the state has long played a crucial role in distinguishing between 'deserving' and 'undeserving' mothers by creating and enacting health and social policies that rest on moral foundations and that are rooted in racism, sexism, and classism. Tait (2003a) argues that in Canada, normalized racial and gender discrimination has focused attention disproportionately on First Nations, Métis, and Inuit women, who dominant society constructs as being in need of FASD prevention and intervention due to defects in character and cultures, rather than as outcomes of colonialism, systemic racism, and discrimination.

I have not come across any research in the literature that explores how FASD public awareness campaigns actively contribute to the reproduction of dominant cultural values that stigmatize women who use substances, particularly those marginalized by race, culture, and socioeconomic status. Indeed, Bell et al. (2015a) suggest that future research should focus explicitly on the production of stigma via FASD public health interventions. Meurk, Lucke, and Hall (2014) are more explicit: they suggest that future

research should critically interrogate the ways in which biological, environmental, and social factors comingle in the case of FASD to inform whether healthcare governance "should be deemed central to the effective and just functioning of the state" (p. 342). It is at this juncture that I propose a project which builds on the literature that is critical of the moral production of FASD (Armstrong, 2003; Golden, 2005; Tait, 2003a) and situates this criticism within a Canadian public health and health promotion context.

Research Questions

In the following chapters, I explore discourses of motherhood as located in FASD public awareness campaigns. I consider their content and imagery, potential to further and create stigma, and potential effects on women who use substances while pregnant. Specifically, the research questions I asked were: 1) Over time, which discourses of motherhood have been reproduced and legitimated in FASD public awareness campaigns? and 2) How might these discourses stigmatize pregnant women and mothers who use substances, particularly when they are marginalized by intersections of race, culture, and socioeconomic status?

Chapter 2: Literature Review

In order to break apart and understand the discourses of motherhood found in FASD public awareness documents, it is necessary to first understand motherhood in its cultural context, as well as how women who use substances while pregnant have been viewed and treated historically. Accordingly, in this section I first examine motherhood, then outline a brief history of FASD from its initial labelling to the present, and later explore the use, function, and potential impacts of health promotion and public awareness campaigns in FASD prevention. While it is beyond the scope of this project to examine the aetiology of FASD or guidelines for diagnosis (although briefly discussed), it is my intention to seek out inconsistencies, gaps in evidence, and ruptures in discourse that suggest FASD has not only been borne of biology, but of various interests, institutions, and moral arguments.

Motherhood

"Motherhood is not for all women, perhaps, but it is surely woman's highest and holiest mission"— John Spargo, *Socialism and Motherhood, 1914, p. 25*

In 1976, Adrienne Rich distinguished the institution of motherhood from the act of mothering, locating the former as the site where institutions impose rules and regulations and the latter as the "potential relationship of any woman to her powers of reproduction and to children" (1986, p. 13). The relationship that Rich illuminated, between the complex ideological terrain of motherhood and women's lived experiences of conception, pregnancy, and childrearing, is complicated and contradictory; women who mother must navigate through the intensely personal experiences of pregnancy, birth, and motherhood while subjected to and surrounded by cultural expectations that are difficult—if not impossible—to satisfy (Jomeen, 2010; O'Reilly, 2010a).

In a Western context, these cultural expectations are shaped by dominant philosophical traditions that rest on binary oppositions (Derrida, 1981). Motherhood becomes characterized in mainstream consciousness as the ultimate and natural opposite to the masculine: as female to male, body to mind, nature to culture, emotion to reason, private to public, and love to labour (Nakano Glenn, 1994). Over time, these traditions have worked to establish a dichotomous Western cultural foundation of motherhood which Rich (1986) labels "the primacy of the mother," wherein mothers must be inherently nurturing, caring, moral, innocent, uncorrupted, and worthy of bringing children into the world or are viewed as unfit to parent (O'Reilly, 2010b; Rich, 1986). For example, in the 19th century the child custody law, the Tender Years Doctrine, was established, which presumed young children would be best taken care of by their mother because of natural inclination. However, women who were deemed alcoholic, adulterous, criminal, abusive, lesbian, neglectful, or simply 'unfit' could have their custody rights removed (Boyd, 2003). Plainly, women who did not fit the normative, cultural prescriptions for motherhood—and Nakano Glenn (1994) argues that only bourgeois European and American women can—are deemed unfit to parent. Kaplan (1992) further suggests that because the present and dominant Western foundation of motherhood is rooted in White, patriarchal, European, and North American middle-class ideologies, all other groups of women and mothers (i.e., those who are racialized, Indigenous, poor, single, queer, disabled, and/or who live in developing countries) are constructed as marginalized.

Who is the 'good' mother and who is the 'bad'?

Hill Collins (1994) argues that the juxtaposition of the male-dominated public, political economy to the female-dominated private, noneconomic, and apolitical domestic household puts some women—namely those who fit the image of the archetypal White, middle-class, heterosexual, stay-at-home mother—in a better-suited position to fulfil dominant cultural expectations of motherhood. This is because women who have the economic liberty to stay at home and raise children, while a patriarchal figure provides financially, have both the choice and resources to do so (Hill Collins, 1994). For many women, this is a privilege they do not have (or do not want). However, even those women who fit and enact the dominant archetype can still face what Hays (1996) calls the "cultural contradictions of motherhood" (p. 34): while some women may fulfil some or most expectations, they are still socially devalued, forced to put careers and education on hold, and can be isolated socially. (While women who are members of dominant racial, cultural, and economic groups may experience this type of stigma, it is less likely that this type of stigmatization is experienced by mothers who are members of non-dominant groups.)

Dubriwny (2010) writes that this form of archetypal motherhood does not reflect the experiences of the majority of mothers, but rather embodies the "ideological privileging of some women based on race, class, the woman's relationship to her child's father, [and] religion" (p. 287). This ideological privileging, which is done by members of dominant racial, cultural, and economic groups, divides women into two camps: "good mothers who are White and middle/upper-class and 'out group' mothers who include poor women, women of color, lesbian mothers, and single mothers" (p. 287). In the Canadian context, this ideological privileging overwhelmingly disadvantages Indigenous

women and mothers who, as a result of the gendered and racialized legacies of colonization, are often unable (or do not desire) to fulfil mainstream expectations of motherhood; and whose behaviours and actions as mothers are regulated and intervened upon by the state via the patriarchal and paternalistic Indian Act (Salmon, 2011).

Hill Collins (1994) argues that for 'out group' mothers, work, reproductive labour, and mothering rarely function as "dichotomous spheres" (p. 46) as they do for many 'in group' mothers. However, while these labours are often predicated by financial necessity, they also play an important role in ensuring the survival of one's family, of group survival, empowerment, and identity. Thus, 'out group' mothers' "motherwork" (p. 47) has and continues to challenge Western ideologies of motherhood and push against "social constructions of work and family as separate spheres, of male and female gender roles as similarly dichotomized, and of the search for autonomy as the guiding human quest" (p. 47).

Tracing the 'bad' substance-using mother

In Canada, the 'bad' mother archetype is pervasive, and women who use substances while pregnant have long been vilified and characterized as 'undeserving' in public discourse (Reid et al., 2008; Strega et al., 2002). This tradition is neither specific to Canada nor new. In the mid-1700s, during the peak of the gin craze, religious and medico-moral entrepreneurs turned their focus to the consumption of alcohol during pregnancy, concerned that such behaviour would lead to the reproduction of "feeble children" (Boyd, 2015, p. 91). Armstrong (2003) argues it was during the gin craze that concern began to connect reproduction to the moral degeneration of society at large, with concern focused specifically on women of lower socioeconomic status.

Prior to the 19th century, using opiates to treat a variety of ailments, like pain related to menstruation and childbirth, was socially acceptable and practised by all classes of people, though medico-moral attention and resulting parliamentary inquiries focused specifically on working-class women (Boyd, 2007). During the 19th century, rhetoric around substance use during pregnancy was marked by tones of racial superiority, hereditarianism, and degeneracy, with one Massachusetts clergyman and anti-alcohol crusader saying, "The free and universal use of intoxicating liquors for a few centuries cannot fail to bring down our race from the majestic, athletic forms of our Fathers, to the similitude of a despicable and puny race of men" (as cited in Armstrong, 2003, p. 37). Ideologically driven moral concern regarding the use of alcohol during pregnancy, particularly among women excluded from and by dominant society, is not new.

In the 1970s, when fetal alcohol syndrome was first coined (Jones, Smith, Ulleland, & Streissguth, 1973), pregnancy and reproduction, particularly in the United States, were becoming increasingly politicized in the wake of growing conservatism and general cultural retrenchment (Armstrong, 2003). During this time there was growing concern around environmental and pharmaceutical toxins, largely due to growing awareness of DDT and PCBs and the thalidomide disaster in Europe and in Canada (Armstrong, 2003). Combined with the increasing use of new technologies like ultrasound and amniocentesis, this created a perfect storm in which the view of the fetus began to shift to one of "a fully formed 'pre-born baby,' a free-floating being temporarily housed in the womb but with interests and needs of its own" (Daniels, 2009, p. 1).

In the 1980s and into the 1990s, the elevated status of the fetus and increasingly devalued status of pregnant women continued with the crack cocaine epidemic. As crack cocaine exploded onto the scene in the United States, particularly throughout low-income African-American communities, the media focused increasingly on the production of "crack babies" by women who were users (Logan, 1999). Images of "trembling, helpless infants irrevocably damaged by their mothers' irresponsible actions" (p. 115) were trotted out by the media, becoming, as Logan suggests, a symbol for all that was wrong with racialized and poor women and mothers in a post-women's movement, post-civil rights world. With the media whipping society into a frenzy over the new "loveless, tortured, and demented" (p. 117) crack babies, drug-using pregnant women and mothers became an easy scapegoat: they represented a dangerous vector of drug addiction, non-marital sexuality, criminality, and aberrant maternal behaviour and presented an easy case for increasing surveillance, prosecution, non-consensual sterilization, "protective incarceration" (p. 120), and legislation regarding women's pregnant bodies. However, extensive scientific evidence suggests that the crack baby epidemic was more of a myth than a reality (Hartman & Golub, 1999; Morgan & Zimmer, 1997), a phenomenon revealed to be a broad conjunction of practices and ideologies concerning race, gender, and class oppression, furthered via the vehicles of the war on drugs and the discourse on fetal rights (Logan, 1999).

In the early to mid-1990s, in Canada, the discourse on mothering and substance use began to shift. This shift is perhaps best personified through the case of Ms. G, an Indigenous woman who, as a result of sniffing glue while pregnant, was declared mentally incompetent and placed under the care of Winnipeg Child and Family Services

(WCFS) (Bennett, 2009; Tait, 2003a). WCFS attempted to force Ms. G into treatment, and although the Supreme Court of Canada later overturned the decision, the case characterized the more dominant response of "two polarized classes of response to perinatal substance use, one voluntary and non-punitive, the other coercive and punitive" (Marcellus, 2007). The coercive and punitive response of WCFS and the Manitoba government and its institutions was reinforced by the media's portrayal of Ms. G as a "selfish villain, the antithesis of the 'good mother'" (Cull, 2006, p. 149), as well as the outraged public's view of her as a "fetus abuser" (p. 150) instead of a woman with a long history of trauma who was struggling with addiction. These dynamics marked a shift to the present Canadian context, in which women who use substances while pregnant are frequently characterized as personally responsible for their actions, with little responsibility assigned to the system or society at large; in which the rights of the child or fetus trump the rights of the mother; and in which mothers who use substances are frequently characterized in the public imagination and in discourse as Indigenous, as women of colour, as immigrant and refugee women, and as poor (Dell & Roberts, 2005; Greaves et al., 2002; Reid et al., 2008; Tait, 2003a). For example, a recent piece in the Ottawa Citizen describes mothers of children with FASD as having "inflicted brain damage" and "imposed a life of disability" on their children (Cobb, 2015). Another, older Globe and Mail article reads, "the growing numbers of teenage girls becoming pregnant think nothing of treating their unborn children as recklessly as they do themselves" (Philip, 2007); and another Canadian Broadcasting Corporation (CBC) article states that two Indigenous brothers with felony charges "didn't stand a chance from the minute they

were born," (Grant, 2017) subtly shifting the blame for their crimes to their mother. Sentiments like these are not hard to come by.

Fetal Alcohol Spectrum Disorder

In 1973, Jones and Smith and their colleagues published two papers describing observed patterns of physical anomalies, growth deficiencies, and behaviour in infants and children born to alcoholic women (Jones et al., 1973; Jones & Smith 1973). While they were not the first to observe these patterns and attribute them to maternal alcohol consumption (Lemoine, Harouseau, Borteyru, & Menuet, 1968), they were the first to label and describe them as "Fetal Alcohol Syndrome" (Jones & Smith, 1973, p. 999). In the years following the first publications by Jones, Smith, and their colleagues, the research literature on FAS grew rapidly (Golden, 2005), with many heeding the call of the authors to research specific causes and prevention in an attempt to stem the "tragic disorder" (Jones et al., 1973, p. 1271).

Aetiology, diagnosis, and confusion

Alcohol is a known teratogen, meaning it can be harmful to the fetus and affect the growth and proper formation of its body and brain (Riley, Infante, & Warren, 2011). It has been generally accepted by the mainstream medical and scientific community that the consumption of alcohol is the primary, if not exclusive, cause of FASD (Shankar, 2011). This is reflected in public awareness campaigns that focus closely on individual alcohol consumption and ignore the widespread availability of alcohol, acceptability of social drinking, peer pressure, issues of addiction, and structural issues like poverty, violence, and marginalization (Shankar, 2011). However, there is a growing literature that suggests other factors play a complementary, perhaps even primary, role in the

causation of FASD. Factors like smoking, under nutrition, illicit and prescription drug use, caffeine intake, environmental pollutants, psychological and physical stress, and alcohol-related health problems have all been shown to influence alcohol's impact on the fetus (Abel & Hannigan, 1995; May & Gossage, 2011). Indeed, new research suggests that deficiencies in vitamin A, folate, and choline are linked to a range of problems impacting birth outcomes, and that providing these supplements to pregnant women may mitigate alcohol's effect on the fetus as well as reduce the severity of FAS (Ballard, Sun, & Ko, 2012). New epigenetics research also indicates that paternal alcohol consumption has an effect on sperm DNA, suggesting that preconceptional paternal alcohol consumption may also negatively affect offspring (Day, Savani, Krempley, Nguyen, & Kitlinska, 2016). The multi-causal nature of FASD has not been reflected in public health messages in North America, which continue to espouse abstinence from alcohol as the sole method of prevention (Tait, 2003a). This one-size-fits-all message fails to explain why some women who drink alcohol while pregnant do not give birth to children with FASD (Tait, 2003a), contributing to confusion about how much is safe to drink during pregnancy, if any at all (France et al., 2014; Machado, 2015).

Abel (1995) suggests that the primary factor associated with FAS is not alcohol but low socioeconomic status. In a report on the incidence of FAS, the author gathered transnational data that included women of different racialized and ethnic backgrounds and found that while the incidence of FAS varied around the globe, the single unifying factor for its occurrence was poverty. Abel's findings provide one piece of much-needed context for higher rates of FASD among the working class, people of colour, Indigenous communities (Abel, 1995), and those in child welfare and correctional systems (Tough &

Jack, 2011). As Loppie Reading and Wein note (2009), poverty is linked to increased poor health outcomes and "individuals, communities and nations that experience inequality in the social determinants of health not only carry an additional burden of health problems, but . . . are often restricted from access to resources that might ameliorate problems" (p. 2). Abel's findings may partially explain why children of some women, particularly those who are middle- to upper-class and for whom drinking is more common (Armstrong & Abel, 2000), have lower rates of FASD.

The making of a syndrome

Since FAS was 'discovered' in 1973 (Jones et al., 1973; Jones & Smith, 1973), the original diagnosis has been ever-expanding and changing. In 2016, the guidelines for diagnosis in Canada were updated to reflect new evidence and expertise in diagnoses and outcomes. FASD, once an umbrella term for multiple diagnostic categories, is now itself a diagnostic term. The new guidelines rely on a nine-point list of recommendations that take into account the strength of recommendation and quality of evidence for diagnosis, including: 1) screening, referral, and support; 2) medical assessment; 3) sentinel facial features; 4) neurodevelopmental assessment; 5) nomenclature and diagnostic criteria; 6) the diagnostic team; 7) special considerations in the neurodevelopmental assessment of infants and young children; 8) special considerations in the neurodevelopmental assessment of adolescents and adults; and 9) management and follow-up. The updated guidelines are designed to reflect the "complexity of multiple risk factors and negative exposures that are substantial contributors to the patient's symptoms" (Cook et al., 2016, p. 195).

Armstrong and Abel (2000) argue that FASD diagnosis expansion is closely related to another phenomenon, "expertise expansion," in which physicians and researchers actively create new opportunities for "entrepreneurial zeal" and research (p. 278). Indeed, some have pointed to relentless diagnostic expansion as a means of feeding unhealthy obsessions with health, obscuring sociological and political explanations for health problems, and focusing undue attention on individual and privatized solutions in order to expand markets (Moynihan, Heath, & Henry, 2002).

The continued evolution and ballooning of terminology and diagnostic categories, in spite of contradictory and inconclusive research on the causation of FASD (Tait, 2003a; Toward Optimized Practice, 2007), point to what Tait (2003a) and Golden (2005) refer to as the 'making of fetal alcohol syndrome.' Tait (2003a) argues that FAS does not have an undiscovered history, as some would like to believe, but that it has been "glued together by the practices, technologies, and narrative with which it is diagnosed, studied, treated, and represented by the various interests, institutions, and moral arguments that [mobilize] these efforts and resources" (Young, 1995, p. 5, as cited in Tait, 2003a). With reports of adverse effects of alcohol on fetal development throughout history (Calhoun & Warren, 2007), and alcohol use during pregnancy as a major concern of 18th, 19th, and 20th century clinicians and researchers (Warner & Rosett, 1975), the 'advent' of FAS in 1973 appears conspicuously arbitrary.

As Armstrong (2003), Golden (2005), and Tait (2003a), point out, this argument does not suggest that FASD is entirely socially constructed, does not have a biological basis, or that it does not have a real impact on the lives of the individuals and families of whom it affects. Rather, that the "motivation behind the discourse and an explanation of

the grounds upon which it is legitimated and reproduced over time" (Tait, 2003a, p. 12) deserves serious and critical attention, because FASD has real and lasting impacts on people, on systems, and on culture; on legal debates, medico-moral decision-making, media analyses, and political debates and decisions (Golden, 2005).

A diagnosis rooted in culture and bias

The problems inherent in the diagnosis of FASD can be traced back to its 'discovery' in 1973. In their first examination of eight children presumed to have FAS, and later examination of an additional three children, Jones et al. (1973) relied primarily on patterns of craniofacial, limb, and cardiovascular defects for diagnosis. The children examined were of three different racialized groups: two White, three African American, and three American Indian (Jones & Smith, 1973; Jones et al., 1973), and the researchers emphasized the universality of their findings to support their position that low threshold levels of alcohol exposure to the fetus were inherently dangerous. Dej (2011) argues that in actuality, the researchers were using scientific rhetoric to mask the racialization of the diagnosis, measuring and assessing facial features of their subjects against those of White children to create the "FAS face" (p. 139). Indeed, Aase (1994) points out that a moderate degree of 'midfacial hypoplasia' (underdevelopment of tissue) is a normal characteristic in many Native American groups, and broader lips in African American children can cancel out the critical diagnostic feature of a narrow upper lip border. The norms for palpebral fissures (space between eyelids) and philtrum (groove between nose and upper lip) are based on Euro-descended, North American subjects, and measurements for other racialized groups are not available to doctors and professionals making FASD diagnoses (Shankar, 2011). In addition, the diagnostic features of FAS change as a child grows

older (Aase, 1994). Aase (1994) acknowledges that it is impossible to prove that the abnormalities of mental deficit, growth delays, and maladaptive behaviour are the result of prenatal exposure to alcohol, given that none of the abnormalities found in FAS are specific to that diagnosis.

Abel and Hannigan (1995) argue that in addition to physical characteristics there are also differences among ethnic groups and cultures, with respect to social and behavioural characteristics, may increase the risk for an FAS diagnosis. The authors reason that differences in medical and diagnostic training, inclination of physicians to report (e.g., physicians in the United States report far more than their colleagues in England), and biases on the part of diagnosticians to label within certain ethnic groups may contribute widely to variations in reported incidences in different locations. For example, the overrepresentation of Indigenous persons with FASD in Canada and in Alaska Native communities in the U.S. has been interpreted as stemming from bias towards diagnosing Indigenous children more readily than non-Indigenous children, who are more likely to be diagnosed with a different neurobehavioural condition, like attention deficit-hyperactivity disorder (ADHD) (Dej, 2011; Ryan & Ferguson, 2006).

There is no one uniform system for diagnosing FASD clinically, although in 2016 the evidence-based guidelines for diagnosis were revised and published in the *Canadian Medical Association Journal* (CMAJ) to reflect advances in basic science, genetics and epigenetics, cognitive profiles, and understanding of mental health problems and growth deficits (Cook et al., 2016). Where a diagnosis used to depend on confirmation of in utero alcohol exposure to alcohol, there is now a comprehensive list of recommendations and an algorithm that can be used to diagnose FASD without this confirmation. These

revisions are, in part, an attempt to address Price and Miskelly's (2015) criticism that an FASD diagnosis "fails the ethics of veracity" (p. 419) because no symptoms, aside from known in utero alcohol exposure, are unique to an FASD diagnosis. They are also an attempt to address the complex, multi-causal nature of FASD, a step that may help to decrease the blaming of mothers for neurodevelopmental issues seen in their children (Price & Miskelly, 2015).

There are numerous practical and logistical issues with FASD diagnosis in Canada that cannot be explored in depth here. First, while no longer necessary, the securing of documentation of in utero alcohol exposure is still a crucial step within recommendation two (medical assessment) of the guidelines for diagnosis (Cook et al., 2016). Given the necessity of retrospective data collection, lag between pregnancy and diagnosis, clear negative consequences of reporting for mothers, and limited access to biological mothers for those children who are adopted or in foster care (Price & Miskelly, 2015), this is a limitation within diagnosis. Second, there is limited capacity and expertise in most communities, particularly those that are small in size or remote, to involve a necessary variety of professionals in the recommended comprehensive multi-disciplinary diagnostic evaluation (Chudley et al., 2005). Of the 56 clinics in Canada that have been identified as having diagnostic capacity, only 44 were determined to be operational largely due to funding limitations, and none of the 56 clinics were located in the Northwest Territories, Nunavut, Quebec, Nova Scotia, Newfoundland and Labrador, or Prince Edward Island (Clarren, Lutke, & Sherbuck, 2011). Furthermore, for some individuals and communities, and particularly for those who are Indigenous, diagnosis can be a double-edged sword: it can open up access to otherwise limited funding,

resources, and support for children with perceived developmental and behavioural problems, but can also inflate the perception that FASD is an epidemic and lead to an increase in stigma and surveillance (Tait, 2003a).

Moral crusade and reform

Although FASD has been categorized as a diagnosis, a scientific subject, and a public health problem, it has also been regarded by some as a symbol of "maternal misbehaviour and moral decay" (Golden, 2005, p. 12). Those who regard FASD in this way have been called moral reformers and moral entrepreneurs (Boyd, 2007; Armstrong, 2003), and can be defined as individuals who operate with an absolute ethic; they are not interested in existing rules because they do not satisfy "some evil which profoundly disturbs," and nothing can be right in the world until new rules are drawn to correct it (Becker, 1963, p. 146). The proliferation of FASD prevention and intervention initiatives, and the incredible amount of funding behind them (Salmon, 2011), suggest that moral reformers have a strong presence in this area.

In the late 19th century, alcoholic degeneration encapsulated the fears of social commentators who were troubled by the inebriety of the urban poor and the conditions of their children, and was regarded as destroying the health of future generations (Golden, 2005). The attitudes of moral reformers toward women who use alcohol regularly and to excess have historically been stigmatic and gender-biased, and women have long been subjected to greater restrictions and punished more harshly than men for defying social drinking codes (Carter, 1997). Holmila and Raitasalo (2005) suggest that this is because an uptick in women's drinking is associated with increasing problems for children, homes, and society's traditional moral order. However, in the 1920s and 1930s, it became

more socially acceptable for women to drink, and with the repeal of Prohibition in the United States the temperance movement that had contributed so greatly to the anti-alcohol fervour lost much of its moral sway (Armstrong, 2003). In this period and throughout the 1950s, alcohol use was glorified, the medical literature was largely silent on alcohol and reproduction, and alcohol was even promoted as a benign, therapeutic, and "safe, easily controlled anaesthetic" in *Life Magazine* (as cited in Armstrong, 2003, p. 70).

Armstrong (2003) argues that in 1973, FAS emerged at the intersection of social trends and events within and outside of medicine. In the early 1970s, Marquis (2005) notes that illicit drug use became the focus of a subjective moral panic in Canada, fuelled by rising levels of violent and economic crime and the rapid pace of social change. Both licit and illicit drugs were redefined in cultural terms and drawn under the umbrella of "substance abuse" (p. 64), and awareness campaigns regarding the detrimental effects of alcohol use increased in number and evolved in message. In addition, the expansion of the social safety net, of health and medical 'experts,' and of the helping professions proved an opportunity to "colonize new social problems" (p. 62), with addictions prevention as key to enlarging budgets, expanding research, and developing new programs. With doctors in the unique position of medical authority and taking up the role of moral reform, the literature proliferated, 'validating' the new FAS and 'confirming' the original diagnosis (Armstrong, 2003).

In the 1980s, the official position of most North American public health agencies became one of total abstinence from alcohol during pregnancy (Bell, McNaughton, & Salmon, 2009). As Tait (2003a) points out, the emergence of the fetus as a powerful

public and political symbol occurred at the same time, fuelling the fetal rights movement and positioning the fetus as victim. The idea that a pregnant woman and her fetus were two separate entities has been "entrenched in the discursive arena attached to the category FAS from the outset" (p. 245), Tait argues, and has contributed to the increasingly harsh treatment of women who know they are pregnant and continue to consume alcohol.

Throughout the 1990s and early 2000s, FASD was increasingly been viewed from two classes of response: one voluntary and non-punitive and the other coercive and punitive (DeVille & Kopelman, 1998). Language and discourse related to the relationship between mother and fetus became highly inflammatory, polarized, and legalized, with mothers often being viewed as the single most important risk to an unborn fetus (Marcellus, 2007). Substance use during pregnancy was frequently presented "as an individual, deliberate, and poor choice," and media discourse was "fundamentally judgmental, blaming, and unsympathetic" (Marcellus, 2007, p. 35). With zero room for tolerance, this climate led to more than 300 American women facing criminal charges of endangering the life of the fetus (Marcellus, 2007), and in Canada to the overrepresentation of arrests, child apprehensions, and medical interventions of Indigenous women who use substances (Boyd, 1999).

In recent years, some authors have found that sympathy has become as commonplace as shame in mainstream media portrayals of FASD (Eguiagaray, Scholz, & Giorgi, 2016). While these authors note the potential of a sympathetic frame to decrease stigma experienced by mothers who consume alcohol during pregnancy, they also recognize that competing frames may contribute to confusion around what and how much is safe to drink; and that often, discourses of sympathy do not acknowledge social

circumstances that can contribute to risk of maternal alcohol consumption (Eguiagaray et al., 2016). An increasing number of individuals, groups, and organizations (Boyd & Marcellus, 2007; Ordean & Kahan, 2011; Poole, 2011) have advocated for woman-centred care for pregnant substance-using women in healthcare, health policy, and social services. Woman-centred care is the predominant model of care in Canadian law and policy (Marcellus, 2007) and can be defined as the expectation that a woman will be supported physically and emotionally from preconception through pregnancy and post-partum (Poole, 2011). However, this model is not always realized or applied in health promotion, public awareness (Bell et al., 2015a; Burgoyne, 2006), or healthcare (Tough, Clarke, Hicks, & Clarren, 2005); and current public health policies and practices continue to produce stigmatic public attitudes and underlying beliefs about FASD and the experiences of those affected (Bell et al., 2015a). Nowhere is this more evident than in the prevention and intervention practices and discourses regarding Indigenous Peoples in Canada.

The legacy of colonization and FASD

While the incidence of FASD in Canada has been estimated at nine per 1000 births (Health Canada, 2006), estimates have ranged as high as 25 to 190 per 1000 in Indigenous communities (Salmon, 2011). These estimates have led to FASD being labelled a ‘crisis situation’ among Indigenous people (Tait, 2000; Salmon, 2011) and have resulted in calls for action from both Canadian and Indigenous health organizations (Di Pietro & Illes, 2013). There are two sides to this issue—one proximally related to colonization and the other distally—yet both are necessarily rooted within a discussion of the legacy of colonization and social determinants of health.

A note on terminology: I use the term Indigenous throughout this paper to refer to First Nations, Métis, and Inuit peoples who reside within the colonial borders of the Canadian nation-state. Although "Aboriginal" has been in predominant legal usage over the past three decades, Indigenous is increasingly being used as a unifying term to denote an identity that is chosen rather than delegated, and is "constructed, shaped and lived in the politicized context of contemporary colonialism" (Alfred & Corntassel, 2005, p. 597). "Status Indian" refers to "a specific legal identity of an Aboriginal person in Canada," defined by criteria developed by the Canadian government and established in the 1876 Indian Act (Indigenous Foundations, 2009).

According to Kelm (1998):

> Colonization is a process that includes geographic incursion, socio-cultural dislocation, the establishment of external political control and economic dispossession, the provision of low-level social services and ultimately, the creation of ideological formulations around race and skin colour that position the colonizer at a higher evolution level than the colonized. (as cited in Loppie Reading & Wein, 2009, p. 21)

Loppie Reading and Wein (2009) write that colonization and the imposition of colonial institutions and systems, as well as lifestyle disruptions, have resulted in diminished self-determination and a lack of influence in policies that directly affect Indigenous individuals and communities. They have also resulted in a large-scale loss of land, language, and socio-cultural resources, while creating and contributing to racism, discrimination, and social exclusion (Loppie Reading & Wein, 2009). Any discussion of FASD as it relates to Indigenous Peoples must be situated within this context.

A crucial piece in the discussion of high FASD prevalence among Indigenous people is the recognition that Canadian studies on women's alcohol use during pregnancy have disproportionately and almost exclusively focused on Indigenous women (Rutman,

2013; Dell & Roberts, 2005; Salmon, 2011; Di Pietro & Illes, 2013). Furthermore, studies have tended to focus on Indigenous communities where alcohol use and dependency are known to be high (Dell & Roberts, 2005). Tait (2003a) reveals that, while American researchers have emphasized the "democratization" of FAS (Armstrong & Abel, 2000) (at least hypothetically), Canadians' normalized racial and gender discrimination has focused attention specifically on First Nations, Métis, and Inuit women. In fact, during the 1980s, prevalence studies targeting Indigenous communities reported that Indigenous women and children were as much as 20 times higher at risk for FAS than their non-Indigenous counterparts (Asante & Nelms-Matzke, 1985; Robinson, Conry, & Conry, 1987). This was explained in the literature with alcohol reported as "a common part of the northern lifestyle," and part of a "cultural attitude towards drinking" (Aase, 1981, p. 335, as cited in Tait, 2003a). The early reported high prevalence rates led federal and provincial governments to prioritize Indigenous communities in the allocation of resources for research, programs, and services (Tait, 2003a), fuelling the notion that FASD was an "Aboriginal problem" (Michaud & Michaud, 2003, as cited in Dej, 2011). This perception has been exacerbated by a lack of formal diagnostic tools and those trained to use them (Salmon & Clarren, 2011), in effect leaving social workers, teachers, and counsellors to 'diagnose' children who exhibit a range of symptoms and functional challenges (Fiske & Browne, 2006). In effect, professionals and community members become more prone to seeking a diagnosis as they are conditioned to expect it, and because diagnosis opens up access to intervention programming and social support (Tait, 2000; Fiske & Browne, 2006).

The introduction of alcohol to Indigenous communities by European settlers in the 17th century occurred at the same time as infectious diseases from Europe were becoming widespread, and drastic social, economic, and demographic changes were being imposed on Indigenous groups. This led to the use of alcohol by some as a method of coping with changes to individual and collective autonomy and the shifting socio-political landscape (Tait, 2003b). Later on, Moss and Gardner-O'Toole (1991) point out that the 1868 federal statute concerning Indigenous peoples and precursor to the 1876 Indian Act contained three separate sections prohibiting the sale or barter of liquor to status Indians. Initially, only fines were imposed on the seller, but in 1874 provisions changed so that any status Indian found in a state of intoxication could be imprisoned for up to one month. Over time, the increasingly strict provisions in the Act did not prevent Indigenous peoples "from the evil influence of intoxicating liquors" (Moss & Gardner-O'Toole, 1991, n.p.), but rather encouraged covert and dangerous drinking practices, illegal consumption and selling, and discouraged social drinking. These provisions were not repealed until 1985, during which time thousands of Indigenous men and women had already been arrested and imprisoned. The measures undertaken by the state, its Indian agents, and police were a punitive and racialized social control mechanism that have contributed to enduring stereotypes and legal discrimination today, and contribute to the stereotyping and discrimination that continues to shape FASD practice and policy.

There was considerable heterogeneity among Indigenous peoples' response to the introduction of alcohol, and there continues to be marked variation in alcohol usage by Indigenous individuals and communities today, with many abstaining entirely (Steckley & Cummins, 2001). Yet, entrenched colonial structures and persistent racism have given

rise to alcohol being linked to higher incidences of homicide, child abuse and neglect, poor health, family dysfunction, violence, suicide ideation, and incarceration among Indigenous peoples (Brady, 2000; Tait, 2003b).

While Canadian studies indicate that Indigenous women are more likely to abstain from alcohol than men and non-Indigenous women, statistics indicate that those who do drink are more likely to drink heavily (Poole, Gelb, & Trainor, 2008). This information must be contextualized within a discussion of the ongoing effects of colonization as well as the social determinants of health. Binge drinking within the general population has been linked to poor physical health, poor mental health, lower socioeconomic status, physical and sexual abuse, intimate partner violence, the death of a loved one, traumatic childhood experience, divorce, separation, familial history of alcohol use, and a personal history of alcohol use (Timko, Sutkowi, Pavao, & Kimerling, 2008; Yang et al., 2006). Many Indigenous women are equally if not more greatly affected by these determinants, which are directly related to the deliberate suppression of Indigenous languages and cultures, imposed substandard living conditions, second-rate education, and the ongoing legacies of residential school, the Sixties Scoop, and forced apprehensions of Indigenous children into state and foster care. These conditions have resulted in widespread physical, emotional, sexual, and spiritual abuse, and must be taken into account when considering the use and effects of alcohol in Indigenous communities (Fournier & Crey, 1997; Smith, Varcoe, & Edwards, 2005).

Although it is “not appropriate to suggest that all Aboriginal women will be equally affected by a history of colonization and marginalization” (Gelb & Rutman, 2011, p. 15), it is clear that, in some communities, the synergistic and cumulative damage

wrought by colonization and residential schools has led to personal, community, and cultural trauma, which are linked to the high prevalence of FASD (Asante & Nelms-Matzke, 1985; Robinson, 1992).

It is also important to recognize how Indigenous women and communities resist pathologizing reports and narratives that they simultaneously mothers and 'children of the state' who are abusive, neglectful, and otherwise dangerous to their children, and therefore must be investigated and supervised by government administrators (Salmon, 2011). As Poole (2000) points out, women with children who have FASD are often resourceful, fulfilling their children's practical and emotional needs while sometimes dealing with their own substance use. These women have often experienced violence, abuse and abandonment, and often feel that they are expected to prove their worth in ways that other mothers are not (Poole, 2000). More recently, Indigenous women and their communities, sometimes in partnership with an evolving research community, are developing community-based, urban prevention and healing initiatives that are respectful of identity, place, and culture (Badry & Wight Felske, 2013; Masotti et al., 2006). And, while Indigenous mothers' voices have largely been excluded from the FASD research literature, some researchers are now working to centre it (Loewen, 2000), while others engage in a critical discussion of how Canadian health policy frames FASD in gendered, racist, and colonial ways (Hunting & Browne, 2012; Salmon, 2011; Tait, 2003a).

While Indigenous women are overrepresented in FASD statistics, the reverse is also true: those who are non-Indigenous are underrepresented. While prevalence studies have been conducted for decades in Indigenous communities, there are no population-level Canadian statistics or studies that have examined FASD in other subpopulations

within Canada (Dell & Roberts, 2005). Increasingly, statistics indicate that older, White, middle- to-upper-class, college-educated American women represent the demographic most likely to drink alcohol while pregnant (Ebrahim et al., 1998; Ethen et al., 2009). For example, the percentage of American women who reported drinking during pregnancy increased with: age, from 19% among women less than 20 years of age to 37.2% among women 35 and older; increasing education, from 20.1% among women with less than 12 years to 37.1% with 16 or more; and increasing income, from 21.1% with annual household incomes of less than $10,000 to 39.8% with incomes of $50,000 and higher. In addition, American Hispanic women and women of other racial and ethnic minority groups were significantly less likely to drink any alcohol or binge drink during pregnancy compared to White women (Ethen et al., 2009). Canadian statistics also reveal that older women who are higher income earners report alcohol consumption during pregnancy, with 40.5% of women with incomes over $80,000 reporting drinking during pregnancy (Dell & Roberts, 2005). In addition, a 1997 study conducted by Toronto's Motherisk Program compared a sample of pregnant women who had reported binge drinking during pregnancy with a comparison group seeking counselling for other reasons; those who reported binge drinking were more likely to smoke cigarettes, use illicit substances, and to be young, single, and White (Gladstone, Levy, Nulman, & Koren, 1997).

Despite these statistics, White middle- and upper-class women's substance use is viewed as less risky or dangerous than that of Indigenous women, and the effects of substance use on the health and well-being of their children are often overlooked or underestimated (Bell, McNaughton, & Salmon, 2009). As a consequence, children who

are non-Indigenous are more likely to receive a diagnosis of ADHD than FASD (Dej, 2011).

Lack of knowledge regarding subgroups

In Huber's (1998) discourse analysis of newspaper articles about FAS, the author notes that only two groups were routinely singled out for being at high risk: Indigenous communities—isolated northern communities in particular—and low-income geographical areas with a predominantly Indigenous population. Similarly, Tait (2003a) asserts that the snowball sampling methods used to locate participants in studies focusing on substance use have been (consciously or unconsciously) biased towards Indigenous participants at the exclusion of other population groups. For example, in one Manitoba study, participants were referred to researchers because they were considered 'best suited' to serve the research purpose. The result: Indigenous women were overrepresented (52/74), despite the community consisting of women from other ethnic, refugee, immigrant, religious, and cultural groups, as well as socioeconomically disadvantaged women, including those racialized as White (Tait, 2000).

Abel's (1995) research indicates that women with low socioeconomic status who drink while pregnant may experience an increased vulnerability to FASD, likely due to poor health outcomes that are linked to smoking, poor nutrition, poor health, increased stress, and other factors. In the Canadian context, people of colour, recent immigrants, women, and people with disabilities—in addition to Indigenous people—are more likely to experience low socioeconomic status due to social and economic exclusion, as well as limited access to social, cultural, and economic resources (Mikkonen & Raphael, 2010), yet these latter groups are mostly absent in FASD studies and statistics. Meurk et al.

(2014) conclude that one of three imminent FASD research priorities must be to "collect health histories of maternal alcohol consumption in families to determine the effect of FASD at sub-cultural and cultural levels" (p. 337). They posit that such information will help to establish a baseline quantitative evidence-base that is divorced from systemic bias, stakeholder interest, and stigmatization.

It is also worth noting that many Indigenous communities have been quick to respond to the perceived "nation-wide health concern" (p. 1) of FASD, developing wide-scale initiatives like "It Takes a Community: Framework for the First Nations and Inuit Fetal Alcohol Syndrome and Fetal Alcohol Effects Initiative" (Health Canada, 1997). This framework in particular aims to address, through an Indigenous and holistic health lens, the root causes of FASD; the regional differences in classification, description, and diagnosis of the condition; community concerns; and community-based and culturally appropriate services and programming for those individuals and families dealing with a diagnosis. Community invitations to qualitative researchers, like that from the Dene Nation's Dene Cultural Institute, have also been extended in an attempt to rectify detrimental effects of earlier epidemiological studies (Kowalsky & Verhoef, 1999). The Dene Nation's opinion was that the earlier study's conclusion of a very high incidence of FASD left community members believing there was little to no hope of fixing the situation, and a study that would assess the level of knowledge, perceptions of FASD, and of potential existing supports would be more useful in reducing rates and supporting community members.

On the other hand, there is a systemic tendency by and for non-Indigenous people, particularly those middle- to upper-class, to want to eliminate the possibility of an FASD

diagnosis. Meurk et al. (2014) state: “the diagnosis of FASD may be more likely to be given to a child of a low SES [socioeconomic status] mother and (related) diagnoses such as ADHD and autism given to children of higher SES mothers” (p. 339). Similarly, Chasnoff, Landress, and Barrett (1990) found that American doctors were more comfortable interviewing poor and African American women about alcohol use during pregnancy than White, middle-class patients. Similarly, when Euro-descended women who have children with FASD are portrayed in the media, the narrative often follows the stereotypical trope of damaged foster kids and White saviour moms (Dej, 2011; Robinson, 2015).

Health Promotion and Public Awareness Campaigns

The World Health Organization (WHO) defines health promotion as “the process of enabling people to increase control over, and to improve, their health” (1986, n.p.). Health promotion has been positioned as an important arm of public health practice, and aims to prevent disease, prolong life, and promote health through the organized efforts and informed choices of society, organizations, public and private, communities, and individuals (Winslow, 1920). One of the ways in which health promotion aims to achieve these objectives is through health education and raising awareness of health issues, often via public awareness campaigns (Thompson, 2014). Groups that plan and deliver FASD public awareness campaigns in Canada include governments, health organizations, agencies that work with pregnant women, agencies that provide service to young families, FASD interest groups, FASD support groups and the alcohol industry (Burgoyne, 2006).

In 1986, the WHO introduced the Ottawa Charter for Health Promotion, which shifted the focus of health promotion from disease prevention to a wider view of the social determinants of health, and committed to social reform and equity (Mold & Berridge, 2013). Despite the broader approach, criticisms persist that health promotion pays insufficient attention to structural issues that underpin health (Marmot, 2004) and continues to place responsibility and blame on individuals for health conditions that are influenced or created by environmental conditions (Salmon, 2011). Health promotion is also viewed by some as a method of surveillance and moral control, in that it encourages and disciplines individuals and groups to behave in culturally normative and desirable ways (Armstrong, 1998).

The state of primary prevention and FASD awareness

Canada spends more on FASD primary prevention than on any other form of FASD prevention (Salmon, 2011). Primary prevention can broadly be defined as strategies used to intercede before the causes of diseases can impact an individual (Cohen, Chavaz, & Chehimi, 2007), and includes activities like population health promotion, alcohol control measures, multicomponent awareness campaigns, and other education efforts (Thurmeier, Deshpande, Lavack, Agrey, & Cismaru, 2007). Public awareness campaigns have been widely used as a prevention strategy by different groups, and some have credited them with drastically reducing the number of women who drink while pregnant (Basford, Thorpe, William, & Cardwell, 2004). Commonly used strategies include brochures, posters, public service announcements, and TV commercials (Poole, 2008b).

Poole (2003) notes that since the early 2000s, a high level of interest in FASD prevention and intervention has led to funding from and initiatives being undertaken by community, regional, provincial, and national organizations and governments. In 2005, Health Canada produced *A Framework for Action* to be used as a map for developing broad goals and strategies as set out within the framework (Public Health Agency of Canada [PHAC], 2005); and British Columbia, Alberta, Saskatchewan, Manitoba, and the Yukon have multi-pronged strategic prevention plans in place, with Ontario's in development (Norris, 2014). In spite of the high level of activity, Poole (2003) notes that there are serious limitations to current approaches.

Problematic prevention

Poole (2003) outlines four areas of prevention and public awareness focus that are limiting and can be damaging to prevention efforts: 1) having a child-centred rather than a woman-centred approach; 2) an exclusive or primary focus on Indigenous women and communities; 3) a narrow, simplistic focus on alcohol consumption at the exclusion of other factors like malnutrition, stress, drug use and exposure to violence; 4) and judgemental messaging. However, Nathoo et al. (2013) also note that primary prevention is increasingly focused on integrating trauma-informed and harm reduction approaches, on reducing inequity, and enhancing women's agency. However, there are no restrictions on who can produce FASD public awareness campaigns or what they contain, only recommendations; and there continue to be concerns around how awareness campaigns "can contribute to the further stigmatizing and isolating (the *othering* [emphasis in original]) of mothers who use substances, by exaggerating risk, focusing on fetal harm, using exploitative imagery, and not identifying how women can access nonjudgmental

support" (Poole et al., 2016). Poole's (2003) recommendations for changing current primary prevention efforts include increasing the general public's understanding of how and why women come to have substance use problems, as well as reducing inequities in health status.

In their literature review, Bell et al. (2015a) explore the pervasiveness of stigma with regards to public attitudes towards women who drink during pregnancy. They highlight the possibility that public health policies and practices may "inadvertently increase the blame towards biological mothers or women who drink during pregnancy, and impact the broader experiences of all those affected by FASD" (p. 72). These authors echo Poole (2003) in their findings that public awareness campaigns continue to focus on the personal responsibility of the mother and "fail to address the social factors surrounding alcohol use during pregnancy and to address local or community factors that may be important to ensuring behaviour change" (p. 8). While this is not true of all public awareness campaigns, these approaches overlook historical and intergenerational abuses and inequalities experienced by disadvantaged groups, and have the potential to deepen health disparities experienced by those already marginalized (Bell et al., 2015a).

Bell et al. (2009) note that when FASD interventions target marginalized women the prevention focus remains fixed on the individual mother, her behaviour, and her responsibility to protect the fetus, in effect giving her "responsibility without power" (Daykin & Naidoo, 1995, p. 63, as cited in Bell et al., 2009). They conclude that, while all mothers are "caught to some degree in the web of punitive discourses woven by [public health] movements" (p. 164), women of colour, single mothers, and women living in poverty are singled out as posing the most risk to their children, thereby legitimating

the entrance of the state into the homes of women who are already subject to marginalization and surveillance vis-à-vis public health interventions.

Neoliberalism as a driving force

Bell et al. (2009) suggest that state institutions repeatedly make reference to the economic 'burden' imposed by 'lifelong disabilities' (p. 162) of those with FASD in order to fortify FASD discourses that are predicated on hegemonic notions of good mothering. It is worth noting that costs of the disorder are not only cited in government documents (Health Canada, 2006; Toward Optimized Practice, 2007), and in research conducted by prominent FASD researchers (Clarren, Salmon & Jonsson, 2011), but that there is an entire literature dedicated to examining associated costs (Stade et al., 2009; Thanh & Jonsson, 2009; Thanh, Jonsson, Dennett, & Jacobs, 2011).

Shankar (2011) asserts that documents and policies which continuously reiterate FASD as a cost to taxpayers helps to depict those with FASD as a financial risk and liability to society, and their mothers as contributing to the financial burden. Shankar (2011) references one Alberta MLA's statement regarding children who are born with FASD as "resulting in significant human cost and cost to public services, which I find disturbing" (Legislative Assembly of Alberta, 2001, p. 512 as cited in Shankar, 2011, p. 99). Thus, economic costs are not only invoked but are intimately tied to social costs, creating a two-fold drain on society. Hunting and Browne (2012) argue that these national-level discourses work to create "a *justifiable need* [emphasis by Norton] to increase intervention and surveillance of inherently neglectful mothers" (p. 44). This is neither farfetched nor futuristic; in the last two decades Western liberal democracies and their social safety nets have undergone major economic, technological, and social

restructuring that has resulted in reduced welfare rates, restricted eligibility, increased surveillance, and social support being tied to work participation (Maki, 2011; McDaniel, 2002). Real life examples like that of Ms. G are not hard to find. As Boyd (2015) notes, women in the U.S., and to a lesser extent in Canada, who are under surveillance by social services are routinely incarcerated for using substances while pregnant, and are subjected to gendered forms of social control in attempting to receive welfare benefits.

Chapter 3: Methodology

This discourse analysis was rooted in feminist poststructuralist methodology in order to enable me to explore the dominant cultural values that are upheld and promoted in FASD public awareness campaigns, as well as recognize, resist, and deconstruct dominant discourses. This methodology works to contribute to meaningful social change while remaining mindful of the power hierarchies that research practices can reinforce, and aims to "challenge knowledge that excludes, while seeming to include" (Hesse-Biber, 2012, p. 3). The chosen research method for this project was a Foucauldian-inspired discourse analysis, drawing on genealogical methods and rooted in Bacchi's (2009) problematization framework. This approach enabled me to focus on the ways in which power and knowledge come together in discourse and how certain statements come to be 'true' over time. It also enabled the tracking of the evolution of discourses of motherhood within FASD public awareness-raising since the labelling of the diagnosis in 1973, and the illumination of how these discourses "[filter] through the arterial and venous systems of the populace and then [are] fed back in a cyclical process through the capillaries, enabling maintenance and reinforcement" (Grbich, 2004, p. 40)—that is, how discourses prop up, reinforce, and protect the dominant culture.

Methodological Fit with Research Question

Armstrong (1998) states that from 1973 onward, moral entrepreneurs in the medical realm constructed FAS as a clinical entity and social problem, powered by moral fervour as much as by medical curiosity. This 'social problem' was deeply rooted in a Western ideology of motherhood, which assumes that women have complete control over their behaviour and therefore are blamed for "wilfully spreading social disorder"

(Ikemoto, 1992, p. 1218). Greaves et al. (2002) suggest that by focusing on discourses of motherhood, particularly those that concern women who use substances while pregnant, it is possible to draw out the strongest elements of prevailing attitudes and cultural values. In drawing out these attitudes and values it was my intention to wilfully break apart this 'social disorder' and expose the discourses that shape it.

For Foucault, discourses are productive; they are sometimes contradictory and sometimes coherent, purposed with building a picture or a representation of an issue or topic (Carabine, 2001). Discursive practices are constitutive and construct these pictures and representations as real, and are productive in that they have power outcomes and material effects. Not only do they define and establish particular 'truths' at particular moments that seek to invalidate other contradictory accounts (Carabine, 2001), but make it "virtually impossible to think outside of them" (Hook, 2001, p. 522). Discursive practices are "strongly linked to the exercise of power: discourse itself is both constituted by, and ensures the reproduction of, the social system, through forms of selection, exclusion, and domination" (Hook, 2001, p. 522). If discourse is constituted by, and ensures the reproduction of the dominant social system, then one must look to the ideologies invested in its propagation to begin to deconstruct discourse and its attendant power relations.

Weber (1968) speaks of power and domination "as the probability that certain specific commands (or all commands) will be obeyed by a given group of persons" (p. 212). This group of persons are likely to act out of obedience, interest, belief, and regularity, and these actions are performed voluntarily. When dominance is enacted over a period of time it becomes a structured phenomenon, realized in the social structures of

society—like the democratic nation state—and is "supported by a system of enforcement on the one hand, and a system of social regulation on the other" (Morrison, 2006, p. 362). Foucault's work extends Weber's concept of domination to the administration of corporeal, attitudinal, and behavioural discipline—that is, the disciplinary society—via discursive practices (O'Neill, 1986). For O'Neill (1986), Foucault "never loses sight of the body as the ultimate text upon which the power of the state…is inscribed" (p. 45). Thus, to dismantle discourses as found in FASD public awareness campaigns is to unveil the discursive practices that attempt to regulate and discipline the female body, the pregnant woman who uses substances; to expose the elasticity of the term FASD and our flawed understandings of it; and locate the exercises of power that seek to reproduce the status quo via exclusion and domination.

While unveiling discursive practices and locating exercises of power are important acts in of themselves, I argue that these steps are not revolutionary enough. A feminist poststructural approach to discourse analysis works to identify the context of ideas in which practices are situated, the history of those practices, and how they relate to social control (White & Epston, 1989). It is concerned with reflecting on, resisting, and transforming the discursive relations that constitute the female subject, the society in which she lives, and the options available to her (Weedon, 1987). Not only is feminist post-structuralism concerned with how discourse shapes women's lives, but with how individual and collective actions can be taken up in resistance and how the subject has the agency to recognize, resist, subvert, and alter the dominant discourse (Strega, 2005). Moosa-Mitha (2005) contends that a macro-level critique like discourse analysis, "which is often used to deconstruct mainstream assumptions, can result in upholding mainstream

assumptions because of [its] lack of a political agenda" (p. 59). By grounding my proposed project in feminist post-structuralist methodology, I choose to make a political statement, backed by an agenda, that has potential to contribute to material change in public health practice and policy and that may open possibilities for the transformation of public awareness-raising in BC.

Although I have come across discourse analyses of Canadian media representations of FASD (Huber, 1998), of prevention efforts targeting Indigenous women (Ferguson, 1997), and of knowledge production and practices associated with FASD (Schellenberg, 2012; Tait, 2003a), I have not discovered any instances of discourse analysis of FASD public awareness campaigns in Canada or elsewhere. The proposed project arrives at a timely and critical juncture, with scholars calling for increased attention to and research that focuses on factors that contribute to stigma for women who consume alcohol during pregnancy (Bell et al., 2015a; Meurk et al., 2014). With Canadian governments committing record-level spending to prevention efforts, for example Alberta's FASD 10-Year Strategic Plan has received $16.5 million per year since 2008/09 (Government of Alberta, 2013), and public awareness campaigns being highlighted in the media (Bell, 2015; CBC, 2014), often with controversy, it is my hope that the proposed project will make a useful contribution to the discourse.

Methodological Framework

Discourse, from a linguistics point of view, is a term commonly used to refer to written and spoken language (Fairclough, 1992). However, in social theory and analysis, language is a vehicle through which discourse is manifested in particular ways, using both language and other symbolic forms like visual images (Fairclough, 1992). Post-

structural understandings of discourse go beyond modernist conceptions of discourse as functional, transparent, and expressive, and "of words as representative of or signifying the objects or concepts to which they refer" (Strega, 2005, p. 215). Rather, discourse from the post-structuralistist point of view, and specifically from Foucault's, is not neutral; it does not simply "translate struggles or systems of domination, but it is the thing for which and by which there is struggle, discourse is the power to be seized" (Foucault, 1970/1981).

Discourse is a way of constituting knowledge together with social practices, forms of subjectivity, and social relations (Weedon, 1987). It cannot be separated from the subject it seeks to govern because it is through discourse and knowledge that the subject is created, constituted, and brought into being (Foucault, 1979). Of course, discourses are not naturally occurring or removed from that or whom by which they are produced. They are about what can be said and thought by whom, when, and with what authority; they embody meaning and social relationships, and constitute both subjectivity and power relations (Foucault, 1972). For Foucault, "discourses are not about objects; they do not identify objects, they constitute them and in the practice of doing so conceal their own invention" (1972, p. 49). They are also, as Foucault points out, in the business of disguising power relations to appear natural and normalized, actively working to maintain systems of domination and repression (Weedon, 1987).

Feminist post-structuralism

Feminism seeks to dismantle interlocking systems of oppression as well as foster women's empowerment and conditions of social justice (Hill Collins, 2000). It is attentive to issues of difference, the questioning of social power and resistance to

oppression, and makes an active commitment to political activism and social justice (Hesse-Biber, Leavy & Yaiser, 2004). However, Tuhiwai Smith (1999) notes that while feminist research has helped to open up new possibilities for working with women, the economically oppressed, ethnic minorities, and Indigenous women, it has also been guilty of promoting and practicing racism, ethnocentrism, and exploitation. The proposed project is aligned with anti-racist, anti-oppressive, and decolonizing philosophy as located within feminist thought, although this claim is not meant to insulate the project from critique.

While Foucault has been described as an "unlikely resource for feminist praxis given…his neglect of gender in his analysis of power and his displacement of the subject as a central agent for social change" (Naples, 2003, p. 27), there is an epistemological similarity among his understanding of local sites of resistance and their potential for transformation and that of feminism. As Strega (2005) points out, post-structuralism's interest in discourse, particularly in the constitution of language as discourse, resonates with feminist understandings of the ways in which discourse shapes women's lives (2005). The feminist post-structural subject does not exist solely as socially constructed by discursive practices, but exists "as a thinking, feeling, subject and social agent capable of resistance and innovations produced out of the clash between contradictory subject positions and practices" (Weedon, 1987, p. 125). Therefore, her choices may be defined by the dominant discourse but these choices can be taken up in resistance, and the subject has the agency to recognize, resist, subvert, and alter the dominant discourse (Davies, 1991). A feminist post-structural approach to discourse analysis then works to identify the context of ideas in which practices are situated, the history of those practices, and

how they relate to social control (White & Epston, 1989); as well as reflect on, resist, and transform the discursive relations that constitute the female subject, the society in which she lives, and the options that are available to her (Weedon, 1987).

A post-structural feminist approach does not insulate the proposed project from critique. Accepting the post-structural assertion that subjectivity is constituted solely through discourse has incited concern from researchers who worry about abandoning knowledge generated from women's experiences, particularly those who are marginalized and silenced in mainstream discourse, as well as "poststructuralists' contention that all accounts are…equally valid" (Strega, 2005, p. 223). An 'equally valid' existence stands in stark contrast to the lived experiences of women, which are inextricably tied to the material social conditions in which they live. Gavey (1989) and Weedon (1987) also wonder whether a feminist emphasis on privileging women's experience, while a valuable political strategy to give voice to women's oppression, risks running "parallel to hegemonic discourse" (Weedon, 1987, p. 110). These are concerns that I do not dismiss or take lightly. I accept that no theoretical orientation or methodology is perfect, just as no researcher is perfect. Rather, I embrace the possibility of this methodology to draw attention to the impact of ideas, norms, and language on lived experience, and the possibilities it enables for social action and social change.

Foucault on discourse and discipline

Foucault (1971/1986; 1972) defines discourse as a system of thought and social boundary that defines what can and cannot be said. It is composed of, and composes, forms of representation, codes, conventions, and habits of language that produce specific culturally and historically located meanings. It takes up ideas, ideologies, attitudes,

actions, and concepts that inform our understandings of self, the world, and others. It exists in both written and oral forms and is embedded in our everyday practices of social life (Weedon, 1987). According to Weedon (1987), in order to "be effective, [discourses] require activation through the agency of the individuals whom they constitute and govern in particular ways as embodied subjects" (p. 108). Thus, discourses are only effective when a person (subject) both consciously and unconsciously regulates his or her behaviour according to the boundaries and subjectivities that are offered by the discourse. Discourse then functions as a form of discipline: a mechanism of power that regulates the behaviour of social bodies (Foucault, 1972). Moral discourse then specifically directs this self-regulation to ethics, values, ideals, and virtues that are preferred and upheld by the dominant culture, encouraging (or threatening) one to fall in line with systems of public thought. The proposed project seeks to uncover these discourses pertaining to motherhood as found in FASD public awareness campaigns.

'What's the problem represented to be?'

Osborne (1997) suggests that Foucault's (1988) notion of problematization is useful when examining government health policy. For Foucault, problematizations "are not modes of constructing problems but active ways of positing and experiencing them" (Osborne, 1997, p. 174). Osborne takes this to suggest that governments cannot 'put policy to work' without first problematizing its territory and delimiting what can and cannot be said about the problem. Further, Bacchi (2009), in tandem with Osborne, makes the point that because policies claim to 'fix' things, and hence assume the existence of problems that need 'fixing,' we need to "direct our attention away from assumed 'problems' to the shape and character of problematizations" (p. xi) instead.

According to Bacchi, it is only when we turn our attention to the characterization of a problem that we begin to understand how an issue is being understood, how it is being enacted upon through policy, and what needs to change.

Bacchi's (2009) analytical framework, "What's the problem represented to be?" (p. xii) is useful for examining how social 'problems,' like FASD, are problematized, and how 'solutions' are actualized in policy. The framework rests on Bacchi's argument that problems are endogenous, or created within the policy-making process rather than existing outside, and that "policies give *shape* to 'problems'" (p. x, italics in original) rather than addressing them. She provides six questions[1] to use when analyzing policy documents, although this project takes up only the first two:

1) What is 'the problem' represented to be in FASD public awareness?
2) What presuppositions or assumptions underlie this representation of 'the problem' in FASD public awareness?

Data Collection

One of my primary concerns regarding data collection was how to obtain a sufficient sample of discursive items for analysis. Given the historical timeframe, I anticipated some difficulty sourcing documents that were produced before the advent of the internet or before its common use. Even then, I thought it might be particularly difficult to source community-produced documents and broad-based documents that had

[1] Questions three through six are as follows:

3) How has this representation of the 'problem' come about?
4) What is left unproblematic in this problem representation? Where are the silences? Can the 'problem' be thought about differently?
5) What effects are produced by this representation of the 'problem'?
6) How/where has this representation of the 'problem' been produced, disseminated and defended? How has it been (or could it be) questioned, disrupted and replaced?

not been archived online. Given the 39 year time period, I also expected that some of the document's producers may have closed or opened as different iterations, and that some documents may be in accessible due to being thrown out or archived. These concerns necessitated a multi-pronged approach to data collection and use of mixed purposeful sampling methods.

Pre-data collection exploration of available resources revealed that sourcing documents would best be performed simultaneously. I conducted snowball sampling, reaching out to researchers working in FASD prevention and authors of dissertations featuring FASD public awareness documents produced in BC or that were critical of FASD prevention, who in turn provided me with the names of others they thought may have documents or know where to find them. This method yielded nine documents. I also reached out to FASD prevention organizations I knew of or that had been recommended by researchers and authors. This method yielded ten documents. I conducted these communications by email, phone, and in-person. I searched through the University of Victoria and Legislative Assembly of BC's Legislative Library archives, sourcing 15 documents; and on provincial and federal government and government agency websites, sourcing another two documents. I reached out to BC Liquor Stores, who provided three documents. Lastly, I used Google and a list of relevant search terms pulled from the literature review (e.g., FAS, FASD, fetal alcohol, British Columbia, alcohol, pregnancy, etc.). I conducted Google searches using all possible search term combinations using until no new results were produced. Then, I systematically looked through the Google image results and listed websites for any FASD health promotion documents produced between 1973 and 2016 in BC. This method yielded two documents.

In order to be included in the study, documents had to meet the following inclusion criteria: be produced in English language, consist of text and imagery (illustration or photographic), be produced in BC by a BC-based organization, have a primary focus on alcohol, and be in a format standard of public awareness campaigns (e.g., posters, brochures, infographic, information booklet). Documents could be sourced in print format or electronically. It was imperative that documents contain both text and imagery, because as Hall (1997) notes, the meaning of a specific image "does not lie exclusively in the image, but in the conjunction of image *and* text" (p. 228, italics in original). Indeed, Hall notes that stereotyping occurs when representation and discourse converge in a way that is powerfully evocative and representative of inequalities of power; thus, documents required both a textual and visual component to be included in the study.

In total, forty-one documents of seven different types produced between 1979 and 2015 were collected (see Table 1). Of these 41 documents, 15 in total were produced by Indigenous organizations and/or for an Indigenous audience; of these 15, four were intended for both a non-Indigenous *and* Indigenous audience (i.e., included Indigenous women and/or services as part of the overall content). Data collection occurred from January to June 2016 in Victoria, BC.

Table 1: Document ID, year produced, type, producer, and process of location

Document ID	Year	Type	Producer	How Document was Located
1A	1979	Brochure	Province of BC, Ministry of Labour and Consumer Services (adapted from Yukon Alcohol and Drug Services)	BC Legislative Library
2A	1998	Brochure	YWCA Crabtree Corner FAS/NAS Prevention & Support Services	YWCA Crabtree
2B	1997	Poster	BC Aboriginal Network on Disability Society in partner with Health Canada	FASD researcher

2C	1997	Poster	BC Aboriginal Network on Disability Society in partner with Health Canada	FASD researcher
2D	1997	Poster	BC Aboriginal Network on Disability Society in partner with Health Canada	FASD researcher
2E	1997	Poster	BC Aboriginal Network on Disability Society in partner with Health Canada	FASD researcher
2F	1999	Poster	BC Women's Hospital & Health Centre, Sunny Hill Centre for Children, BC Liquor Stores	BC Legislative Library
2G-1–10	1993	Calendar	BC Ministry of Health and Ministry Responsible for Seniors, Alcohol and Drug Programs	BC Legislative Library
2H	1993	Poster	BC Ministry of Health and Ministry Responsible for Seniors, Alcohol and Drug Programs	BC Legislative Library
2I	1993	Recipe card	BC Ministry of Health and Ministry Responsible for Seniors, Alcohol and Drug Programs	BC Legislative Library
2J	1998	Brochure	BC FAS Resource Society, endorsed by the Doctors, Nurses and Midwives of BC	BC Legislative Library
2K	1998	Information booklet	Vancouver Aboriginal Friendship Centre Society	Spirit of the Children Society
2L	1999	Poster	Ktunaxa Independent School Society	FASD researcher
3A	2003		Children's and Women's Health Centre of BC, adapted with permission from Vancouver Island Health Authority, revised by Fir Square Family Education (2004)	BC Women's and Children's Hospital
3B	2005	Brochure	YWCA Crabtree Corner	YWCA Crabtree Corner
3C	2006	Information card	SNAP and Groundwork Press	Spirit of the Children
3D	2006	Poster	The Asante Centre in partner with Katzie First Nation, funded by First Nations Inuit Branch	Spirit of the Children
3E	2006	Information card	SNAP and Groundwork Press	Spirit of the Children
3F	2005	Poster	PEERS, funded by Health Canada	FASD researcher
3G	2006	Poster	The Asante Centre	The Asante Centre
3H	2006	Poster	BC Women's Hospital & Health Centre, BC Centre for Social Responsibility, ActNowBC, BC Liquor Stores	FASD researcher
3I	2005	Brochure	The Asante Centre	The Asante Centre
3J	2005	Brochure	YWCA Crabtree Corner	YWCA Crabtree Corner
3K	2005	Brochure	YWCA Crabtree Corner	YWCA Crabtree Corner

4A	2011	Brochure	Future Cents Youth, Northern Family Health Society, funded by the BC Ministry of Employment & Income Assistance	Aboriginal Child Family Support Services
4B	2015	Brochure	BC Liquor Stores, BC Women's Hospital & Health Centre	BC Liquor Stores
4C	2010	Brochure	BC Liquor Stores, BC Women's Hospital & Health Centre	BC Liquor Stores
4D	2014	Poster	BC Liquor Stores	BC Liquor Stores
4E	2015	Poster	Education Training Council, BC Centre for Excellence in Women's Health, Canada FASD Research Network	FASD researcher
4F	2012	Comic	Health Canada, The Healthy Aboriginal Network	Google
4G	2013	Poster	District of Maple Ridge	FASD researcher
4H	2013	Poster	Nisga'a Valley Health Authority	Google

Following Foucault's genealogical methods (1970/1981), I planned to organize the documents according to the decade in which they were produced in order to create an historical snapshot of the discourse. Once I finished data collection and could confirm the dates of document creation and/or dissemination, the time periods were finalized, beginning with the year of the earliest sourced document: 1979–1989, 1990–1999, 2000–2009, and 2010–2015. In some cases, the exact year of the document's production was not clear due to employees having moved on, the organization having lost the original copies, or there being no recorded date of document production. In these instances, organizations were asked to provide an estimate of the year of production and documents were then evaluated on appearance and content to corroborate the estimate (e.g., type of clothing worn in photographs, style of document, or whether a website or hotline number was provided).

Data Analysis

According to Carabine (2001), there are no "hard and fast rules" (p. 268) for performing a Foucauldian-inspired discourse analysis. Rather, what genealogy provides is a lens for historical inquiry that enables the researcher to deconstruct concepts of discourse/power/knowledge by focusing on the specificity and locality of universal 'truths' (Carabine, 2001; Scott, 2009). Of course, the difficulty of such discourse analysis is its inherent lack of structure—there is no guidebook, no how-to manual.

Once the data was collected the documents were imported into ATLAS.ti Mac qualitative data analysis software (ATLAS.ti), I created an initial coding schedule using Bacchi's (2009) first and second questions and drawing from the literature review. Then began three rounds of iterative coding: codes were revised, collapsed, and added. As Fusch and Ness (2015) note, there is no *one-size-fits-all* [emphasis in original] method to reaching data saturation. Rather, the best way to think of saturation may be to think of data as becoming rich and thick—rich in quality, thick in quantity. After three rounds of coding, and with no new emergent themes or sub-themes, saturation was reached. Alongside the process of coding, I highlighted and marked up paper copies of the documents, made notes in the margins, and created a web of sticky notes on an office wall. In tandem, these processes helped me to organize and to see connections I had not noticed before. Through the messiness of discourse and without a how-to-manual, I was able to make sense of the many conflicting discourses of motherhood found in the documents.

Chapter 4: Findings and Data Analysis

I have structured this discourse analysis around Bacchi's (2009) problematization framework and its first two questions. During analysis, I moved through the questions in sequence, as they are interrelated yet the second builds upon the first. Following Foucault's genealogical methods (1970/1981), I analyzed the data as a single unit but through a temporal lens, deconstructing the discourses and also tracing their evolution in terms of shifts and consistencies, convergences and divergences, over time. While I moved chronologically through the data, I structured my findings according to the themes that emerged most dominantly and that I considered most important. For instance, themes that appeared infrequently or not at all sometimes deserved as much critical attention as those that were prevalent, given DeVault and Gross's (2012) assertion that:

> One of feminism's central claims is that women's perspectives have often been silenced or ignored; as a result, feminist researchers have been interested in listening for gaps and absences in women's talk, and in considering what meanings might lie beyond explicit speech. (p. 217)

Throughout my analysis I made a conscious effort to examine textual content for its explicit and implicit meanings, as well as for the ideological significance of image and text together. I considered which discourses of motherhood were reproduced and legitimated, how discourses evolved over time and why, and whether these discourses contribute to stigma experienced by pregnant women who use alcohol. Some quotes drawn from the documents are used more than once in analysis, as they cross and/or intersect multiple discourses.

What is the 'Problem' Represented to Be?

Bacchi's (2009) first question, "What is 'the problem' represented to be?" is intended to reveal how a specific issue, in this case FASD prevention and public

awareness-raising, is being thought and talked about by bringing to light how it is represented. I began my analysis by asking this question of the data, finding overwhelmingly that in each of the documents and across the four constructed time periods, the 'problem' to be solved is women who drink while pregnant, and the problem representation is a woman's 'choice' to either consume or abstain from alcohol during pregnancy.

This 'woman's choice' discourse, which can be situated within a larger personal responsibility discourse, varies in the way it is framed, commonly involving only the mother-baby dyad. It often focuses strictly on alcohol use prevention and sometimes extends beyond a pregnant woman's agency to the individuals and circumstances that might affect her decision to drink alcohol. These individuals and circumstances include a pregnant woman's circles of support, her social and physical environments, overtly 'risky' behaviours like smoking and drug use, as well as other lifestyle choices (e.g., diet) that either support or denigrate fetal health. In order to solve the 'problem' of women who drink alcohol while pregnant, prevention messaging aims to persuade women to abstain from alcohol during pregnancy, encourages others to help her abstain, and works to raise public awareness. In order to achieve these goals, documents employ three overarching variations of the woman's choice discourse: 1) a woman has a duty to her fetus, 2) a woman has a duty to her own health, and 3) a woman has a duty to her community.

Duty to the Fetus

A woman's duty to her fetus was the most dominant theme found within the documents and can be interpreted as a woman's self-sacrificing 'natural and maternal'

obligation to her fetus and baby. Over time, maternal duty has been described as a "divine duty" (Richardson, 1740, p. 49) and "the preferred biological, social, and ethical destiny of all women" (Markey, 2010, p. 169). Realistically, it can be defined as the socially prescribed responsibilities of a particular time period that concern the behaviour of pregnant women and mothers, who are seen as assuming the social role and (dominant) cultural connotations of motherhood, often before giving birth.

In these data, a woman's duty to her fetus was often portrayed as her obligation to protect it from all risk, harm, and sickness associated with FASD, and the pregnant woman was depicted as both protector and threat. This duty was sometimes presented as one of preventing lifelong social suffering associated with FASD for the future child as well as its mother, family, and community. While these two representations of maternal duty remained consistent over time, the tone of messages became increasingly polarized, with some retaining or escalating punitive and fear-provoking messaging and others moving towards messages of harm reduction, acceptance, and support.

To a lesser degree, this messaging was framed around women's lack of knowledge regarding how much alcohol is safe to consume during pregnancy, thereby deeming all alcohol use unsafe or potentially harmful, despite advancements in research complicating or negating these claims. In addition, these representations of maternal duty sometimes ascribed human characteristics to the fetus, for example "Baby knows when you're drinking alcohol too" (2G-6, 1993), in an attempt to position the fetus as a thinking and feeling baby. This rhetorical strategy works to promote alcohol abstention by highlighting the relationship and culturally understood bond between mother and baby.

The following sub-sections elucidate how the general theme of maternal duty was framed in order to persuade women to abstain from alcohol during pregnancy, to persuade others to help, and to raise public awareness: 1) by protecting the fetus from risk, harm, and sickness, 2) by preventing social suffering associated with FASD, 3) by focusing on the lack of knowledge regarding how much alcohol is safe to consume during pregnancy, and 4) by attempting to humanize the fetus.

Fetal health and preventing risk, harm, and sickness

A pregnant woman's duty to her fetus was primarily depicted as her role in keeping the fetus safe and healthy as well as protecting it from any risk, harm, or sickness associated with alcohol consumption and other external stressors. Most times these physical harms were explicitly labelled as or connected to FASD. For example, one poster of three males presenting diagnostic FASD facial features negatively states: "We live with Fetal Alcohol Syndrome every day of our lives. Please don't drink alcohol during pregnancy" (2B, 1997). This message is simple: do not consume alcohol while pregnant as it will result in FASD (meaning, a damaged life). In many other documents these threats remained vague or unspecific, never mentioning FASD and offering little explanation, scientific or otherwise, as to how and why alcohol is detrimental: "Why alcohol is bad for your baby: You share whatever you drink with your unborn baby. Alcohol can damage your baby's brain, heart, and other organs for life" (2G-4, 1993). Other times this duty to protect extended beyond alcohol consumption to threats posed by a pregnant woman's lifestyle choices, like poor nutrition, smoking, as well as other licit and illicit drug use: "Stay away from alcohol, drugs and things that will harm you and:

get lots of rest, eat healthy meals, visit a doctor regularly, go to prenatal classes" (2A, 1998).

In the only document produced between 1979 and 1989, pregnant women are consistently reminded that drinking during pregnancy can harm the fetus or make the future baby sick:

> "Drinking during pregnancy can hurt your unborn baby" (1A, 1979).
>
> "If mother drinks too much or often it can make the baby sick" (1A, 1979).
>
> "Babies who have had too much to drink because their mothers drank too much are often sick a lot" (1A, 1979).

The document does not explicitly connect potential harm and sickness to FAS, perhaps due to the relative newness of the disorder and the poster's production only six years after its labelling. The research to that point, with some uncertainty, discussed FAS as "a series of rather aspecific abnormalities…observed only in the offspring of chronic alcoholic mothers" (p. 6), while recognizing that lower levels of alcohol consumption still had the potential to produce poor health outcomes (National Institute on Alcohol Abuse and Alcoholism, 1979). This may account for a lack of specificity regarding exactly how much alcohol is most threatening to the fetus, alcohol's teratogenic effects, or how to mitigate risk; as well as the tendency of messaging at that time to rely on fear and potential judgement of hurting or producing a sick infant to motivate pregnant women to abstain (e.g., an illustration of a male doctor examining an infant accompanies the document's second statement).

At the same time, as new mothers were still being encouraged to drink beer to increase lactation (Mennella, 1995) and rub alcohol on teething babies' gums (Peele, Brodsky, & Arnold, 1991), prevention messaging in the 1990s increasingly connected

FASD directly to alcohol consumption during pregnancy. In this climate of contradictory advice, some claims about alcohol-related harms increased in specificity—to an extent—and talked about how to mediate risk:

> "To you it's just one drink, for your baby it could mean a lifetime of struggles. The truth is, when you drink, so does your baby. The more you drink, the more your baby drinks, increasing the risk of birth defects such as Fetal Alcohol Syndrome" (2L, 1999).

> "What else can I do to protect my baby? 1) Get lots of rest, 2) see your doctor, nurse or midwife regularly, 3) eat healthy food, 4) stop, or cut down, your use of cigarettes and other drugs, 5) reduce your stress" (2J, 1998).

However, fear-based and vague messaging persisted. For example: "Your baby can't get FAS if you don't drink alcohol" (2G-3, 1993), and "Pregnant? Did you know alcohol can hurt your baby?" (2J, 1998). Despite this persistence, prevention documents generally included more information on behaviours that increased the risk of FASD as well as how to mitigate risk. Messages also took on a less punitive tone and became more instructive:

> "Breastfeeding creates a special bond between you and your baby. But remember, whatever your drink your baby drinks too – so choose a healthy drink. Avoid alcohol" (2G-10, 1993).

> "The safest choice you can make is **not** to drink while you are pregnant. If you need help, be sure to talk to someone. Friends, family, or a doctor, nurse, or counsellor can help" (2J, 1998).

This shift in messaging and tone occurred at the same time harm reduction approaches were being integrated into service delivery for pregnant women and mothers and elsewhere in public health in Canada (BC Centre of Excellence for Women's Health [BCCEWH], 2015). These trends continued throughout the 2000s and into the 2010s, with most documents now making an explicit link between FASD and alcohol consumption during pregnancy. For example: "If you are pregnant and can't stop drinking seek help! FASD is forever" (3F, 2005), and "50% of women do not know they

are pregnant for 6-8 weeks…if you consume alcohol, FASD can occur" (4A, 2011). On one hand, some messages were increasingly grounded in evidence-based rhetoric, written in supportive, non-judgemental language, and took into account other detrimental substance use and lifestyle activities on the health of a developing fetus:

> "When you drink during pregnancy, your baby is at risk of Fetal Alcohol Syndrome (FAS). This is especially true with heavy drinking. People with FAS: 1) [are] smaller all their lives, 2) have central nervous system damage resulting in learning problems, short attention span, hyperactivity, poor muscle tone and coordination, 3) have facial abnormalities (i.e., small eye openings, drooping eyelids, flat wide nose bridge, thin upper lip, flattened area between nose and lip)" (3A, 2003).

> "It can be a fight every day to not drink or use. Every step you take to stop drinking alcohol or using drugs will help you and your baby" (4E, 2015).

> "Healthy mothers and babies need everyone's support" (4D, 2014).

On the other hand, despite an increase in scientific evidence, some documents communicated information that was misleading or incorrect:

> "What about just one drink? A woman doesn't have to be a heavy drinker for her baby to be affected. Current research shows there is no safe limit of alcohol. The type of drink a pregnant woman consumes doesn't matter either. Beer, coolers, or hard liquor all have negative effects on a baby before it is born" (3C, 2006).

However, some research suggests that pregnant women can consume up to nine drinks per week with no significant effect on attention function in children (Underbjerg et al., 2012); and that spirits, rather than wine and beer, have a more detrimental impact on a developing fetus and more frequently result in miscarriage (Avalos, Roberts, Kaskutas, Block, & Li, 2014). Some documents used non-judgemental and supportive language to convey ideas that were actually very judgemental or supported policing pregnant women's behaviour. For example:

> "As an employee or proprietor of a bar, restaurant, pub or other licensed establishment, you can't legally stop a woman from drinking…As caring

> members of the community, you can suggest alternatives to drinking alcohol while pregnant such as non-alcoholic beverages…remember – she's not drinking alone" (3C, 2006).
>
> "Let's face it, saying "NO" to alcohol can sometimes be hard. You're at a party or a bar and everyone is having lots of fun. You might think that drinking mineral water or fruit juice is boring. After all, what's one drink going to do to the unborn baby?" (3E, 2006).

Interestingly, from 2010 forward, documents trended away from explicitly making a connection between alcohol use during pregnancy and FASD, with many posters focusing instead on simple messaging and imagery of pregnant bellies. Despite often using the same format, there was a notable divergence between documents with supportive and punitive messaging. Posters with supportive language and imagery centred pregnant bellies and happy heterosexual and cisgender couples, effectively excluding the pregnancy experiences of non-binary, trans, and queer women, alongside messages like: "Alcohol and pregnancy don't mix: Healthy mothers and babies need everyone's support" (4B, 2015; 4C, 2010; 4D, 2014). Punitive documents excluded all but a woman's bare pregnant belly from the frame, alongside messages like: "Nine Zero: Nine months, zero alcohol" (4H, 2013) and "I'm [fetus] here: Zero alcohol. No safe time. No safe amount." (4G, 2013).

Prevent social suffering

In addition to ensuring the physical health of her fetus and preventing alcohol-related harms, messages presented a pregnant woman's maternal duty as also protecting the fetus from any social suffering that may arise from FASD. Similar to her role in preventing physical harms, the pregnant woman was positioned both as threat and protector: if she 'chooses' to consume alcohol while pregnant she may condemn her child to a life of social deviance and punishment, whereas abstaining makes a 'normal' social

life possible. Her duty to protect the fetus from alcohol-affected socially deviant behaviours is easily found across all time periods and in many of the documents, for example:

> "FAS is a group of problems that can show up in babies whose mothers drank alcohol while pregnant, including: … learning slowly, too active (hyper), problems getting along with others" (2A, 1998).

> "As the child grows older he or she may have trouble with: school, paying attention, seeing & hearing, making friends, the law, holding down a job" (3E, 2006).

> "The effect of drinking alcohol during your pregnancy on the developing brain can mean that your child can have learning difficulties and problems with memory, reasoning and judgment" (4B, 2015).

While these behaviours are often traced back to physical qualities, like a "smaller brain" (2A, 1998) or "mental handicap" (2J, 1998), the implication is that physical and mental deficits guarantee social deficits. This is not to say that individuals with FASD do not experience social difficulties—research shows that alcohol-affected individuals often lack emotional lability, social competence, and communication skills, and exhibit problem behaviours like physical aggression, disruptiveness, impulsivity, and hyperactivity (Rasmussen et al., 2008). However, social 'difficulties' are culturally defined using value-laden knowledges. As FASD has been constructed and continually portrayed as undesirable within biomedical and social contexts, it has reflected a socially defined binary of 'ideal' and 'deviant' social behaviour, as well as the assumption of stigma against individuals and families affected by FASD (Armstrong, 2003).

The social suffering associated with FASD is also seen as having a potentially negative impact on families, communities, and society in general. For example, one message produced by the BC Aboriginal Network on Disability Society and Health

Canada states: “We all have a role to play in a healthy family. Please don’t drink alcohol during pregnancy” (2C). Another shows a photo of 11 smiling youths with the message: “Friends help friends choose a healthy lifestyle…Healthy pregnancy. Healthy baby. Healthy Nation” (2D). One information card produced by Snap and Groundwork Press encourages employees and proprietors of bars, restaurants, pubs and other licensed establishments to suggest alternative drinks to pregnant women because they are “caring members of the community” (3C, 2006). The insinuation is that pregnant women and mothers, and society in general, have a responsibility—an obligation, even—to produce healthy babies and citizens in order to ensure healthy families, communities, and nations.

Foucault describes culture as “a hierarchical organization of values, accessible to everybody, but at the same time the occasion of a mechanism of selection and exclusion” (2001, p. 173). In this case, a pregnant woman’s duty to prevent social suffering is anchored within discourses that reproduce cultural and social hierarchies and delineate how social beings can acceptably behave. For example, when a pregnant woman is encouraged (or mandated) to abstain from alcohol in order to produce a healthy (i.e., able-bodied, self-regulating, socially competent, and communicable) infant, those qualities are reinforced as culturally and socially desirable. The data do not just reflect messages about social difficulties associated with FASD; rather, by describing ‘abnormal’ behaviours, they illuminate what is considered acceptable social behaviour in Western culture. Western culture can be defined as Western civilization, with its roots in European and Mediterranean antiquity, and is based on three major traditions including: classical Greek and Roman culture, the Christian religion, and the scientific method (Perry, Chase, Jacob, & Jacob, 2009). The term “Western” as used in this thesis refers to

"a mind-set, a worldview that is a product of the development of European culture and diffused into other nations like North America" (Ermine, Sinclair, Jeffery, & IPHRC, 2004, p. i). The pregnant woman's duty then is not only to protect the future social life of her developing fetus, as well as her own and that of her family and community, but to preserve and reproduce dominant cultural values. Although this cultural transmission can be subtle to detect, it is sometimes blatantly exemplified by messages that encourage women or society members to prevent FASD for the greater collective good: "Healthy pregnancy. Healthy baby. Healthy Nation" (2B, 2C, 2D, 2E, 1997).

Generally, messages regarding alcohol-related social concerns for developing babies, families, communities, and society in general varied little from one time period to the next. The earliest document, produced in 1979, advises pregnant women to abstain from alcohol, otherwise their babies will be smaller than "normal" babies and "stay that way for a long time…never getting as big as other children their own age" (1A, 1979). This message is accompanied by an illustration of a short, cowering male child being looked down at by two older 'normal' (i.e., average-sized, Euro-Canadian, middle-class) children. The document also contains an illustration of a baby with building blocks and a large question mark hovering over its head, with the message: "Some even have mental problems and can't think straight" (1A, 1979). The pregnant woman's duty then is to make the right 'choice' so that her baby is not socially ostracized by its 'abnormal' size and/or mental abilities.

From the 1990s to 2015, messages about fetal exposure to alcohol and children with FASD highlight potential health and learning problems.

> "FAS is a group of problems that can show up in babies whose mothers drank alcohol while pregnant, including: small size and not growing well, small eye

> openings, thin upper lip, crowded teeth, smaller brain, learning slowly, too active (hyper), problems getting along with others" (2A, 1998).

This quote is accompanied by a commonly used brain scan photo of a "normal brain" and "FAS brain" (2A, 1998). It should be noted that scholars have critiqued this type of brain scan imagery as being misleading for inferring that brain function is directly related to brain size and appearance—a kind of modern phrenology (Roskies, 2010; Uttal, 2011). Although most 'problems' listed are physical abnormalities associated with FASD, the insinuation is that physical problems lead to social problems (e.g., "getting along with others"). Another brochure warned that babies and children with FAS "may be hyper" and "may have problems seeing, hearing or speaking", and "older children and adults with FAS may be at risk for: depression, dropping out of school, alcohol and drug problems, trouble with the law" (2J, 1998). While none of these issues is connected only to FASD, or even considered pathologic outside the context of FASD, they are problematized as specific to FASD.

Lack of knowledge

One of the ways that public awareness documents promote alcohol abstention during pregnancy is by claiming there is a lack of knowledge regarding how much can be safely consumed before harm is done to the fetus (thus, it is better to consume none at all). This message can be found across all time periods and in a large number of documents, remaining fairly consistent from 1979 to 2015. In 1979, the lack of knowledge message was simple and straightforward: "No one knows just how much alcohol an expectant mother can drink without hurting the baby…so it's best not to drink at all" (1A, 1979). This simple and dominant variation was repeated throughout the 1990s, 2000s, and 2010s:

> "There is no known safe amount of alcohol for your baby" (2G-4, 1993).
>
> "A woman doesn't have to be a heavy drinker for her baby to be affected. Current research shows that there is no safe limit of alcohol" (3C, 2006).
>
> "With alcohol and pregnancy: No safe time…No safe amount" (4A, 2011).

However, messages did not always maintain this uniformity. There were some shifts regarding quantity, frequency, and timing of drinking beginning in the 2000s. For example, one document produced in 2003 warns women: "If you drink a lot of alcohol while pregnant (either bingeing or drinking regularly), you increase your risk of having a baby with lasting birth defects" (3A, 2003). This same document also recommends not drinking alcohol or "[drinking] small amounts occasionally" while breastfeeding. Another document produced in 2015 poses three somewhat contradictory questions and answers:

> "Are there any safe times for pregnant women to drink alcohol? Drinking alcohol can be harmful at any point during pregnancy. The baby's brain and nervous system develops throughout the entire pregnancy" (3A, 2003).
>
> "Is there a safe amount to drink when pregnant? There is no known safe level of alcohol use during pregnancy, so it is safest not to drink at all when women are pregnant or planning to become pregnant" (3A, 2003).
>
> What if I was drinking before I knew I was pregnant? Having a small amount of alcohol before you knew you were pregnant is not likely to harm your baby" (3A, 2003).

In this document pregnant women are advised to abstain from alcohol because there is no known safe amount and the baby's brain and nervous system is said to develop throughout pregnancy, yet are also advised that drinking before pregnancy is known is not likely to harm the developing fetus. This contradiction indicates a disconnect between public health messaging and biomedical research.

Research that followed the labelling of fetal alcohol syndrome in 1973 maintained that any woman who drank a substantial amount of alcohol during pregnancy could give birth to a child with FAS, the most severe form of alcohol-related harm. According to May and Gossage (2011), “no one was fully aware then of how much prenatal exposure to alcohol in any particular individual woman was necessary to cause the recognizable features of FAS that met the diagnostic criteria at the time” (p. 16). Thus, the 1979 prevention message was closely in line with medical understandings at that time. However, in the mid 1990s research began to emerge that indicated, while FASD had only one known necessary factor—alcohol—it was intimately linked to other “permissive” factors, like behavioural patterns of alcohol consumption, low socioeconomic status, cultural influences, and cigarette smoking. Abel and Hannigan (1995) define these permissive factors as socio-behavioural risk factors for FAS, and argue that in turn these permissive factors can become “provocative” biological causes, “provoking cellular changes which enhance alcohol’s toxic actions” (p. 455). Of course, risk factors like smoking, low socioeconomic status, and cultural influences are closely linked to the social determinants of health, or those “overlapping social structures and economic systems that are responsible for most health inequities” (Centers for Disease Control and Prevention [CDC], 2014). This means that pregnant women who experience greater health inequities may be at higher risk of producing an alcohol-affected infant if they consume alcohol during their pregnancy.

Throughout the 2000s, research continued to elucidate connections between FASD and the quantity, frequency, and timing of alcohol consumption during pregnancy (May et al., 2013); as well as maternal age, number of pregnancies, number of times

given birth, body size, nutrition, socioeconomic status, metabolism, other drug use, and social relationships (May & Gossage, 2011). However, the prevention message remained the same: no one knows how much is safe to drink. Inherent in this kind of messaging are two underlying beliefs: one, that pregnant women are unable to comprehend the complexity of FASD-related biomedical research or may become confused when encountering varying international health guidelines (Holland, McCallum, & Walton, 2016); and two, that any ambiguity in the guidelines might provide an 'excuse' for women to drink while pregnant and therefore must be avoided. The latter belief is just one of the ways those in power have attempted to control pregnant women's substance use: by promoting a view of the fetus as "in need of protection from [its mother's] 'immoral' or 'irresponsible' behaviour" (Rutman, Callahan, Lundquist, Jackson, & Field, 2000, p. 7).

Endowing the fetus with human characteristics

According to Williams, Alderson, and Farsides (2001), the status of the fetus is "socially, culturally and politically constructed, and varies depending on who is caring for it, who is attributing the meanings, and what the work goals are" (p. 226). Therefore, it is not accidental that the fetus has been positioned in public awareness documents as a thinking and feeling baby—as a *human*. This works as a rhetorical strategy to highlight the relationship and culturally understood bond between mother and baby, with hopes of strengthening a pregnant woman's conviction to abstain from alcohol. It is critical to note that in Canada the fetus is not a legal person, although this has not prevented efforts to criminalize women who consume substances while pregnant (Boyd, 2015).

In nearly all of the documents the fetus was repeatedly referred to as “baby” or “developing baby,” and was often endowed with human characteristics and capabilities, for example sentience and the ability to consume alcohol and verbalize thoughts (see Figure 1):

> “Did you know when a pregnant woman drinks, so does her baby?” (3C, 2006).
>
> “You share everything with your baby. Your baby feels it when you roll over…hears you when you sing…knows when you’re asleep. Baby knows when you’re drinking alcohol too” (2G-6, 1993).
>
> “I’m here [writing across bare pregnant belly]” (4G, 2013).

Figure 1: "I'm here," written on a pregnant woman's belly (4G, 2013)

Featherstone (2008) argues that twentieth-century technologies like ultrasound, X-rays, and intra-uterine photography have changed our relationship with the fetus, shifting our gaze away from the pregnant woman to the fetus or developing ‘person’ within her. McCullough and Chervenak (2008) further argue that attempts to elevate the fetus to personhood status are not simply about whether a fetus constitutes a person, but part of a larger strategy to promote its status—its ‘rights’—and often at the expense of women’s. By attributing human characteristics to the fetus, public awareness documents serve two purposes: to encourage a pregnant woman to reflect on her relationship with

her ‘developing baby,’ but also to divert public attention from the mother to the fetus. By diverting this attention, documents invoke dominant discourses of child-centred mothering, neoliberal self-responsibility, and risk, positioning children as more vulnerable than in the past and decreasing legitimacy of women’s own needs and desires (Wall, 2013). This in turn may motivate the public to feel outraged at maternal alcohol use and motivated to police pregnant women’s behaviour.

Preferred meaning

Visual scholar Stuart Hall (1997) suggests that meaning is constructed through both language and visual representation, and that in order to ascertain the meaning of a specific image, one must study the image in conjunction with its text. Furthermore, Hall maintains that when images are used repeatedly over time (e.g., the juxtaposed image of a “normal brain” and an “FAS brain”) their meanings accumulate, creating and perpetuating stereotypes and reducing people to “simple, essential characteristics” (p. 257).

Happy babies and booze bottles

While visual and textual representations of a pregnant woman’s duty to the fetus shifted in content and presentation from 1979 to 2015, representations deviated little thematically from one time period to another. In some cases, image and text were effectively combined to produce fear and shock-tactics, particularly in the 2000s: “Any chance you might be PREGNANT? ZERO ALCOHOL” (4G, 2013) is displayed on a poster featuring a pregnant belly inscribed with white lettering saying, “I’m here” (4G, 2013). This poster used intimidating black and red colours for background and text as well as a jailhouse font, similar to those used in legal commercials.

However, in most cases text and image acted in juxtaposition: if the text used non-judgmental and supportive language the imagery depicted danger, threat, and even punishment, and vice versa. For example, one poster's text, which states, "Alcohol can hurt your baby", is overlaid on an image of a mother holding her happy, healthy baby close to her chest; her eyes are closed and she appears serene and satisfied (2F, 1999). In another brochure the text states, "You can make a difference to your child's health," and just below is a photograph of a teddy bear, a bottle of dark liquor with a bottle nipple instead of a cap, and an intravenous needle (2A, 1998) (see Figure 2). Into the 2000s, this thematic juxtaposition remained but was more understated: for example, some posters and brochures stated, "Alcohol and pregnancy don't mix" and featured photographs of happy, embracing, heterosexual couples (4B, 2015; 4C, 2010; 4D, 2014). Often the male partner or expectant father embraces the woman from behind, encircling her pregnant belly. These types of images seem to suggest that so long as alcohol consumption during pregnancy is avoided, and a happy, healthy, and 'normal' baby is produced, a happy and healthy life awaits baby, mother, and family.

Figure 2: Teddy bear, liquor bottle, and syringe (2A, 1998)

Images also served to bolster textual messaging. Explicit warnings of alcohol-related harms were accompanied by images of illustrated babies shrieking in discomfort and crying (1A, 1979; 2J, 1998), or with a blue face (3F, 2005), or with a "small head, thin lips, short eye slits, small nose" (2K, 1998). They were also presented as a photo of disabled adults (2B, 1997) and as distinct "FAS brain[s]" (2A, 1998; 3J, 2005). More veiled warnings featured photos of happy, healthy babies with warning messages like, "Please don't drink during pregnancy" (2C) and "Healthy Choices Healthy Baby" (2H, 1993), as if to suggest a healthy baby will be produced if a pregnant woman just avoids alcohol, although there is no guarantee.

Messages regarding lifelong suffering were accompanied by images of smaller than average and disabled babies, children, and adults, and were compared to their 'normal' counterparts: average-sized, middle-class, Euro-Canadian children (1A, 1979); healthy babies without small heads, thin lips, small noses, and short eye slits (2K, 1998); and happy, smiling children in the arms of their mothers (3J, 2005). Images accompanying lack of knowledge messaging depicted confused pregnant women (1A, 1979) and cartoon animals with reminder checklists about what is considered safe and what is not (2G-4, 1993). Perhaps most provocatively, the fetus was frequently presented as a developing or fully-formed baby or sentient being within the pregnant belly (1A, 1979; 2G-1-10, 1993; 2J, 1998; 2L, 1999; 4G, 2013; 4H, 2013).

Duty to her own Health

In addition to the general theme of maternal duty, a secondary theme that emerged was a pregnant woman's responsibility to make 'good choices' for the benefit of her own health—the maternal health theme. These 'good choices' can be interpreted as lifestyle

behaviours that contribute to her health and well-being as well as avoiding those that pose risk (e.g., eating nutritious foods and/or abstaining from alcohol). This theme appeared to occur separately from the maternal duty theme, although it soon became clear that fetal health was also implicated. For example, nearly every statement concerning pregnant women's health did so in relation to the developing fetus:

> "Your baby needs you to take care of yourself" (2E).
>
> "Loving yourself is loving your baby" (2G-6, 1993).
>
> "Every step you take to stop drinking alcohol or using drugs will help you and your baby" (4E, 2015).

Even the following statement that appeared to prioritize women's health connected the potential risky effects of maternal alcohol consumption to fetal development, labour, and miscarriage:

> "What are the effects of alcohol for the pregnant woman? Effects of alcohol include: 1) loss of appetite, resulting in a slow weight gain, 2) anemia (low red blood cells) and tiredness, 3) increased risk of miscarriage in the first three months, 4) rapid (really fast) labour (hard for the baby), 5) low blood sugars, 6) premature (early labour)" (3A, 2003).

These messages can be interpreted in two ways: 1) that fetal and maternal health are connected and cannot be considered independently of one another, and 2) that pregnant women's health is secondary to fetal health. The former view, that fetal and maternal health are inextricably connected, is indisputable: the creation and growth of a fetus depends, in many ways, on the female body. Indeed, some researchers suggest that reproductive, maternal, newborn, and child health exist on a continuum of care and "can be managed most effectively in an integrated way" (Lassi et al., 2013, p. 5). For example, detection and/or management of diabetes during pregnancy can not only lower elevated

rates of pre-eclampsia, preterm labour, and fetal malformation, but also contributes to positive trends in maternal and post-pregnancy health outcomes (Lassi et al., 2013).

While it is obvious that maternal and fetal health are intimately connected, this relationship is not the focus of public awareness documents. Rather, purported concern for pregnant women's health serves to bolster the maternal duty theme by using maternal health as a proxy for fetal health and protection:

> "Good for me! These are the choices I've made for me and my baby [checklist]: 1) Eat healthy foods, 2) no alcohol, 3) lots of water to drink, 4) rest and relax, 5) no smoking, 6) regular exercise, 7) no drugs, 8) keep medical appointments" (2G-4, 1993).

> "If you suddenly stop drinking, it can cause withdrawal symptoms for you and your baby. If you want to quit, tell your doctor so that you and your baby can be kept safe" (3A, 2003).

While these recommendations may contribute positively to a pregnant woman's health, they are primarily concerned with improving fetal and infant health. Meanwhile, there is little attention paid in the documents to important health issues that women may experience during pregnancy. For instance, few mentions are made of maternal mental health despite the fact that approximately 10 to 20 percent of pregnant and postpartum women experience depression and/or anxiety during pregnancy or after childbirth (Bowen, Bowen, Butt, Rahmann, & Muhajarine, 2012), and depression has been linked to increased alcohol consumption during pregnancy (Basford et al., 2004). The only document that makes vague reference to maternal mental health does so, once again, in relation to fetal health:

> "[Question] How can I be a mom? [Answer] You are not alone. If you are pregnant and can't stop drinking seek help! FASD is forever" (3F, 2005).

When documents did focus exclusively on women's health it was often superficially:

> "If you experience: 1) Bleeding, spotting or smelly discharge from vagina, 2) headaches, blurry vision or dizziness, 3) less movement by baby, 4) being overly tired, 5) sudden swelling or puffiness of feet, hands or face – CALL YOUR DOCTOR RIGHT AWAY" (2G-5, 1993).

> "Backache? Wear lower heels, sit with your knees propped higher than your hips, or have a warm bath" (2G-6, 1993).

> "Hard to sleep? 1) Enjoy a relaxing bath before bed, 2) sleep on your side, 3) tuck a pillow between your knees and under your tummy" (2G-8, 1993).

This type of messaging fails to take maternal health seriously, often prioritizing fetal health over women's health and constructing the fetus as more valuable than the woman who carries it. It also ignores the social contexts of a woman's life, and presumes that she has access to a relaxing bath and a private place to sleep—to middle-class spaces and status. Greaves and Poole (2004) argue that pregnant women and mothers with substance use problems are often set in competition with their fetuses, and that the focus is rarely on the health, welfare, and resources of the pregnant woman—in what has been labelled a "fetus-centred approach" (p. 88). This approach can be dangerous because it discourages substance-using pregnant women from seeking treatment "out of fear of prejudicial treatment and eventual child apprehension" (p. 88), as well as contributes to a culture of shame, guilt, and stigma for pregnant women whose lifestyle behaviours (whether they are chosen or imposed via structural factors) pose risk to the fetus.

Another dimension of the maternal health theme is the view that lifestyle behaviours are always a result of choice. 'Good choices'—avoiding alcohol, eating healthy foods, exercising—are positioned as steps that can easily be taken to improve maternal and fetal health. For example:

> "As well as not drinking alcohol, there are other steps you can take to be healthy and to protect your baby: 1) Get lots of rest, 2) see your doctor, nurse or midwife

> regularly, 3) eat healthy food, 4) stop or cut down your use of cigarettes and other drugs" (4C, 2010).

While these steps may be easily taken by some women, particularly for those who have access to economic and social resources, for certain groups of women who experience greater health and social inequity, this may not be the case.

Basford et al. (2004) note that women who live in remote, rural, Indigenous, poor, and inner-city communities—and in Canada's northern communities (Roberts & Nanson, 2000)—appear to be at an increased risk of giving birth to infants with FASD. Despite their diverse geographic, social, and economic characteristics, these communities often have one thing in common: their populations have poorer health status than their urban counterparts (Ministerial Advisory Council on Rural Health [MACRH], 2002). This is due to a variety of factors, including geographic isolation, the ongoing effects of colonization, lower personal incomes, 'boom and bust' economies, higher unemployment rates, higher rates of smoking and heavy alcohol consumption, obesity and physical inactivity, large populations of young people and seniors but a relatively small working age population, and limited access to fresh (affordable) food and safe drinking water (MACHR, 2002). This is not to say that all of these communities experience these realities homogenously, but that for some women making 'good choices' or engaging in healthy lifestyle behaviours may be difficult, inaccessible, or unrealistic. Messages that convey this false simplicity, for example "Your baby needs you to take care of yourself" (2E) and "Loving yourself is loving your baby" (2G-6, 1993), place pregnant women in the difficult position of being evaluated and judged for making choices that are severely constrained. For example, pregnant women who live in communities with a strong shared sense of identity and cultural norms, for example First Nation and Inuit communities,

may have to physically remove themselves from social environments and relationships in order to avoid normalized damaging health behaviours; however, this can also "be detrimental to one's emotional status" and "lead to feelings of loneliness and isolation" (Richmond, 2009, p. 69).

The content of the maternal health theme shifted little across the constructed time periods. While the theme of 'lifestyle choices' did not appear until the 1990s, once established, it remained remarkably consistent, using maternal health and women's 'lifestyle choices' in an attempt to positively influence fetal health:

> "Stay away from alcohol, drugs and things that will harm you and: get lots of rest, eat healthy meals, visit a doctor regularly, go to prenatal classes" (2A, 1998).
>
> "It helps you and your baby if you cut back or stop using alcohol at any point in your pregnancy" (3A, 2003).
>
> "As well as not drinking alcohol, there are other steps you can take to be healthy and to protect your baby: 1) Get lots of rest, 2) see your doctor, nurse or midwife regularly, 3) eat healthy food, 4) stop, or cut down, your use of cigarettes and other drugs" (4C, 2010).

'Common sense' messages like those above, while useful and important for fetal and maternal health, fail to adequately address the real health concerns of pregnant women at higher risk of producing an alcohol-affected child, as well as those who may be unable to quit drinking. For example, pregnant women who have experienced a stressful life event during pregnancy (e.g., violence or the death of a family member) are likely to consume more drinks on average than those who have not (Witt et al., 2015). These women are unlikely to be reached by messages that tell them to simply "reduce [their] stress" (4C, 2010).

Some documents advertised pregnancy outreach programs and services specifically for women who use drugs and alcohol while pregnant, for example:

Healthiest Babies Possible (2A, 1998), Sheway (3A, 2003), Motherrisk infoline (confidential counselling) (3A, 2003), and the YMCA FASD Prevention Program (3J, 2005; 3K, 2005), which may be a constructive alternative to fetus-centred messaging. Likewise, visiting a doctor regularly may be difficult or impossible for some women, so that advertising midwifery, traditional birth attendant, and doula services may be a viable alternative that is useful for a wide range of women, including those experiencing greater health inequity or geographic isolation.

Pregnant woman as vessel

If meaning can be truly construed by evaluating an image in conjunction with its text, as Hall (1997) argues, then the images that accompany the pregnant women's health text reinforce the importance of fetal health over maternal health, as well as the idea that lifestyle behaviours are choices that can be made.

In one document that states, "Your baby needs you to take care of yourself" (2E), the accompanying image is of a pregnant woman dressed in a white, flowing top that accentuates her belly; her hand is laid on her belly protectively and she looks serious but tranquil. In another document an illustrated mouse holds two posters—one of a cigarette and the other a martini, both overlaid by a "no symbol" (a red circle with a diagonal line)—accompanied by the text, "Start making healthy choices today for you and your baby!" (2G-1, 1993). Additional images with similar textual content include an illustrated pregnant zebra holding a "healthy choices" checklist (2G-4, 1993) and an illustrated pregnant woman eating an apple and holding a carton of milk (2J, 1998). One document produced in 2010 states, "Reduce your stress…Try reducing stress by going for walks or talking with a supportive friend or family member" (4C, 2010) and features a photograph

of a heterosexual couple with the husband (wearing a wedding band) encircling the pregnant woman's belly from behind. These images, particularly those produced in the 1990s that feature illustrated images of pregnant women and animals advocating for 'healthy choices,' refer to women's health almost mockingly. Further, all documents centre the pregnant belly in their imagery, reinforcing fetal health as a higher priority than maternal health. Greaves and Poole (2004) argue that this kind of messaging reinforces the view of pregnant women as "vessels" and can lead to the "devaluation of women's lives, health, and experiences, while ignoring structural circumstances that affect them" (p. 87).

Figure 3: Pregnant woman as vessel (1A, 1979)

Duty to Community

The duty to community theme can be interpreted as a pregnant woman's obligation to the health and well-being of her community through FASD prevention. Although this theme was found in a limited number of documents, it emerged only in those produced or co-produced by Indigenous organizations or intended for an Indigenous audience. This is remarkable because it indicates a difference in the way pregnant Indigenous and non-Indigenous women are thought about in FASD public awareness-raising and health promotion.

Within the documents where this theme emerged, messages presented pregnant Indigenous women as having a responsibility to abstain from alcohol and maintain or

increase their own health and that of their fetus and future child, and by doing so contribute to the health of their families, communities, and Nations:

> "We [three males with FASD] live with Fetal Alcohol Syndrome every day of our lives. Please don't drink alcohol during pregnancy. Healthy pregnancy. Healthy baby. Healthy Nation" (2B, 1997).
>
> "We all have a role to play in a healthy family. Please don't drink alcohol during pregnancy. Healthy pregnancy. Healthy baby. Healthy Nation" (2C, 1997).
>
> "Your baby needs you to take care of yourself. Please don't drink alcohol during pregnancy. Healthy pregnancy. Healthy baby. Healthy Nation" (2E, 1997).
>
> "Future generations rely on healthy and informed decisions" (2K, 1998).

In these four documents, three of which are from the same campaign, pregnant Indigenous women are portrayed as community members responsible to four different but interconnected levels of community: self, family, community, and nation. This is in contrast to documents intended for a mainstream audience, which overwhelmingly focus on a pregnant woman's duty to her fetus as the primary reason for abstaining from alcohol while pregnant: "For baby's sake don't drink" (1A, 1979) and "When you drink, your baby's blood alcohol is the same as yours" (3A, 2003).

In mainstream Euro-Canadian society, dominant discourses of motherhood are predicated on Western concepts and systems of individualism, patriarchy, risk management, and intensive child-rearing practices, and public awareness documents reflect these values and practices. In many ways, Indigenous motherhood contradicts and opposes these dominant discourses. The dominant culture expects pregnant women and mothers to be their children's primary caregivers, to rely on 'expert' advice, put their careers on hold, be ultra-knowledgeable about childrearing theories, and engage in labour-intensive and costly child-rearing practices (Hays, 1996; O'Reilly, 2006).

Indigenous cultures value mothers as "people with a sense of purpose, with responsibilities, and with a connection to creation that runs through the generations" (Anderson, 2000, p. 163). Of course, there is no universal or essential experience of Indigenous motherhood, as Indigenous women and mothers are as diverse as the cultures, communities, and geographies they come from. However, Mihesuah (2003) argues that it is a "commonality of difference" (p. 31) that unites Indigenous women's mothering experiences. For example, they often share histories of matrilineal and egalitarian societies, in which women held positions of leadership and responsibility, particularly as mothers, and where gendered divisions of labour were valued equally (Anderson, 2000; Mihesuah, 2003). Childrearing responsibilities were shared among biological mothers, grandmothers, aunties, older siblings, cousins, and the community at large (Lavell-Harvard & Corbiere Lavell, 2006) and Indigenous cultures hold common views and practices regarding child autonomy and the importance of enabling children to make their own decisions (Muir & Bohr, 2014). Thus, it makes sense that documents make an effort to prevent FASD in Indigenous communities by acknowledging and utilizing these differences, and by centering collectivism, interconnectedness, and pregnant women as protectors:

> "Fetal Alcohol Syndrome bears more than a financial price. It also affects individuals, their family members, teachers, caregivers, foster parents and whole communities" (2K, 1998).
>
> "The best medicine for you now is love. Love yourself, and be around people who love you. Your baby knows how you feel" (4F, 2012).
>
> "Hear me' [pregnant Indigenous woman]: I will honor, cherish and protect this child within" (3D, 2006).

However, at the same time as Indigenous women in North America are working to revitalize Indigenous motherhood and birth practices (Tabobondung, 2016), and bring justice to Indigenous peoples and heal via women's activism, they are "continuously assailed by the ongoing damages that are wreaked by racism, gender violence, political powerlessness, and the continuing breakdown of affective networks, our communities, and our families" (Million, p. 20). For example, one "commonality of difference" that Indigenous women share is the threat of state violence and threat of child apprehension (Gelb & Rutman, 2011).

It may also be argued that by encouraging Indigenous women to abstain from alcohol during pregnancy, communities and organizations that produce documents, like the following booklet, are actively combatting the stereotype of FASD as an 'Indigenous problem' (Tait, 2003b):

> "The author would like to acknowledge that, although this booklet contains Aboriginal illustrations, it is not meant to imply that FAS is only an Aboriginal issue, rather we are taking a leadership role in the prevention of FAS. By doing so, it is our hope others will decide to address FAS in their communities as well" (2K, 1998).

This message goes beyond recognizing the presence of FASD in some Indigenous communities and advising pregnant women to abstain from alcohol to reduce its incidence. It also works to deconstruct the 'Indigenous problem' stereotype and communicates that communities are well-equipped and motivated to address FASD on their own terms. Indeed, the booklet goes on to advertise pregnancy outreach services, educational workshops, a resource library, counselling, a parenting support group, and advocacy offered through a local friendship centre (2K, 1998).

In other documents, the duty to community theme is seen as not only a pregnant woman's obligation but as one of her friends and community members, too:

> "Friends help friends choose a healthy lifestyle. Please don't drink alcohol during pregnancy" (2D).

> "In order to realize this goal [reduced incidence of FASD], we [the community] must educate our community members, both young and old, of the risks of drinking any alcoholic beverages during pregnancy" (2K, 1998).

Another document highlights the obligation of family members, as shown in an interaction between a pregnant adolescent, Lara, and her Gran:

> "How are you, my girl? … Well, you eat this. And drink this. It's good fish. Something whispered in my ear – said you have to eat more fish. And you have to make sure you eat enough whole grains and dairy and veggies and fruit. All that healthy stuff. Baby needs it… Eat our foods. That's all I had when I was pregnant with your mom – just our traditional foods" (4F, 2012).

One way to interpret this messaging is that similar to shared childrearing responsibilities, FASD prevention is a shared responsibility among women, their friends, family, and community members. However, given the role of governmental institutions and non-Indigenous partners in producing some of the aforementioned documents (Health Canada, 2B, 2C, 2D, 2E, 1997 & 4F, 2012; B.C. Liquor Distribution Branch, Vancouver Richmond Health Board, & Western Brewers Association, 2K, 1998; The Asante Centre, 3D, 2006), these messages must also be situated in an historical context. As Fiske (1993) states:

> The degree to which the Canadian state has interfered in aboriginal women's lives and the ways in which it has denied them full social adulthood is without parallel in Canadian society. From the outset, colonial forces viewed the Indians through the lenses of paternalism, that is, as children neither competent in their own affairs nor capable of exercising the responsibilities of Canadian citizenship…in its efforts to achieve assimilation through the most effective and parsimonious route, the colonial (and contemporary) state appropriated control over biological and social reproduction through the inferiorization of aboriginal motherhood. (p. 19–20)

By positioning pregnant Indigenous women as requiring external support, whether from family, friends, or community, or via public health interventions and health promotion, it might also be interpreted that the state, its institutions, and some non-Indigenous organizations are motivated to act because of a lack of faith in the capacity of Indigenous women and their communities to prevent FASD.

Because of the small number of documents in which the duty to community theme emerged, it is difficult to draw conclusions regarding how the message shifted thematically from one time period to another. However, one notable observation includes an emphasis beginning in the 2000s for documents to be anchored in Indigenous ontology. For example, one poster co-produced by Katzie First Nation and the Asante Centre writes, "Listen my child" (3D, 2006) in an Indigenous language with the English translation bracketed and in smaller print below. In another comic, there is an emphasis on eating traditional foods, using traditional medicines, being on the land, and seeking advice from Elders:

> "Eat our foods. That's all I had when I was pregnant with your mom – just our traditional foods" (4F, 2012).
>
> "You know you have to be careful about medicines – even our traditional ones. You can't just be taking anything" (4F, 2012).
>
> "Give your baby happy energy. Keep moving and do good things for your body. Walk in the sun, feel the wind on your face" (4F, 2012).
>
> "Exactly. [Your gran] has so much knowledge and power. You could learn so much from her" (4F, 2012).

This is a departure from earlier documents produced in the 1990s, which feature photographs of individual pregnant Indigenous women, their family, friends, and community members beside simple prevention messages:

"Apple juice…a drink we can both enjoy" (2L, 1999).

"Please don't drink alcohol during pregnancy" (2B, 2C, 2D, 2E, 1997).

This shift towards decolonizing and de-stigmatizing content is reflective of the movement towards self-determination and sovereignty in Canada by Indigenous peoples. As Salmon (2007) notes:

> In their struggles to achieve self-determination and decolonization, Aboriginal peoples in Canada have demanded that the State recognize the importance of cultural revitalization and renewal efforts…The importance of Aboriginal people's movements in constructing the current responses of the Canadian State to FAS/FAE in Aboriginal communities should not be overlooked or underestimated (p. 259).

Indigenous motherhood, Euro-Canadian values, and incongruity

Within the documents where the duty to community theme emerged, images and accompanying text were both similar and distinct representations of motherhood. While the preferred meaning that emerged in each document promoted the idea that Indigenous women have a duty to their communities to prevent FASD by illuminating subthemes of intergenerational responsibility, shared childrearing responsibilities, and pregnant women as protectors, the documents also represented values that are similar to those of Euro-Canadian culture.

In one poster, a photograph of three male community members of different ages who are presenting diagnostic FASD facial features states: "We live with Fetal Alcohol Syndrome every day of our lives. Please don't drink alcohol during pregnancy…Healthy pregnancy. Healthy baby. Healthy Nation." (2B, 1997). In another, an illustrated pregnant Indigenous woman dressed in 'traditional' attire stands at the front of a Venn diagram of multicultural and multiracial children, saying: "Hear me' I will honor, cherish and protect this child within" (3D, 2006). Another features a photograph of a pregnant woman

standing by herself, holding her belly, with the words: “Your baby needs you to take care of yourself. Please don’t drink alcohol during pregnancy” (2E). These posters imply that women have a responsibility to their children, to future generations, and to entire Nations to prevent FASD and produce ‘healthy’ babies, yet bear the sole responsibility for doing so. This has the effect of representing pregnant women as responsible to their communities while also individualizing them and negating messages of shared responsibility, reproducing dominant health discourses that focus on women’s behaviour, choices, lifestyle, and personal responsibility (Reid et al., 2008).

Salmon (2011) argues that positioning Indigenous women as contemporary targets for FASD prevention results in “women from the poorest communities with the fewest resources gradually coming to shoulder the greatest burden for ensuring the health of their children” (p. 168). It would be erroneous to perceive the targeting of Indigenous women as accidental, because as Tait (2008) argues, perceived reproductive and maternal ‘failures’ have been “invoked to support increased surveillance and control of Indigenous women’s fertility, without meaningful supports and services being put in place for them” (p. 69). Of course, it is crucial to note that amid this climate of reproductive surveillance and despite ongoing colonial policies, Indigenous women and mothers have worked to resist these reductive narratives and reclaim Indigenous ideologies of motherhood (Anderson, 2000).

In other documents, images worked to transmit values and produce meaning that text alone could not convey. In one poster that stated, “We all have a role to play in a healthy family. Please don’t drink alcohol during pregnancy” (2C), the accompanying photograph communicates what constitutes a ‘healthy family.’ The family at the centre of

the photo consists of grandfather, grandmother, father, mother, and baby. The family appears clean-cut and while the grandmother wears beaded earrings, a necklace, ring, and bracelet, the family is otherwise plainly dressed: the grandfather wears a light blue button-down dress shirt, the parents don beige slacks and plain T-shirts, and the baby wears a blue jean dress with frilly hem. All are smiling and leaned in close to one another, and the parents resemble a modern version of the grandparents with their wedding bands—an imposed Christian European tradition—visible. As Boyd (2015) writes, the idealized nuclear family consists of a White, heterosexual couple with biological children: racialized and Indigenous women and their families fall outside of this construct, and have long been targeted by the state, systematically prevented from forming families (e.g., residential schools, child apprehension). The addition of grandparents to the family's frame may be interpreted as a nod to Indigenous familial structure and kinship relations, intended to enhance the document's relevance, but still falls within the construct of nuclear family.

In another document, a comic (4F, 2012), a young woman named Danis mysteriously materializes to convince Lara, a pregnant adolescent, that consuming alcohol while pregnant is a bad idea. To prove her point, Danis brings Lara to a mirage of the future—the promise of what will unfold if Lara commits to good behaviour. In this vision, Lara's partner Todd, who she "wishes would help out more" and who has been inconspicuously absent until this point, appears in a playground with the baby, who is walking and playing with Todd. Todd shows Lara how to change a diaper, swings the baby to sleep, and at the end of the vision an image of Todd kissing Lara's cheek in a heart appears while Lara states, "Wow." Up to this point, Lara has been represented as

irresponsible and lazy, preferring to eat chips and drink soda while lying on the couch and opting to party instead of walking with her mother to visit her grandmother. Todd is presented as Lara's salvation, and if she can abstain from alcohol during her pregnancy she too is promised the perfect nuclear family.

Figure 4: Todd, Lara, and baby as the perfect nuclear family (4F, 2012)

Both of these documents reveal that dominant discourses of motherhood, which promote individualism, personal responsibility, patriarchy, nuclear family values, heterosexism and cisgender privilege, and marriage—and guilt and shame for not achieving the above—are upheld, despite a decolonial focus on intergenerational responsibility, shared childrearing responsibilities, and pregnant Indigenous women as protectors.

Question 1: In Conclusion

Bacchi's (2009) first question, "What is the problem represented to be?" is intended to reveal how a problem is being thought about by illuminating how it is represented. In the case of FASD prevention and public awareness-raising, women who

drink while pregnant are portrayed as the ‘problem’ and the problem representation is a woman’s choice to either consume or abstain from alcohol during pregnancy. Public awareness documents work to resolve this ‘problem’ by presenting three arguments that are intended to encourage women to abstain from alcohol, to encourage others to help, and to raise awareness. The first argument states that a woman has a duty to her fetus—a natural and maternal obligation—to protect its health by preventing all harm, risk, sickness, and by preventing potential social suffering associated with an FASD diagnosis. The second argument posits that a woman has a duty to her own health to abstain from alcohol while pregnant, and that this duty can be enacted by engaging in ‘good’ lifestyle behaviours. This argument can be deconstructed to reveal that the object of concern is not the pregnant woman herself, but the fetus. The third argument is directed solely at Indigenous women, and contends that they have a duty to their communities to prevent FASD, thereby maintaining or increasing community health and well-being.

What Presuppositions or Assumptions Underlie this Representation of the ‘Problem’?

Bacchi’s (2009) second question, “What presuppositions or assumptions underlie this representation of ‘the problem’?” is intended to reveal the assumed and implicit knowledge that is relied upon and that is “necessary for statements to be accorded intelligibility” (p. 5). That is, the unspoken ‘truths’ that support and substantiate particular problem representations. The problem representation that is the focus of this analysis—that a woman has a choice to either consume or abstain from alcohol during pregnancy, or the ‘woman’s choice’ discourse—relies on an inherent assumption that all pregnant women are personally responsible for their actions. However, within this problem representation all women are not represented equally; while all are held

personally responsible, particular groups of women are consistently characterized as more likely than others to choose to consume alcohol during pregnancy. Over time, the repetition and dominance of these characterizations can lead to assumptions and stereotypes about pregnant women who consume alcohol—who they are, how they look and act, the lives they lead. As Hall (1997) notes, "stereotyping reduces people to a few, simple, essential characteristics, which are represented as fixed by Nature" (p. 257). As a result, documents that affix certain characteristics to particular groups of women reinforce stereotypes and reproduce dominant discourses of motherhood. Solving the 'problem' of women who consume alcohol while pregnant then becomes a targeted attempt to fix *some* women, rather than a one-size-fits-all solution.

In this section of analysis, I analyze and deconstruct some dominant (and harmful) assumptions made about women represented as most likely to drink during pregnancy. By deconstructing how certain groups of women and characteristics are problematized, it becomes possible to know who the dominant culture values and devalues as mothers, which discourses of motherhood and upheld and which are degraded, and who "receives our assignment of blame for the social harm from alcohol" (Armstrong, 2003, p. 207). Those assumptions analyzed here include: 1) behaviour and self-control and 2) social stratification as an indicator for maternal substance use. I have integrated Hall's (1997) theory of visual representation throughout this section's analysis because, as Hall argues, in order to truly discern meaning and the "normal and the acceptable from the abnormal and unacceptable" (p. 258), one must study an image in conjunction with its text; thus, in order to deconstruct behaviour, appearance, ethnicity,

etc., visual representations must be taken into consideration as they speak more loudly and can ‘say’ things not communicated through textual content.

Behaviour and Self-Control

When women are held personally responsible for their actions, including not only their use of alcohol and other substances but all behaviour during pregnancy, then behaviour (or misbehaviour) becomes a measure against which to evaluate their suitability for motherhood. For example, in one report that examined policy documents and media portrayals of women’s experiences (Greaves et al., 2002), the authors found that women who were considered to pose risk to their children—due to substance use, inadequate housing, drug use, etc.—often had their “fitness to mother” (p. 4) come into question, sometimes resulting in child apprehension and unfair treatment by the media. In all documents and across the constructed time periods, the aspect of maternal behaviour that was repeatedly invoked as cause for concern was self-control. Crawford (1994) writes, “health can be understood as a metaphor for self-control, self-discipline, self-denial and willpower…health continues to be a moral discourse, an opportunity to reaffirm the values by which self is distinguished from Other” (p. 1353). In this sense, health is a measure for self-control and a means of conforming to dominant cultural norms—meaning that a lack of self-control is unhealthy, abnormal, and unacceptable. Of course, concerns over women’s ‘lack of self-control’ can also signal the interest of corporate and state actors (including the alcohol industry), who emphasize individual responsibility in order to download “the social and economic factors that shape alcohol problems” (Boyd, 2015, p. 96). Maternal substance use is not only perceived as a demonstrable example of lack of self-control, but signifies the absence of health and a

moral failing on the part of women and mothers. The varying degrees to which pregnant women are represented as being able to control or not control their behaviour indicates which groups of women constitute potential 'ideal' mothers and which groups do not.

There are three behaviours by which pregnant women are evaluated and that attention is repeatedly drawn to in the documents: alcohol use and misuse, drug use, and risk management practices. The prevention of any behaviour *seen* to increase the risk of producing a child with FASD—including light to moderate alcohol consumption, heavy drinking and binge drinking, and alcohol addiction during pregnancy—is the primary focus of the documents. For example, binge drinking is associated with drug use and 'out of control' behaviour (3G, 2006), like partying, whereas general concern over maternal alcohol consumption elicits softer text and imagery, like "Alcohol and Pregnancy Don't Mix" alongside a photo of an embracing heterosexual couple (4D, 2014). Women are gently cautioned not to use licit drugs (e.g., caffeine, cigarettes) (2J, 1998) but warned more strongly about illicit drug use (e.g., methamphetamines, cocaine) (2A, 1998). Other lifestyle behaviours are also problematized differently, for example, the language used around 'partying' is more cautionary (3I, 2005) than that used to encourage healthy eating habits (2I, 1993).

The use of illicit drugs like cocaine, heroin, and marijuana are presented as secondary items of concern. Other behaviours and licit drugs (e.g., caffeine, nicotine, prescription drugs) that are considered 'risky' and potentially detrimental to fetal health or the health of the future child are not focal items of concern, but are still presented as problematic (e.g., partying, poor eating habits, not visiting a doctor regularly, not breastfeeding). These three behaviours are problematized in varying degrees—for

example, light maternal alcohol consumption is portrayed differently than alcohol addiction—and some groups of women are constructed as more likely to engage in more extreme degrees of behaviour. However, at the root of these concerns is concern over pregnant women's lack of self-control. By considering the intended audience of the document, the organization that produced the document, and how particular groups of pregnant women are characterized as more at risk and more likely to consume alcohol than others, it is possible to deconstruct longstanding stereotypes about women who drink while pregnant.

Alcohol use and misuse

Although some women are depicted as more 'at risk' than others, all pregnant women are constructed as 'at risk,' and their perceived lack of self-control is constructed as the single greatest obstacle to FASD prevention. Accordingly, documents employ strategies that encourage (or threaten) women to abstain and that are matched with the perceived level of risk. Those documents that characterize pregnant women as at risk of light to moderate alcohol consumption construct messages that match this perceived level of low risk, like general appeals and strategies for abstention. General appeals can be found consistently throughout the time periods, with some gently advising against consuming alcohol to using punitive language to warn and provoke feelings of guilt:

> "Please don't drink alcohol during pregnancy" (2B, 2C, 2D, 2E, 1997).
>
> "The best time to stop drinking is now" (2H, 1993).
>
> "Alcohol and pregnancy don't mix" (3H, 2006; 4B, 2015; 4C, 2010; 4D, 2014).
>
> "100% PREVENTABLE" (4H, 2013).
>
> "ZERO ALCOHOL. No safe time. No safe amount" (4G, 2013).

Other documents suggested utilizing strategies for abstention, like drinking alcohol substitutions and "mocktails":

> "Apple juice…a drink we can both enjoy" (2L, 1999).

> "Don't drink alcohol now…try a mocktail instead! NEW BABY SPLASH: ½ glass chilled apple juice, 1 tablespoon lemon juice, ½ glass club soda. Combine the apple and lemon juice in a glass. Add club soda to taste. Mix well. Enjoy!" (2G-8, 1993).

> "Cool Orange Delight: 4 oz. orange juice, 4 oz. ginger ale, crushed ice, twist of lime. Load a tall glass with ice, add the juice and ginger ale, top it all off with the lime twist. A refreshing and healthy treat" [recipe for bartenders] (3C, 2006).

These types of messages assume that pregnant women possess self-control but require strategies and reminders—whether from a poster or a bartender—to abstain. (They also work to obscure social determinants of health and structural inequality that may influence maternal alcohol use by simplifying a complex issue). General appeals with gentle language could be found in many documents, particularly as titles and headlines, but were especially found in documents intended for a broad audience and produced by large and geographically expansive organizations, like those produced by BC Liquor Stores (4D, 2014) and in conjunction with BC Women's Hospital (4B, 2015; 4C, 2010), and the BC Aboriginal Network on Disability Society (2B, 2C, 2D, 2E, 1997). Burgoyne (2006) notes that because the general public recognizes the threat of alcohol use during pregnancy, warm and positive themes and tones may be more appropriate for this broad audience. General appeals using punitive and fear-based language could be found in documents produced more locally, for example by the District of Maple Ridge (4G, 2013) and Nisga'a Valley Health Authority (4H, 2013). Communities and organizations employ a variety of strategies for selecting campaign messages (e.g., utilizing resources from other campaigns, input from women in recovery and FASD experts, committee

discussions, feedback from community partners), some of which are not evidence-based, which may account for punitive and fear-based approaches. Unfortunately, these types of approaches are not uncommon despite a lack of evidence that they are effective and appropriate, and indeed may contribute to "increased stigma about alcohol use in pregnancy, increased stress for pregnant women, and decreased access to services and increased fear of disclosure of alcohol use in pregnancy" (Burgoyne, 2006, p. 41; Thomas & Poole, 2014).

Other strategies for abstention, like the promotion of alcohol substitutions and "mocktails," were suggested by a range of document producers, including the BC Ministry of Health and Minister Responsible for Seniors, Alcohol and Drug Programs (2I, 1993), Ktunaxa Independent School Society (2L, 1999), and the Society of Special Needs of Adoptive Parents (3C, 2006). The range and diversity of document producers and intended audiences for this type of strategy and messaging indicates that it is generally assumed that most women understand that maternal alcohol consumption may be detrimental to fetal health and simply need to be reminded. However, if most women have some awareness of the risks, as has been repeatedly shown (Hammer & Inglin, 2014; Holland, McCallum, & Walton, 2016), then the application of risk and abstinence messaging to all women can be interpreted as a paternalistic action that displays "scant regard for the autonomy of pregnant and prospectively pregnant women and a confused grasp of the principles of beneficence and non-maleficence" (Gavaghan, 2009). Indeed, Holland et al. (2016) have shown that some women interpret abstinence messaging as an example of moral policing that has potential to exacerbate stress during pregnancy.

Other documents characterized some pregnant women as being at high risk for engaging in frequent, heavy, and binge drinking. Often these documents were so focused on the quantity and frequency of drinking that FASD prevention receded into the background and pregnant women's drinking and lack of self-control became the primary focus. The messages within these documents reflected and emphasized concern over heightened risk:

> "The more alcohol mother drinks, the more baby drinks. If mother gets drunk, so does baby" [empty alcohol bottles surround a pregnant woman who appears intoxicated] (1A, 1979).
>
> "The chance of hurting your baby is higher if: **you drink every day; you drink 3 or more drinks at one time**" [emphasis in original] (2J, 1998).
>
> "What is binge drinking? When a woman has 4 or more alcoholic beverages at a party or social gathering she is said to be "binge drinking". Daily drinking and binge drinking are very dangerous during pregnancy" (3I, 2005).

Some documents progressed past concerns regarding quantity and frequency of drinking to depict pregnant women as out of control around alcohol:

> "My darling baby oh so sweet / I cannot wait until we meet / why do I drink and hurt you so / Why can't I stop – I do not know" (3F, 2005).
>
> "Are you worried about your own use of alcohol? If so, please call…" (3I, 2005).
>
> "Screw this, I can party if I want…" [Lara picks up a beer can at a party, is stopped from drinking by another woman] (4F, 2012).

These kinds of messages are not simply reminders to abstain, but warnings and calls to action: they not only scold women for their failure to control their drinking, but imply that action must be taken, whether by the pregnant woman herself or by an intervenor. Similar to messaging that reflects low and moderate risk, documents that constructed women as frequent and binge drinkers were produced by a wide and diverse range of organizations and institutions and for a wide variety of audiences, for example: The

Province of BC (1A, 1979), BC Liquor Stores (2J, 1998), Health Canada (3F, 2005), the Asante Centre (3I, 2005), and Health Canada and the Healthy Aboriginal Network (4F, 2012). This practice of labeling many and diverse groups of women as high risk for frequent and binge maternal drinking stands contrary to research, which shows that certain sub-populations of women, specifically those who are socioeconomically, culturally, and racially disadvantaged, who have adverse social experiences, mental health issues, and histories of abuse (Astley, Bailey, Talbot, & Clarren, 2000) are more likely to engage in this type of alcohol use. In addition, it unnecessarily contributes to fear, anxiety, and moral panic that is unwarranted by evidence of impact and prevalence (Armstrong & Abel, 2000). The trend of characterizing some women as more 'at risk' of frequent and binge drinking, or as out of control around alcohol, is part of a long tradition in which, during periods of social and political change, women's misuse of alcohol has been "roundly condemned and stigmatised" (Thom, 1997, p. 49) in order to be brought to the front of the policy agenda. Thom argues that this is due to anxiety and a desire to preserve women's roles as the "mothers, wives, carers, and, more broadly, the 'moral guardians' of society" (p. 49). In addition, documents that depict pregnant women as drinking too much or too often, or as out of control around alcohol, may invite and incite intervention as they are seen as being needed "to be managed by others as they are incapable of a rational choice" (p. 182).

A smaller number of documents conflated alcohol addiction with a high risk for FASD and alcohol-affected births. However, the way these documents construct the 'addict' is revealing. In one brochure (2A, 1998), contact information for Alcoholics Anonymous, Narcotics Anonymous, the Downtown Eastside Community Health Clinic,

and the Aboriginal Friendship Centre is provided; and referrals to detox, doctors, and treatment centres and single mothers/family programming are advertised alongside a provocative photograph of a teddy bear, a bottle of dark liquor with a bottle nipple instead of a cap, and an intravenous needle. In this brochure, a specific picture of the 'addict' is painted: urban, low-income, racialized as non-White and/or Indigenous, high risk, and an intravenous drug user. In another two brochures for the YWCA Crabtree Corner FASD Prevention Program (3J, 2005; 3K, 2005), located in Canada's poorest urban neighbourhood, Vancouver's Downtown Eastside (DTES), (Boyd & NAOMI, 2013), pregnant women at high risk are also constructed as non-White and as potentially struggling with drug use. Because there is a large population of Indigenous women who live in the DTES (30–40% of all women residents), and high rates of drug use by women residents (Vancouver Coastal Health, 2016), the women depicted in the brochures likely resemble Crabtree's service users. However, in terms of producing and contributing to FASD discourses, these documents depict a specific kind of pregnant woman who is addicted to alcohol and at high risk of producing a child with FASD. However, in another document produced more recently by the BC Centre for Excellence in Women's Health (BCCEWH) (4E, 2015), an organization that promotes women-centred, harm reduction health policies, this stereotype is avoided. The poster states:

> "SMALL STEPS MATTER. It can be a fight every day to not drink or use. Every step you take to stop drinking alcohol or using drugs will help you and your baby" (4E, 2015).

Figure 5: Harm reduction FASD prevention poster (4E, 2015)

The accompanying photo on the poster features a pregnant woman holding the hand of a male partner, pregnant belly centred, both in plain clothing and faces obscured. As Williamson and colleagues (2014) point out, while stigmatizing strategies are often purposefully employed in the field of public health, particularly in the substance use field, their:

> …deleterious impact risks exacerbating substance use problems, particularly amongst the least well off. Furthermore, the strategy may impede the commitment to empowerment which has been fundamental to health promotion since the publication of the Ottawa Charter in 1986. (p. 333)

Not only are these types of harm reduction-oriented messages more appropriate for women who struggle with alcohol use and who require social support (Thomas & Poole, 2014), but can be seen as actively combatting stereotypes of women who use substances while pregnant. While BCCEWH promotes a harm reduction approach in this poster, the message reinforced by the image is also hetero-centric and assumes women struggling with substance use are/should be supported by male partners.

Illicit drug use

Like alcohol consumption, narratives of drug use within the documents do not shift chronologically but according to which group of women they are crafted for. Although only 10 of the 41 documents address drug use (outside of alcohol), within these 10 there is a difference in how pregnant women and mothers who use drugs are depicted: those who live in low-income, urban settings are depicted as more likely to use criminalized drugs, such as heroin or cocaine, while those documents produced for a more general audience are less explicit. In a document produced by YWCA Crabtree Corner, a resource centre located in the DTES, contact phone numbers are provided for Cocaine Anonymous and Narcotics Anonymous, referrals to detox and treatment centres are advertised, and women are warned that the following drugs may cause problems in newborns: "cocaine, heroin, T's and R's, marijuana, prescription drugs, solvents (sniffing things like glue and paint thinner)" (2A, 1998). In another document produced by Children's & Women's Health Centre of BC and revised by Fir Square, a combined care unit in Vancouver that cares for women who use substances and their exposed newborns (BC Women's Hospital & Health Centre, 2018), the brochure advises:

> "Remember… Effects of drug and alcohol use are different for every pregnancy and every baby, depending on: amount used; if other drugs are used, and which ones; when in pregnancy the drugs are used…" (3A, 2003).

A number for a detox access line is also provided and a referral to a drug and alcohol counsellor is advertised. In another document aimed at young women who drink socially, the brochure notes: "It is also true that cigarettes, marijuana, cocaine, crack, crystal meth, heroin and other drugs can be very dangerous for both mothers and babies during pregnancy" (3I, 2005). These narratives differ from those intended for a broader and more mainstream audience. For example, in brochures produced by BC Liquor Stores

women are encouraged to "quit, or cut down, your use of cigarettes and other drugs" (2J, 1998) and to "avoid cigarettes and other drugs during pregnancy as well as alcohol" (4B, 2015). While low-income, urban women who use drugs are depicted as addicted and in need of intervention, and as using illicit drugs' (e.g., heroin, cocaine, and meth), documents intended for a more general audience depict women as requiring gentle reminders to cease or cut back on their drug use—drugs which are not specified. In one document, young women are not constructed as addicted but as using a variety of drugs and acting recklessly, for example, its heading states: "The sky's the limit… One more drink and I'll be flying" (3I, 2005).

In Canada, while it may be true that rates of FASD are higher in some Indigenous communities than among the general population (Fraser, Muckle, Abdous, Jacobson, & Jacobson, 2012; Popova, Lange, Probst, Parunashvili, & Rehm, 2017), and that young women are more likely to engage in socially accepted binge drinking than their older counterparts (BCCEWH, 2014), discourses of risk are also applied inequitably to different populations of women while structural inequalities and social determinants of health are obscured. Some researchers point out that Indigenous people and other minority populations are overrepresented in FASD statistics because research itself disproportionately focuses on these populations (Nanson, 1997; Oldani, 2009; Stewart, 2016). Romagnoli & Wall (2012) contend that uneven application of risk is a product of those who "fall outside of middle-class social values and norms" being labelled as riskier than others; and that, because of an increasing trend toward neoliberal governance, there is increasing focus on identifying and intervening upon "high-risk groups" (p. 275). According to Reid et al.'s (2008) study of discourses of substance-using mothers, 'bad

mothers' are constructed as requiring occasional help and intervention from the government and are often juxtaposed alongside images of drug paraphernalia. 'Good mothers', on the other hand, are constructed as doing everything in their power to protect the fetus and future child and take responsibility for their actions by admitting that they need help.

Risk management practices

Many documents went beyond problematizing pregnant women's alcohol and drug use to highlight other 'risky' behaviours considered detrimental to fetal health and health of the future child. While some of these behaviours, like smoking, poor nutrition, and caffeine consumption have been identified as cofactors for FASD (Abel & Hannigan, 1995; May & Gossage, 2011), it is difficult to discern the full gravity of their impact and interaction with alcohol. This is not only because maternal risk factors for FASD are multidimensional (e.g., include mother's number of pregnancies, metabolism, and body size), but because accurate and detailed – and often difficult to procure – information on maternal drinking and other risk factors is required to make any FASD diagnosis (May & Gossage, 2011). This can be due to women's fears and/or experiences of stigma, blame, mistreatment by medical professions, child apprehension, etc. (Green, Cook, Racine, & Bell, 2016).

The documents also problematize a range of behaviours and traits not identified as cofactors for FASD, like exercising, socializing, and single pregnancy (i.e., without a partner). It seems that behaviours like these are included in FASD public awareness-raising as part of a broader pregnancy risk management project, wherein pregnant women:

> …are held to heightened and intensified standards of risk minimisation. They are encouraged to discipline virtually all dimensions of their bodies and behaviours (what they eat and drink, where they work and recreate, when and how they exercise, and so forth) in accordance with elaborate, ever-proliferating, ever-changing rules of risk minimisation. (Kukla, 2010, p. 323–324)

These behaviours which are unrelated to the production of FASD are a point of focus in the documents throughout the time periods, although from 2000 forward, they begin to recede from view in place of a more dominant emphasis on alcohol and drug use prevention. Cofactors like smoking, poor nutrition, and caffeine consumption, however, consistently remained a point of focus throughout the time periods:

> "These things may also harm you and your baby: *smoking, caffeine (coffee, tea, soft drinks), poor eating habits*, stress" (2A, 1998).

> "It is also true that *cigarettes*, marijuana, cocaine, crack, crystal meth, heroin and other drugs can be very dangerous for both mothers and babies during pregnancy" (3I, 2005).

> "It is never too late to quit or cut down on your drinking. As well as avoiding alcohol, pregnant women may benefit from: lots of rest; regular medical care (doctor, nurse, or midwife); *healthy food*; supportive friends and family members; healthy recreation and physical activities; *it is best to avoid cigarettes* and other drugs during pregnancy as well as alcohol" (4B, 2015).

These concerns are warranted. According to Abel and Hannigan (1995), cigarette smoking augments the toxic effects of alcohol on the fetus by reducing blood flow and oxygen content, decreasing overall nutrient availability, and promoting teratogenesis through free radical formation. It is also highly correlated with alcohol abuse and poor nutrition. Caffeine consumption, in association with alcohol intake, can also "[exacerbate] alcohol's effect on the fetus, possibly by reducing folate and/or zinc levels" (p. 452). In addition,

> research suggests that deficiencies in vitamin A, folate, and choline are linked to a range of problems impacting birth outcomes. It is believed that alcohol may inhibit vitamin A, folate, and choline and thus have an adverse impact on birth

> outcomes. Thus, providing increased vitamin A, folate, and choline supplements to pregnant might "mitigate the effects" of alcohol and the "severity of prevalence of FAS." (Ballard, Sun, & Ko, 2012, as cited in Boyd, 2015, p. 93).

Finally, Abel and Hannigan (1995) note finally that poor nutrition is a cofactor for FAS because it reduces the nutrient pool necessary for fetal growth: poor nutrition on its own can reduce these vital nutrients, but for women who are heavy drinkers these nutritional deficiencies can be compounded. For example, May et al. (2016) found that women who consume large quantities of alcohol may have abnormal digestion, malabsorption of nutrients, decreased renal function, and alterations in the gut microbiome that put them at an additional nutritional disadvantage. Critical to Abel and Hannigan's analysis is their recognition of poverty as highly correlated with these three cofactors, as well as their understanding that some racialized and ethnic communities (e.g., African Americans and Native Americans in the U.S.) experience poverty at higher rates due to structural inequity and resulting systemic, disadvantageous socioeconomic conditions. So, while advising women to make healthy, nutritious choices and avoid cigarettes and caffeine may be useful for some, it is also highly ignorant of the socioeconomic conditions that put some women at higher risk than others for poor fetal outcomes. As Kukla (2008) notes, evaluating women for 'proper' maternal performance on these factors alone further re-inscribes social privilege and

> deficient maternal character into the bodies and actions of underprivileged and socially marginalized women, whereas privileged women with socially normative home and work lives will tend to serve as our models of proper maternal character. (p. 82)

Leppo (2012) adds that through these processes it becomes easier to demonize pregnant women and develop punitive attitudes toward 'improper' pregnancy and parenting behaviours because they are seen as having made their own personal choices. These

punitive attitudes contribute to stigma, present a significant barrier to treatment, lead to guilt and shame and the perpetuation of misinformation and denial (Finnegan, 2013).

As for other 'risky' behaviours featured in the documents, pregnant women and new mothers are advised to visit a doctor or health care professional throughout their pregnancies, to engage in self-care practices (e.g., enjoy relaxing baths), remain cognisant of safety, breastfeed, exercise, refrain from partying, reduce stress, use family planning, go to prenatal classes, have an overnight labour bag ready, purchase baby goods, read parenting manuals, recognize labour signs, rest, have sex with a partner, sleep on their sides, avoid negative peer pressure, and keep medical appointments—and the list goes on. Throughout the 1990s, there was a concentrated and expansive emphasis on risk management practices:

> "Stay away from alcohol, drugs and things that will harm you and: get lots of rest, eat healthy meals, visit a doctor regularly, go to prenatal classes" (2A, 1998).
>
> "See your doctor to get "Baby's Best Chance" parents' handbook" (2G-4, 1993).
>
> "Things to know: Think about family planning. Take time between pregnancies. Discuss birth control options with your doctor. Where to get help: health unit, doctor, family/friends, babysitter" (2G-10, 1993).
>
> "Trust: Pay attention to your thoughts and feelings. Act on what you believe is right. Do what makes you happy and fulfilled" (2K, 1998).

From 2000 to 2015, there were fewer mentions of risk management practices, but those that did appear were explicit, comprehensive, and less overtly paternalistic, and messages were increasingly directed at friends, family, and partners of pregnant women:

> "Reduce your stress. Stress that results from cutting down or quitting alcohol is not as harmful to your baby as the alcohol itself. It is better to quit or cut down on your drinking. Try reducing stress by going for walks or talking with a supportive friend or family member" (4C, 2010).

> "Tips for partners and friends of pregnant women. Women need support to avoid alcohol and have healthy pregnancies: …Participate in recreation and physical activities with your pregnant friend or partner; ask her how to help reduce stress in her life" (4B, 2015).

As Greaves and Poole (2004) note, women-centred drug and alcohol services and prevention have been chronically underfunded in Canada, and FASD prevention campaigns have put little emphasis on women's health. The shift in messaging in the 2000s might be attributed to the push for harm reduction and women-centred health and social supports, and increased prevention messaging produced by women-focused organizations and researchers (Hunting & Browne, 2012; Poole, 2007; Rutman et al., 2000). However, this may also be an effect of the shift towards more simplistic documents and messages in the later 2000s and 2010s, both supportive and punitive (e.g., a poster with a large photograph of a bare pregnant belly inscribed, "I'm here" in white lettering) (4G, 2013).

The focus on risk management practices of pregnant women and mothers can be interpreted as a form of social control—a way of conforming mothering behaviours to dominant cultural expectations. As Lupton (2012) notes, pregnancy is increasingly defined in terms of risk:

> Part of this risk consciousness is individualisation, a process by which traditional mores and social structures which once shaped people's decisions and behaviours have broken down. Individualisation assumes agency and is dependent on individuals' decision- making, the ability to shape one's destiny through choice rather than social expectations. (p. 331)

By framing pregnancy in terms of risk, as the medical view frequently does, women can experience increasing and often unnecessary anxiety and concern over the health of the fetus (Mitchell, 2010). But this view also detracts from the joy and celebration that many women experience during pregnancy and birth. As Modh, Lundgren, and Bergbom

(2011) note, pregnancy is often viewed as a "catastrophe waiting to happen" (p. 1) and this focus diminishes the aspects of pregnancy that are positive and transformational—the transition to motherhood, changing relationships and values, growing closer to loved ones, and spiritual experience. For Indigenous women, who are often perceived as being more 'at risk' than non-Indigenous women during pregnancy, this focus on risk detracts from pregnancy as life-giving, as a sacred time, and as celebration (National Collaborating Centre for Aboriginal Health [NCCAH], 2012). Pregnancy can be a joyful and fulfilling experience but also one of misery and suffering, yet "all societies strive to ensure that pregnancy is indeed a happy event" (WHO, 2005, p. 41).

Not only do these narratives of risk enforce discourses of personal responsibility, but also discourses of motherhood that are valued and upheld by the dominant culture. Risk categories—or risk labels—draw attention to racialized and low-income women who have poor pregnancy outcomes in order to increase access to specialized care; however, because they "appear neutral and scientific" their use as "gendered, class-based, and racialized measurements" is often neglected (Boyd, 2015, p. 99). The narratives of risk employed in the documents devalue and stigmatize women and mothers who cannot perform mothering to the standards of cultural expectation: for example, women who cannot purchase healthy, nutritious foods because of socioeconomic exclusion. Further, Gavaghan (2009) argues that by overstating risk and spreading misinformation (e.g., awareness documents that state that any and all alcohol consumed during pregnancy is harmful) the autonomy and self-governance of women is dishonoured and disrespected, and women are at risk of experiencing "advice fatigue"—that is, in the face of "unduly onerous requirements" they may abandon medical and public health advice entirely (p.

303). And, the effects of these paternalistic warnings and advice can lead to unnecessary stress and anxiety for pregnant women and discomfort and self-consciousness when under the public gaze (Lupton, 2012).

Social Stratification as an Indicator for Maternal Substance Use

In his work on representation, Hall (1997) argues that there are four ways in which stereotyping occurs: by reducing, essentializing, naturalizing, and fixing 'difference' to people, in effect reducing them to simple, essential, and definable characteristics. He makes the important point that stereotyping "tends to occur when there are gross inequalities of power" and "is usually directed against the subordinate or excluded group" (p. 258). When examining how pregnant women are represented in the documents in terms of race, socioeconomic status, age, gender identity, and sexual orientation, the 'subordinate' within each social stratification—racialized, low-income, adolescent women and non-binary, trans, and queer folks—is over- or under-represented, although there are fluctuations between time periods. This has the effect of reproducing and reinforcing stereotypes of groups perceived as most likely to consume alcohol during pregnancy (e.g., Indigenous, poor, and young women); and excludes other groups from FASD prevention entirely (e.g., non-binary, trans, and queer folks). These acts of stereotyping and exclusion not only reproduce and entrench stigma directed at already marginalized groups of women, but label some women unfit for motherhood.

In order to deconstruct these stereotypes, it was necessary to consider the documents as a whole set; one document on its own does not construct a stereotypical picture of the pregnant woman who consumes substances, but among 41 documents a picture begins to emerge. Although there were marked shifts in time periods—for

example, a more diverse range of ethnicities was common from the 2000s forward—some stereotypical tropes remained consistent, like that of Indigenous women and women of colour being represented as more likely than White women to drink while pregnant.

In order to break apart this construction of the pregnant woman who consumes alcohol, and the implicit claims about her social status and identity, I searched for signifiers: what does she look like? Does she live in an urban location? Is it a poor neighbourhood, like the Downtown Eastside? How is she addressed and communicated to? These signifiers included, but were not limited to: her environment, perceived lack of knowledge, marital status or partner, connection to family and friends, level of alcohol consumption, perceived ethnicity, appearance, the format and delivery of the document itself, the document's producer, and geographic location of the intended audience. Through the five analytical lenses of race, socioeconomic status, age, gender, and sexual orientation, a representation emerged of the type of woman seen as most likely to consume alcohol during pregnancy and who is seen to require a certain level of intervention. Conversely, through her limited appearance or absence, it also became evident who was considered least likely, or not likely at all, to drink and require intervention; and, in some instances, who did not even register as a mother or potential mother. The following sections analyze these five social stratifications and the significance of this analysis is elaborated on in the Discussion chapter. Because representations of race, socioeconomic status, age, gender, and sexual orientation rely on text and imagery to convey information, this section of analysis weaves throughout Hall's (1997) understanding of stereotyping as relying on fixed images in conjunction with text over time to produce 'accumulated meanings' or stereotypes.

Race

Throughout the four time periods, there was a significant overrepresentation of Indigenous women and women of colour in the documents (women of colour, or people of colour (POC), is a political term intended to unite women who are racialized as non-White and who have shared experiences of systemic racism) (Women of Color Network, n.d.). At times this was more obvious, like when documents utilized photography to reach their intended audience, and in other cases it required 'reading between the lines'—analyzing text alongside imagery or text alone. For example, one document produced by YWCA Crabtree Corner in Vancouver's Downtown Eastside (DTES) (2A, 1998) does not picture any women but directs readers (presumably women at risk of maternal alcohol consumption) to the Aboriginal Friendship Centre and Downtown Eastside Community Health Clinic for help. In the DTES in Vancouver, a neighbourhood with a significant representation of diverse Indigenous women (30–40% of its women residents), and that has high rates of substance use (Vancouver Coastal Health, 2016), it can be inferred that one of the intended audiences for this document, if not *the* intended audience, is Indigenous women.

Of course, when interpreting the 'race' of women in the documents—even when seemingly obvious, as with a photograph—I had to be aware of my own biases and of race as a socially constructed category. 'Race' is a socially constructed category that classifies human beings according to characteristics like skin colour, hair texture, and facial features (Loppie, n.d.). In order to preserve the dominant social order, racial categories are ascribed stereotypes that gain traction and evolve over time—for example, that Indigenous peoples are prone to alcohol misuse—that have real consequences on people's lived experiences. By assessing pregnant women and mothers in the documents

according to their race, I am effectively *racializing* them, or assigning them a racial identity. However, I considered this a necessary exercise in order to determine which groups of women are overrepresented in and most negatively impacted by FASD prevention materials and maternal alcohol use stigma.

In general, the most striking racial observation was that a majority of women in the documents were Indigenous women or women of colour, or it could be inferred that they were the intended audience. In the only document produced from 1979–1989 (1A, 1979), an illustrated brochure, the woman depicted has a broad forehead and wide-set eyes, a flat nose with wide nostrils, and is wearing large hoop earrings. While it is not clear from the illustration what racial identity has been ascribed to this woman, when analyzed in conjunction with the document's original producer, Yukon Drug and Alcohol Services, the significant Indigenous population within the Yukon territory (23% of the total population) (Statistics Canada, 2016), and the tendency of Canadian FASD prevention research within the 1979–1989 time period to focus almost exclusively on Indigenous populations (Bray & Anderson, 1989; Robinson et al., 1987), it can be inferred that the woman pictured is Indigenous.

Throughout the 1990s this trend persisted. Within the documents where racial identity could be deduced, the dominant intended audience was pregnant Indigenous women. Documents produced by the BC Aboriginal Network on Disability Society (2B, 2C, 2D, 2E, 1997) encourage viewers to have a "Healthy pregnancy. Healthy baby. Healthy Nation," and centre photographs of Indigenous women, family, and community members. Respective documents produced by the Ktunaxa Independent School Society (2L, 1999) and Vancouver Aboriginal Friendship Centre (2K, 1998) feature a photograph

of a pregnant Indigenous woman (2L, 1999) and a variety of illustrations depicting Indigenous women, families, cultural activities, and artifacts (2K, 1998). It must be noted that most documents depicting Indigenous women throughout this time period were produced by Indigenous organizations (e.g., BC Aboriginal Network on Disability Society) and those serving a large population of Indigenous women and families (e.g., YWCA Crabtree Corner). Because health promotion strategies recommend constructing materials for a well-defined and target audience, and FASD health promotion in particular encourages culturally specific campaigns for effectiveness (Burgoyne, 2006), these targeted documents may reflect these strategies. However, this overrepresentation of Indigenous women still runs the risk of entrenching the stereotype that Indigenous women are most at risk for maternal substance use and of producing a child with FASD.

In the 2000s, diversity of representation increases. In a document intended for employees and proprietors of bars (3C, 2006), an illustrated White woman orders drinks from a server and socializes; in another produced by Katzie First Nation and the Asante Centre (3D, 2006), an illustrated Indigenous woman is pictured in ‘traditional’ regalia. Another information card (3E, 2006) features two young, Black women walking down the street in a dilapidated neighbourhood with one wearing a head covering and the other a leather belt with metal studs.

Figure 6: Two urban, adolescent Black women walking (3E, 2006)

Two brochures (3J, 2005; 3K, 2005) produced by the YWCA FASD Prevention Program, located in Vancouver's Downtown Eastside, use photographs of Indigenous women, women of colour, and their children. Although there is increased diverse representation in this time period, these representations rely on stereotypical tropes to convey information: Indigenous women are only pictured outdoors or in rural environments, as stereotypical and illustrated caricatures, or as living in poverty and in urban contexts, and being at high-risk of misusing substances; Black women are urban, young, and poor; and White women are middle- to upper-class, urban, and socialite—for example, in one information card, White, urban women are pictured ordering cocktails in a lounge (3C, 2006).

There is another trend that emerges in the early 2000s and throughout the 2010–2015 period: photographs of pregnant bellies that obscure or cut out women's faces (3A, 2003; 3J, 2005; 3K, 2005; 4E, 2015; 4G, 2013; 4H, 2013). According to Greaves and

Poole (2004), this type of representation can work to further discourses of pregnant women as fetal vessels; however, it can also be read as a means of purposely obscuring the identity of the pregnant woman who consumes alcohol in order to universalize and destigmatize FASD prevention. This narrative is supported by a pattern that emerged in the 2010s, with prevention materials featuring increasingly diverse photographs of Black, Asian, White, and Indigenous women (and their increasingly diverse male partners). In one poster, a Black pregnant woman and Black heterosexual partner embrace (4B, 2015); in another, a pregnant White woman and Asian male embrace (4C, 2010); a pregnant Asian woman and Hispanic male embrace (4D, 2014); a White male and pregnant female with faces obscured hold hands (4E, 2015); and an Indigenous male and new Indigenous mother are shown being affectionate and kissing (4F, 2012). Both of these approaches—diversifying those persons featured in FASD prevention materials and obscuring their identities— might be seen as working to de-stigmatize FASD prevention by overturning stereotypes and furthering the idea that anyone can be at risk of consuming alcohol while pregnant.

However, feminist scholar Sara Ahmed (2012) warns that the appearance of diversity can allow individuals and institutions to feel that problems of representation have been solved without ever having disrupted or altered unbalanced and oppressive power dynamics. Diversifying the images of pregnant women and mothers may make FASD health promotion look more inclusive, but not actually work to disrupt the stigma that already marginalized groups—like Indigenous women who use substances—face. And, although these photographs are increasingly ‘diverse,’ there is still an underrepresentation of White women, perpetuating the myth that White women are least

at risk—or not at risk at all—for maternal substance use, despite reports that White women have the highest substance use prevalence estimates compared to their racial counterparts (CDC, 2012).

Socioeconomic status

Observations and analysis regarding the socioeconomic status (SES) of women in the documents are deeply tied to other social indicators like race, age, gender, and sexual orientation.. This is because low SES is intricately linked to other social stratifications, a concept known widely as intersectionality, wherein "multi-level interacting social locations, forces, factors and power structures that shape and influence human health" impact health outcomes and social status (Hankivsky, 2012). In Canada, women, single mothers, racialized and Indigenous women, young people and children, queer and gender non-conforming folks experience higher rates of poverty than others (Canada Without Poverty, 2017; McGarrity, 2014). Therefore, discerning a woman's socioeconomic status required looking for signifiers and picking up on subtle nuances and imagery; sometimes race and geographic location provided clues, or it was the type and quantity of resources listed on a document, or it was the language and images used. Over time, certain patterns emerged that remained remarkably consistent, for example: documents targeting low-income women were generally content-heavy and highly prescriptive, not only warning women to abstain from alcohol and drugs but extending into the arena of mothering and lifestyle behaviours:

> "Keep medical appointments for you and your baby" (2G-10, 1993).
>
> "Breastfeed before having a drink so there will be less alcohol in your breastmilk the next time you breastfeed" (3A, 2003).

> "Healthy choices: Visiting the doctor, eating good food, resting when tired, drinking water daily, wearing a seatbelt, exercising, asking your doctor questions, not drinking alcohol, not smoking" (2G-5, 1993).

Figure 7: 'Healthy' choices (2G-5, 1993)

In North America, targeting low-income women with prescriptive (and presumptive) mothering advice is part of a long tradition. As Romagnoli and Wall (2012) note, low-income mothers have long been considered a group 'at risk' to both themselves and their children, and as lacking necessary parenting skills, often necessitating state intervention. Low-income mothers have reported feeling especially stigmatized, spoken down to, and regulated in terms of their mothering behaviours, and believe that these experiences are directly related to their poverty (Romagnoli & Wall, 2012; Whitley & Kirmayer, 2008).

On the other hand, documents targeting middle-class women or the general population of mothers often had simple and supportive headlines and little other content:

> "Healthy choices. Healthy baby … We can help: The best time to stop drinking is now" (2H, 1993).

> "Alcohol and pregnancy don't mix: Healthy mothers and babies need everyone's support" (4B, 2015).

This pattern follows Romagnoli and Wall's (2012) assertion that while low-income mothers are inundated with intensive parenting advice and educational programs, middle-class mothers (at least those who abide by social norms and values) are seen as less 'at risk' and in need of guidance. Because middle-class mothering practices are seen as fitting the dominant ideology and are considered less 'risky,' it makes sense that documents intended for this audience are often simple reminders rather than explicit advice.

Because the manner in which documents targeted pregnant low-income and middle-class women shifted little over time, with few exceptions, it was unnecessary to analyze one constructed time period to the next. Rather, I looked at the consistencies and patterns over time, as well as notable exceptions. Instead of analyzing isolated messages or images—for example, warnings about binge drinking—I interpreted the documents in terms of the scaffolding of messaging and imagery: if a woman is described as a binge drinker, is she also pictured as Indigenous? Is she also described as living in a low-income area, or targeted with 'easily-digestible' information, as in the form of a cartoon?

Documents that targeted low-income pregnant women and new mothers tended to depict them as illicit drug users and heavy drinkers, often referencing binge drinking or listing illicit drugs women should be avoiding:

> "These drugs may also cause problems in newborns: cocaine, heroin, T's and R's, marijuana, prescription drugs, solvents (sniffing things like glue and paint thinner)" (2A, 1998).

> "If you drink a lot of alcohol while pregnant (either bingeing or drinking regularly), you increase your risk of having a baby with lasting birth defects" (3A, 2003).

To fully assess the construction of the pregnant substance-using woman and her SES, these documents had to be examined in their entirety. In the first document quoted (2A, 1998), produced by YWCA Crabtree Corner in the DTES, there is a single mothers/family programming group listed, contact information for the Aboriginal Friendship Centre, fear-provoking language (e.g., babies born to mothers who drank alcohol will have a "thin upper lip," "crowded teeth," and "smaller brain"), and provocative imagery: a syringe, teddy bear, and liquor bottle with a nipple for a cap; and a "normal brain" juxtaposed with a degraded looking "FAS brain." In the second document quoted (3A, 2003), there is a plethora of fear-provoking information about the effects of alcohol and drugs on a fetus and pregnant woman (e.g., the effects of alcohol on a pregnant woman can include "anemia (low red blood cells) and tiredness," "increased risk of miscarriage in the first three months," and "rapid (really fast) labour (hard for the baby)." The second document also lists resources for mental health support, Aboriginal health support, detox, and healthcare located in the DTES. In these two documents it is clear that the target audience is presumed to be low-income and urban, Indigenous, and single mothers who may be addicted. Generally, and perhaps most importantly, in documents intended for a low-income audience there is an overwhelming overrepresentation of racialized women, primarily represented as Indigenous (1A, 1979; 2A, 1998; 3A, 2003; 3J, 2005; 3K, 2005) and Black women (3E, 2006; 3J, 2005; 3K, 2005).

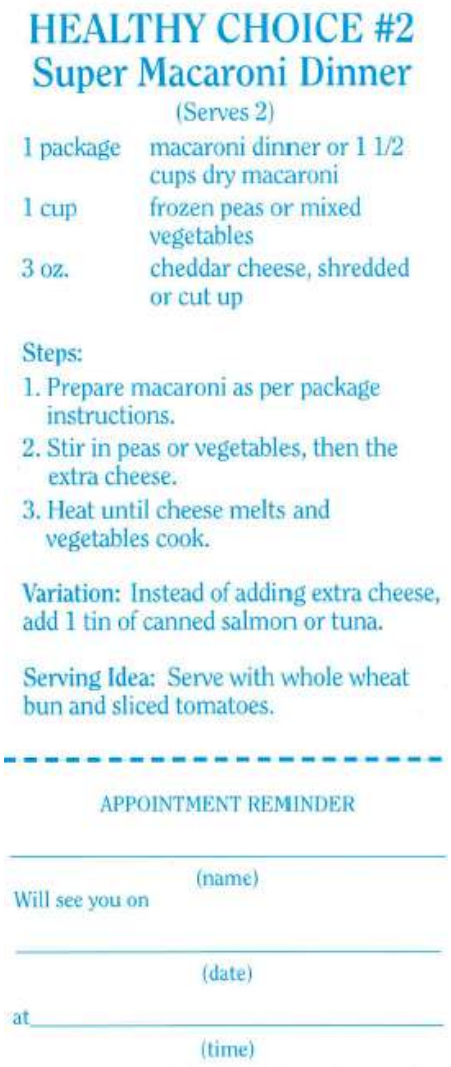
This tendency to represent low-income substance-using women as racialized, urban, addicted, and struggling with mental health is part of a well-established narrative. In a 2002 study, Greaves et al. found that news articles that focused on mothering under

duress often mentioned race and socioeconomic status, in some instances explicitly identifying women as working class or Indigenous. Women with addictions were depicted as being on welfare, and stereotypical tropes of women with substance use and mental health issues were common.

In general, those documents directed at low-income women not only depicted women as heavy drinkers and illicit drug users, but were created to be easily digestible (e.g., cartoons), used menacing and punitive language, pictured and described women as living in urban and low-income environments, and depicted women as single mothers or mothers-to-be. Images used were often clearly intended to elicit fear and intimidate women into abstinence. Resources listed or shown were often medical professionals, addiction and treatment centres and programs, and FASD-specific organizations, support groups, and mental health supports. There are other clues, as well: in one document, a recipe card (2I, 1993) instructs women to create a "Healthy Choice #2 Super Macaroni Dinner" using dry macaroni, frozen peas or mixed vegetables, cheddar cheese, and a recommended tin of canned salmon or tuna instead of extra cheese. Not only does this recipe suggest foods that are traditionally thought of as 'low-income'—dry pasta, frozen vegetables, tinned meats—it assumes that the reader lacks knowledge as to what a healthy meal is and how to prepare it. It is difficult to imagine this information being delivered to middle-class or 'mainstream' women.

On the other hand, documents targeting middle-class and 'mainstream' women gently warned women about alcohol use and made vague references to drugs:

> "Did you know that alcohol can hurt your baby?" (2J, 1998).
>
> "It is best to avoid cigarettes and other drugs during pregnancy as well as alcohol" (4B, 2015).



HEALTHY CHOICE #2
Super Macaroni Dinner
(Serves 2)

1 package	macaroni dinner or 1 1/2 cups dry macaroni
1 cup	frozen peas or mixed vegetables
3 oz.	cheddar cheese, shredded or cut up

Steps:
1. Prepare macaroni as per package instructions.
2. Stir in peas or vegetables, then the extra cheese.
3. Heat until cheese melts and vegetables cook.

Variation: Instead of adding extra cheese, add 1 tin of canned salmon or tuna.

Serving Idea: Serve with whole wheat bun and sliced tomatoes.

APPOINTMENT REMINDER

_____
(name)
Will see you on
_____
(date)
at_____
(time)

Figure 7. Healthy choice #2: Super Macaroni Dinner

Images generally featured new mothers embracing their infants, particularly in the 1990s (2F, 1999; 2H, 1993), and happy, pregnant women being held by husbands and male partners with bellies encircled from the 2000s forward (3H, 2006; 4B, 2015; 4C, 2010; 4D, 2014). Resources listed were often toll-free numbers and websites, like a confidential FAS hotline (2J, 1998), the Alcohol and Drug Information and Referral Service (3C, 2006), and website for the BC Association of Pregnancy Outreach Programs (4B, 2015).

Because of these documents' lesser content, nonspecific resources, and images featuring only infants, mothers, and pregnant bellies, with little other context, it was difficult to discern in what kind of environment these imagined women lived—as Romagnoli and Wall (2012) note, middle-class mothers are seen as less in need of prescriptive advice and intervention than low-income mothers. This was in stark contrast to documents directed toward low-income women, who were often explicitly pictured or described as living in low-income, urban environments like the DTES. Whether photographs or illustrations were used, the race of these 'mainstream' women was often obscured, with the visual emphasis on the mother-baby relationship instead: for example, in one poster there is a photograph of a racially ambiguous, brown-haired woman cradling her infant that states, "Alcohol can hurt your baby … Fetal alcohol syndrome is preventable (2F, 1999); in another, a mother whose head and face are not shown holds a fair-skinned baby and it reads, "Healthy choices, Healthy baby" (2H, 1993).

Despite statistics that indicate that older, White, middle-to-upper-class, college-educated American women are the demographic most likely to consume alcohol while pregnant (Ebrahim et al., 1998; Ethen et al., 2009) (Canadian statistics are harder to come by), these documents purvey the idea that middle-class women are a lower risk population.

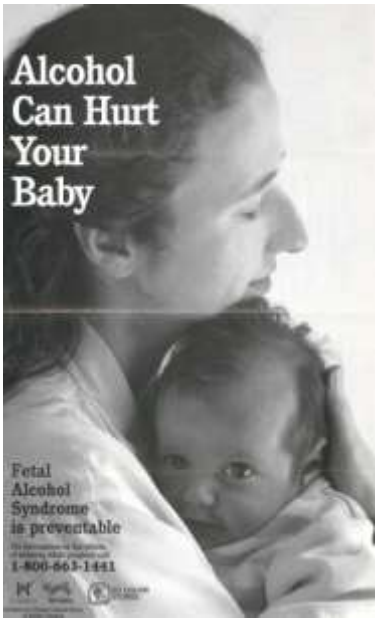


Figure 8: Poster of mother and baby, produced for a general audience

Notable exceptions were those documents produced by Indigenous organizations and for an Indigenous audience. These documents often featured pregnant Indigenous women and new mothers with their families, among community, with friends, and nearly always in a natural environment. It was difficult to discern the income level of those women represented as most are pictured in casual dress, and messages are minimal and supportive:

> "[Grandparents, parents, and baby sit on a log in front of a body of water, in casual dress] We all have a role to play in a healthy family. Please don't drink alcohol during pregnancy" (2C).
>
> "[Pregnant woman outdoors in casual dress, holding apple juice bottle] "Apple juice…a drink we can both enjoy" (2L, 1999).

When documents were directed at urban Indigenous women, they not only made it difficult to discern what their socioeconomic status was, but sometimes made explicit efforts to destigmatize classist (and racist) thinking about FASD production, for example: "FAS crosses all cultural, economic, and social boundaries" (2K, 1998). As Hunting and

Browne (2012) note, Canadian health discourses tend to frame FASD in "gendered and colonial ways that marginalize the needs of women" (p. 35). The authors also call out the need to re-contextualize current discourses in ways that "foreground women's health experiences within intersections of power and ongoing processes of discrimination" (p. 35). These documents might be interpreted then as a paradigm shift and an attempt to subvert stereotypical representations of Indigenous women as most likely to drink while pregnant, and as striving for relevancy and effect by grounding culture, community, family, friends, and land.

Age

In general, and across the time periods, the majority of documents focused on preventing maternal substance use among adult women. Indicators of this included 'motherly' or mature appearance and clothing, like styled hair, feminine shirts and sweaters covering most exposed skin, and jewelry, including earrings, necklaces, and wedding bands. Later on, from 2000 forward, pregnant women also tended to be represented as married, middle-aged women. The language used in these documents exclusively referred to pregnant women and mothers, and did not explicitly mention age as a factor. This dominant focus on adult women can be attributed to reports and studies that show the highest prevalence estimates of reported alcohol use among pregnant women to be among those aged 35–44, at 14.3% (CDC, 2012); that show advanced maternal age in combination with heavy drinking is a risk factor for FASD (Lewis, Shipman, & May, 2011); and that show a majority of births in Canada (almost 50%) occur to women aged 30 and over (Whitley & Kirmayer, 2008). As well, in Western culture teenage pregnancy and motherhood has been constructed as deviant and

problematic, making adult motherhood the de facto and normative form of motherhood (Whitley & Kirmayer, 2008). By placing an emphasis on FASD and maternal substance use prevention among adult women, prevention materials further reinforce dominant ideals about who is fit for motherhood.

However, six documents focus explicitly on preventing young girls and women from drinking during pregnancy. Within these documents, three are produced by Indigenous organizations and target young Indigenous women (2D, 2K, 1998; 4F, 2012), and the others specifically problematize young non-Indigenous women's drinking (3E, 2006; 3G, 2006; 3I, 2005). Among the latter three there is an emphasis on reckless partying, binge drinking, peer pressure, irresponsibility, 'bad attitude,' sexual activity, and illicit drug consumption:

> "Let's face it, saying "NO" to alcohol can sometimes be hard. You're at a party or a bar and everyone is having lots of fun. You might think that drinking mineral water or fruit juice is boring. After all, what's one drink going to do to the unborn baby?" [Two young, black women walking down the street in a dilapidated neighbourhood with one wearing a head covering and the other a punk-looking belt] (3E, 2006)

> "Do you drink alcohol alone or with friends? Are you sexually active? Did you know drinking alcohol during pregnancy could seriously harm a baby?" [Blurry image of a young woman in club attire covering her mouth, as if she's about to be sick, drinking a martini] (3G, 2006)

> "When a woman has 4 or more alcohol beverages at a party or social gathering she is said to be "binge drinking … Daily drinking and binge drinking are very dangerous during pregnancy" [Title of the document: "Young Women & Alcohol, Feeling Pretty Good…; Subtitle: "The Sky's the Limit … One more drink and I'll be flying"] (3I, 2005)

> "It is also true that cigarettes, marijuana, cocaine, crack, crystal meth, heroin and other drugs can be very dangerous for both mothers and babies during pregnancy" (3I, 2005)

These representations of teenage pregnancy support narratives of teenage pregnancy as a social problem and threat to the dominant social order. They paint young women as promiscuous, or threatening to the heterosexual, two-parent model; as easily influenced and unknowledgeable about alcohol; and as lacking compassion for the fetus and future child. As Duncan notes, teenage pregnancy is often "linked to social disadvantage" (2007, p. 308) and seen as a problem associated with women living in poorer (and often racialized) areas. In the three documents quoted, racialized women account for 3/5 of the young women featured; these representations of teenage pregnancy and parenthood then might be seen as working to reinforce disadvantage.

Young Indigenous motherhood and pregnancy is portrayed in a different light. These three documents emphasize community, friend, and family support throughout pregnancy, particularly to abstain from alcohol; male partnership and support; self-esteem and acceptance; and cultural values and intergenerational support during pregnancy. In these documents, teenage pregnancy and parenting is not the problem focus—FASD prevention and maternal drinking is:

> "Friends help friends choose a healthy lifestyle. Please don't drink alcohol during pregnancy" [Group of smiling young men and women, physically leaning on one another and supporting each other] (2D).

> "Men can be very powerful role models for the next generation. Children need to see men taking an active role in supporting their partner during pregnancy. Children also benefit from having a loving, supportive father who takes a positive role in their upbringing" [Foreword: "This booklet was prepared for teens to create awareness and provide information about fetal alcohol syndrome [FAS]"] (2K, 1998).

> "How to think positively about yourself: … Love: Learn to love the unique person you are. Accept and learn from your mistakes. Accept your successes and shortcomings – those who love you do!" (2K, 1998).

> "You know you have to be careful about medicines – even our traditional ones. You can't just be taking anything. The best medicine for you now is love. Love yourself. And be around people who love you. Your baby knows how you feel" [Grandmother says to her teenage granddaughter] (4F, 2012).

In these documents, the social pressures of teenage pregnancy and parenthood are recognized, as are the potential consequences of maternal alcohol consumption: "FAS and other alcohol related birth defects are preventable!" (2K, 1998). However, in these documents teenage pregnancy is also seen as a positive opportunity, for example: "Future generations rely on healthy and informed decisions" (2K, 1998); and a vision of the future where a pregnant teenager, Lara, is shown that if she makes the right choices (including abstaining from alcohol), she and her boyfriend Todd will have a happy family and partnership (4F, 2012).

These documents also differ from the mainstream documents in their portrayal of relationships—of pregnant women in relationship with men, in relationship with themselves, with family, friends, children, Elders, and to the land. These relationships are positioned in a positive, strengths-based manner, where in the mainstream documents women are often portrayed as isolated, as single mothers, or as unsupported; and when men are or partners are included, the text does not refer to them directly. That documents created for an Indigenous audience are strengths- and community-based is in line with Health Canada's recommendation in its resource manual for FASD prevention in Indigenous communities (Health Canada, 1997), wherein FASD prevention work is supposed to strengthen and support families and communities holistically, and build capacity.

These representations of Indigenous women work on a number of levels. In a study of young Indigenous mothers' experiences with pregnancy and parenting, Eni and Phillips-Beck (2013) found that young women felt

> …almost unanimously, that in spite of the persistent effects of colonization and cultural and geographic marginalization, a sense of the traditional has endured. In spite of great threats against their families, and perceived attacks against their very identities, a central value for children and family has remained. (p. 5)

The mothers interviewed emphasized the impacts of historical and ongoing child apprehensions, residential schools, and intergenerational abuses. The act of teen parenting in these instances became resistance, similar to the positive representations in the documents. However, as Eni and Phillips-Beck (2013) also argue, an explicit and concerned focus on Indigenous teen pregnancy and parenting might be interpreted as racially motivated and driven by dominant fears that more babies are being born to non-White mothers, skewing the dominant social order: statistics that show while the fertility rate among Canadian women as a whole was 1.5 between 1996 and 2001, it was 2.9 children for First Nations women, 2.2 for Métis women, and 3.4 for Inuit women (NCCAH, 2011). In addition, this focus on FASD prevention among young Indigenous women may further contribute to stigma surrounding Indigenous women and alcohol.

Gender identity and sexual orientation

When analyzing gender identity/presentation and sexual orientation, I chose to combine the two social categories for the reason that there are no instances of gender non-binary, trans, or queer folks appearing within the documents. In each document and in every time period, women are presented as heterosexual and cisgender, or as people "who exclusively [identify] as their sex assigned at birth" (Trans Student Educational Resources [TSER], 2017) and have a feminine gender identity and expression. Here,

gender non-binary can be defined as: “an umbrella term for all genders other than female/male or woman/man”; trans can be defined as a term that encompasses “many gender identities of those who do not identify or exclusively identify with their sex assigned at birth”; and queer can be defined as “a term for people of marginalized gender identities and sexual orientations who are not cisgender and/or heterosexual.”

Deconstructing the gender and sexual orientation of women in the documents involved recognizing the accumulation of images and representations of traditionally feminine attire and ‘maternal’ behaviours; of heteronormative gender roles and involvement with male partners (or, alternately, single motherhood); and normative pregnant bodies and language like “mothers,” “women,” “her,” and “she.” Similar to other sections of analysis, this exclusion of gender non-binary, trans, and queer folks was determined not by assessing one component within a document, but by interpreting the whole document and dataset. Most often, it was explicit that documents targeted cisgender, heterosexual women, even where there were few or no photographs or imagery:

> “Nightie, robe, slippers, underwear, brush, make-up, toothbrush, toothpaste, clothes for you to wear home, clothes for baby, baby blanket [overnight hospital bag packing list]” (2G-9, 1993)

> “No safe time … no safe amount. Prevent FASD, always use protection” (4A, 2011).

Given the dearth of health research on gender non-binary and trans folks (Coulter, Blosnich, Bukowski, Herrick, Siconolfi, & Stall, 2015), as well as their near erasure from the institution of motherhood itself, it is not surprising to find these populations completely absent in FASD prevention and health promotion documents. The following is a quote from a trans mother:

> When I first started searching for "transgender mother" resources online, I found pages upon pages of information about mothers raising children who are transgender—which is wonderful!—but almost nothing about trans mothers themselves. (Wilkinson Saldaña, 2015)

This is concerning given that some research concludes that transgender-identified people engage in heavy episodic drinking more than their nontransgender-identified counterparts (Coulter et al., 2015), and heavy episodic drinking is a known factor in FASD causation (May et al., 2013).

It is also not surprising that the documents exclude queer and lesbian women, another population that has a higher morbidity rate in conditions like mental health problems and substance use disorders, but whose "distinctive healthcare needs … go unnoticed, are deemed unimportant or are simply ignored" (Hayman, Wilkes, Halcomb, & Jackson, 2013, p. 120). These exclusions make plain the dominant discourses and ideologies around motherhood, pregnancy, and FASD prevention. As Luce (2002) writes, "most medical and health care literature and most research on infertility and assisted reproduction are targeted at and focus on heterosexual women or heterosexual couples" (p. 5). With increasing visibility of gender non-conforming, trans, and queer folks, and increasing availability and use of reproductive technologies to assist with reproduction, it is imperative that FASD prevention take into account the evolving motherhood landscape, given that the Public Health Agency of Canada's own framework for action states:

> Community capacity, priorities and strengths vary – calling for flexible approaches that provide the supports that the community needs and that can be provided and/or tailored to take action. Each community and sector needs to develop plans for action that build on local needs, strengths and networks, while drawing on a growing national body of tools and knowledge. (2005, p. 15)

In conclusion, the apparatus of FASD public awareness-raising must evolve to adequately address the health needs of *all* women, self-identified women, and non-binary folks, not only to reduce the incidence and prevalence of FASD, but to combat stigma experienced by women who do not and cannot conform to, and who resist or refuse to conform to, dominant discourses of motherhood.

Chapter 5: Discussion

The following discussion 'makes meaning' of the findings and analysis in the previous chapter. Drawing on Foucault's genealogical methods and using the first two questions in Carol Bacchi's (2009) problematization framework, I have explored the discourses of motherhood that are reproduced and legitimated in FASD public awareness-raising documents produced in BC from 1979 to 2015. Using this approach, I was able to trace these discourses, following their shifts, consistencies, and ruptures from one constructed time period to the next—examining how they are "produced, sustained, and revised over the course of a particular historical period" (Koopman, 2008, p. 362). Because drinking during pregnancy is considered a "social problem" (Armstrong & Abel, 2000, p. 276), Bacchi's (2009) framework was useful in problematizing, drawing out, and critically interrogating prevailing attitudes and cultural values and norms regarding substance use and motherhood.

The purpose of this project was to uncover how discourses of motherhood have shaped and continue to shape FASD public awareness campaigns, and to consider the potential implications and material effects they have on women, particularly those marginalized by race, culture, and socioeconomic status. From the findings and data analysis emerged three overarching conclusions about FASD public awareness-raising campaigns and how they contribute to stigma production: 1) they work to further neoliberal regimes of self-governance via the 'woman's choice' discourse; 2) they act as a vehicle for the transmission of dominant cultural values; and 3) they promote the 'rights' and health of the fetus above those of women. However, although all of the documents subscribe to these conclusions in some way, by utilizing an historical

analytical lens and taking into account the different aims, methods, producers, and targeted audiences of documents, I can also say that these conclusions are pliant. While they can be applied to the data as a whole, they play out slightly differently in each document and time period. As well, some documents were produced with specific goals of resisting and transforming the current state of FASD public awareness, although I argue that none fully succeeds. In this discussion, I pay careful attention to shifts in discourse because they open possibilities for transformation of future practice.

Neoliberal Regimes of Self-Governance and the 'Woman's Choice' Discourse

All of the FASD public awareness-raising documents within this project are predicated on the assumption that pregnant women have a choice to either consume or abstain from alcohol during their pregnancy. This assumption both furthers discourses of personal responsibility and obscures the impact of the social determinants of health and structural inequality on women who produce alcohol-affected children. Despite it being known that the documented incidence of FASD "varies with maternal poverty, poly-drug use, and nutritional deficiencies as well as socio-historical factors such as the impacts of colonialism on indigenous peoples" (Meurk et al., 2014), awareness-raising campaigns are persistent in their presentation of FASD as solely alcohol-related and as "100% preventable" (2K, 1998). As Stewart (2016) writes, these 'preventable' narratives are flawed because they fail to take into account a woman's life circumstances, available supports, and overall awareness of pregnancy. Although documents produced in the 2000s, and especially from 2010 onward, increasingly frame prevention as reliant on available services and a woman's built-in support systems, and increasingly connect FASD causation to non-alcohol related factors, the onus to abstain unanimously remains

on the woman. Some researchers (Salmon, 2011; Stewart, 2016; Wall, 2013) contend that these discourses of personal responsibility can be attributed to creeping neoliberalism in public health, and the persistence of the 'woman's choice' discourse is evidence for these claims.

As neoliberalism was becoming the dominant guiding principle of economy, social, and political life in the Western world and globally, in the early 1980s (Wall, 2013), FAS had recently been labelled and the earliest document in this project (1A, 1979) had just been produced. Gabe, Harley, and Calnan (2015) argue that during this time period, "the notion of choice" (p. 624)—which is at the heart of neoliberalism—was being embedded in and beginning to shape healthcare policy and reform. Harvey (2005) names this integration and promotion of personal "choice" as the direct product of austerity, deregulation, privatization, and free trade; a means of cutting costs, of downloading responsibility onto citizens, and of enabling the state to withdraw from areas of social provision. The effects of this shift can generally be seen in public awareness-raising documents as the 'woman's choice' discourse, which puts ultimate responsibility for FASD prevention (and production) on a woman's shoulders. However, it can also be seen specifically in what is offered to pregnant women via public awareness campaigns and in the apparatus of health promotion generally. Campaign documents encourage (and intimidate) women to abstain by employing images, offering advice, and by connecting women and others to prevention services' phone numbers and websites. What they fail to do is emphasize the structural, social, and environmental conditions (e.g., poverty, psychological distress, nutrition) that are by now firmly established as co-factors in FASD causation (Abel, 1995; Lewis et al., 2011; May & Gossage, 2011),

particularly for women who are marginalized and living in high-risk environments for alcohol-affected births. Schrecker (2016) recognizes this contemporary and neoliberal version of health promotion as a danger: as not only "a disciplinary system, organised around the trope of individual responsibility … with scant attention to the constraints imposed on 'choice' for some of us…," but one that severely limits the "political possibilities for reducing health inequalities" (p. 478). In this specific FASD prevention context, not only do neoliberal health discourses reduce chances for reducing health inequities, but they actively promote and contribute to stigma production for women who are not able to abstain from alcohol during pregnancy. Women who may not be able or willing to abstain from alcohol during pregnancy are often socioeconomically marginalized and socially dislocated: they have experienced poverty, racialization, discrimination, and interpersonal violence, and do not have access to (safe, culturally relevant) health and social services (Hunting & Browne, 2012; Varcoe, Hankivsky, & Morrow, 2007). Varcoe et al. (2007) argue that neoliberalism has exacerbated these social conditions by encouraging cutbacks to social housing, mental health and addictions programs, and women's shelters. For Indigenous women, the intergenerational trauma, poverty, systemic racism, discrimination, and displacement that colonization has wrought are directly linked to substance use issues (Hunting & Browne, 2012).

FASD Public Awareness-Raising and Transmission of Dominant Cultural Values

FASD public awareness campaigns are a tool of first-level prevention in Canada, designed to raise awareness of the risks of drinking alcohol during pregnancy, signal where help is available, and promote community involvement in bringing awareness to action (Poole, 2008b). However, it is evident that campaigns go beyond their mandate,

acting simultaneously as vehicles for the transmission of dominant cultural values. This occurs via the selection of certain messages and images, through targeting certain groups over others, and addressing those groups in different ways (e.g., by utilizing illustrations and dense, prescriptive content for a low-income audience but photographs and simple, supportive messages for a mainstream audience—conveying 'proper' mothering to low-income women but trusting that middle-class women already know how to do so).

Some scholars have critiqued FASD prevention as being overly moralistic, citing concerns over prevention practices that unnecessarily attempt to regulate pregnant women's non-alcohol related behaviours (Bell et al., 2009; Stewart, 2016) and that reproduce "hegemonic depictions" of substance-using mothers that are gendered, racist, classist, and ableist (Salmon, 2004, p. 112). On the other hand, Salmon (2007) notes that First Nations and Inuit communities have developed their own prevention activities as a means of decolonizing and culturally grounding FASD prevention. What the findings generally suggest is that FASD public awareness-raising, via its depictions of motherhood, furthers certain ideologies of motherhood that support (and sometimes negate) dominant cultural values. Diduck (1993) writes:

> Ideologies of motherhood … are a reflection of both the ideological effect of many discourses and the interaction of these different, sometimes competing discourses, whereby certain of them emerge as dominant in any given place and time in a kind of shifting hierarchy. In as much as power can be located within these discursive sites, the dynamics of the interaction often include both domination and resistance, so that discourses such as feminism, modern rationality, science, social work and psychology are imbued with such factors as race, class and sexuality. The ultimate tapestry which emerges is a law infused with constructs of motherhood interwoven with many different strands. (p. 462)

Diduck's analysis helps to explain how the documents can promote dominant, White, Euro-Canadian, middle-class values while also acting as objects of resistance that

promote women-centred discourses, an Indigenous worldview, harm reduction, and diversity and inclusion. There are three arenas in which FASD public awareness-raising actively transmits values: motherhood, Indigenous motherhood, and Nation-building.

Motherhood values

The apparatus of FASD public awareness-raising, throughout the time periods, unanimously promotes dominant values and institutions like heterosexuality, femininity, and marriage that work to preserve dominant social order (and that contribute to stereotyping for women who behave outside of the prescribed norms). By presenting pregnancy and motherhood as homogenously heterosexual, feminine, and as ideally occurring within the context of a heterosexual marriage, or at the very least, a heterosexual relationship, awareness efforts effectively exclude lesbian, trans, queer, non-binary, and two-spirit folks from FASD public awareness-raising and the institution of motherhood generally. In a rapidly-evolving landscape in which queer identities are more socially accepted, and reproduction is increasingly divorced from heterosexual intercourse as a result of increasing technologies and fertility services (Mamo, 2007), this is problematic for two reasons: 1) it effectively excludes sub-populations at higher risk for maternal substance use than cis-gendered and heterosexual women (Gattis, Sacco, & Cunningham-Williams, 2012; O'Hanlan & Isler, 2007); and 2), it perpetuates discourses of motherhood that contribute to stigma and stereotyping for those who do not fit within these narrow definitions.

FASD public awareness-raising upholds the institution of motherhood as naturally suited to women and as inherently feminine. In the context of FASD prevention, maternal substance use is presented as preventing women from performing motherhood and

enacting their maternal duty. By extension, pregnancy is framed as a joyous occasion, a celebratory and happy event that can be derailed by maternal substance use. As Armstrong (2003) notes, there is a strong investment in pregnancy and its 'success' by individuals and society in general; maternal substance use risks upsetting this occasion.

These presentations of motherhood and pregnancy support age-old narratives of motherhood as the "divinest function" (Spargo, 1914, p. 11) and of pregnancy and childbirth as "transcend[ing] the biophysical processes of conception and gestation" and of creating "something magical" with new life (Armstrong, 2003, p. 215). These narratives, while not to be discounted, leave little liminal space to conceptualize motherhood and pregnancy as anything but wanted and joyous. This has the double-edged effect of neutralizing or erasing the conditions— socioeconomic, physical, familial, cultural, and otherwise—that make motherhood and pregnancy difficult, as well as those that lead to addiction and maternal substance use. Further, while these narratives recognize that pregnancy and motherhood may be unplanned, they exclude the possibility they may be unwanted and undesirable, and even contribute to substance use:

> Nanson (1997) noted that, in a Saskatchewan clinic for children with FAS and related effects, many of the biological mothers reported that the pregnancy that resulted in the affected child had been unplanned and unwanted, and sometimes occurred as a result of sexual assault. Further, many women reported experiencing domestic assault for the first time during the pregnancy. Horrigan et al. (2000) found a high correlation between heavy substance use, mental health and exposure to violence among a sample of 271 women registered for prenatal care in an Ohio hospital. (Roberts & Nanson, 2000, p. 10)

By erasing structural conditions like poverty, marginalization, colonization, and violence, as well as social conditions like availability of alcohol and drinking norms that play an integral part in FASD production (Shankar, 2011), narratives of self-responsibility, guilt, shame, and blame are reinforced for women who are unable to perform 'ideal' mothering.

As well, this positioning of pregnancy and motherhood fortifies the 'good' versus 'bad' mother dichotomy, setting up women who are unable to quit using alcohol during their pregnancies—or who may not *want* to quit—for failure, based on the strict (i.e., abstinent) expectations that Canadian society enforces via health norms. Further, some women are more likely to be labelled 'bad mothers' for their inability to abstain while pregnant. Pregnant women and mothers who live in high-risk environments, where maternal alcohol consumption may be more prevalent (and who are more likely to experience the stigma that accompanies maternal substance use), are often those with lower incomes, lower levels of education, and "who are experiencing severe economic and social problems, and/or have histories of abuse and psychological issues" (Shahram, Bottorf, Kurtz, Oelke, Thomas, & Spittal, 2017, p. 249). Although problematic substance use (including maternal substance use) is more prevalent among wealthy, educated women (Bennett, 2009; Ethen et al., 2009) than low-income women, it is less commonly constructed as a "social problem."

In Canada, as a result of imposed colonial conditions, this means that Indigenous women in particular are likely to be affected (Shahram et al., 2017), as well as women who are "located within [the] intersections of marginalization" (Hunting, 2011, p. 98) of race, socioeconomic status, culture, ability, etc. By portraying low-income, Indigenous, single, and racialized women as most likely to drink (and binge drink, drink uncontrollably, and use illicit drugs) during pregnancy, from 1979 through 2015, public awareness documents perpetuate stigma and reinforce discriminatory stereotypes of these women as 'bad' mothers. As a result, this type of awareness-raising has real potential to increase surveillance, by the state and in everyday social interactions, of marginalized

"women of colour, single mothers, and women living in poverty [who] have been most notably singled out as posing 'risks' and 'dangers' to their offspring" (Bell et al., 2009, p. 164). And, by extension, by generally portraying White, Euro-Canadian, and middle-class women as inherently nurturing, and as only requiring gentle messages to abstain, stereotypes of this sub-section of the population as least likely to consume alcohol while pregnant are reinforced. This is troubling given that women with higher incomes and higher ages are more likely to report drinking alcohol during their pregnancy (Dell & Roberts, 2005; CDC, 2012). While these types of messages further narratives about some populations of women as problematic (and thereby others as less problematic or more valued), it is also a biased portrayal of FASD mothers.

Although there are some organizations (e.g., the BC Centre of Excellence for Women's Health) that produce documents that encourage harm reduction, acknowledge the difficulties of addiction and substance use during pregnancy, centre increasingly racially diverse women in document imagery, and incorporate women-centred discourses—although only from 2010 forward—these documents are still predicated on women making a *choice* to abstain, even if that choice is presented as requiring intervention or support. Further, the apparatus of FASD public awareness-raising, throughout the time periods, unanimously promotes dominant values and institutions like heterosexuality, femininity, and marriage that work to preserve dominant social order (and that contribute to stereotyping for women who behave outside of the prescribed norms). By presenting pregnancy and motherhood as homogenously heterosexual, feminine, and as ideally occurring within the context of a heterosexual marriage, or at the very least, a heterosexual relationship, awareness efforts effectively exclude lesbian,

trans, queer, non-binary, and two-spirit folks from FASD public awareness-raising and the institution of motherhood generally. In a rapidly-evolving landscape in which queer identities are more socially accepted, and reproduction is increasingly divorced from heterosexual intercourse as a result of increasing technologies and fertility services (Luce, 2002), this is problematic for two reasons: 1) it effectively excludes sub-populations at higher risk for maternal substance use than cisgendered and heterosexual women (Coulter et al., 2015); and 2) it perpetuates discourses of motherhood that contribute to stigma and stereotyping for those who do not fit within these narrow definitions.

Indigenous women and 'Mothers of the Nation'

FASD public awareness-raising that is specifically directed at Indigenous women and their communities, and that is produced or co-produced by Indigenous organizations, differs in that the values transmitted are (sometimes, though not always) different from those transmitted to a mainstream audience. These documents, while focusing primarily on the mother-baby relationship, also include grandparents in the nuclear family frame; emphasize relationships to family, friends, community, and land in their imagery; are sometimes anchored in Indigenous ontology; work to de-stigmatize FASD generally and adolescent motherhood specifically; and promote cultural practices as part of a healthy pregnancy. This is significant in that it works to shift Indigenous FASD public awareness-raising away from a deficit model that relies on fear tactics and towards a more "culturally-grounded [approach] to health and healing" (Hunting, 2012, p. 104). As well, these documents promote different cultural norms, like relationship, shared parenting, connection to the land, and practicing culture. These acts can be seen as working to restore Indigenous motherhood norms above colonially-imposed norms and as

acts of self-determination. Indeed, Indigenous women and mothers are constructed explicitly within this subset of documents as Nation-builders (e.g., "Healthy pregnancy. Healthy baby. Healthy Nation") (2B, 2C, 2D, 2E, 1997), and as not only having the power and responsibility to prevent FASD but to produce healthy babies, families, communities, and Nations. In this context, maternal substance use is not only depicted as a disruption to the performance of motherhood, but to the production of healthy and functioning families, communities, and Nations. Rebeka Tabobondung (2016) writes:

> From the earliest points of contact, processes of colonization attempted to destroy Indigenous midwifery and birth knowledge. In the first half of the twentieth century, the disruption of traditional birth practices escalated through the deliberate dispossession of land; the fragmentation of families and communities through the residential school system; and the medicalization of birth as part of the overall imposition of Western beliefs, values, and ideological frameworks upon our nations. (n.p.)

A healthy pregnancy in which substances are not consumed is promoted not only as FASD prevention, but as a decolonial and self-determining act and duty. Of course, by upholding motherhood as a sacred duty, Indigenous women who are unable to abstain from maternal substance use may also experience compounded stigma, guilt, and shame.

However, many dominant discourses of motherhood—like those of self-sacrifice, mandated femininity, and sole responsibility for fetal health—are also easily found within these documents, which are frequently produced in tandem with Canadian and non-Indigenous organizations like Health Canada, the First Nations Inuit Branch (a branch of Health Canada), and the Asante Centre, a not-for-profit organization. Salmon (2011) warns that state-sponsored public awareness campaigns have long targeted Indigenous women and mothers, disciplining them for "failing to conform to liberal ideologies of 'good mothering'" (p. 167), and that this discipline has been moral and real, metered out

through forced removal of children from their homes, residential schools, and imposed birthing practices (Salmon, 2007). Although it is beyond the scope of this project to evaluate the material effects of such campaigns, it is clear that public awareness-raising documents, even those ones rooted in Indigenous ontology and with a wellness-focus, are value-laden and moralistic in ways that support dominant (i.e., mainstream, Euro-Canadian, middle-class) discourses and values. This alone has the potential to stigmatize Indigenous women who may not be able to, or may not want to, or who resist prescribed motherhood values—even those of Indigenous cultures.

For pregnant women in general, the 'woman's choice' discourse is employed in a variety of ways to encourage women to 'choose' to abstain from alcohol; at the heart of this discourse is the implication that women are personally responsible for their actions, as well as the erasure of structural and social conditions that lead to maternal substance use. For Indigenous women, being held personally responsible for maternal substance use and FASD production means public awareness-raising must work to obscure and erase the imposed colonial conditions—historical and ongoing—that affect and cause substance use and addiction as well as poverty, marginalization, intergenerational trauma, and violence. As Hunting & Browne (2012) write, "the cumulative effects of colonization—intergenerational traumas, poverty, systemic discrimination, and displacement—have been directly connected to substance use and addiction issues" (p. 39). In a neoliberal and colonial context, these actions might also be interpreted as the state working to absolve itself of responsibility—fiduciary, political, and symbolic—to Indigenous women. For example, by promoting personal responsibility discourses, the state is able to distance itself from responsibility for ongoing effects of colonialism (e.g.,

problematic and maternal substance use, structural inequality) and their impact on the production of FASD.

It should also be noted that while the root causes of FASD production—like colonization, geographic and socio-cultural dislocation, and systemic racism—are named as factors in Indigenous women's maternal substance, the same discussion is less likely to occur (or simply does not) for non-Indigenous women. This has the effect of making Indigenous women's maternal substance use (and substance use generally) seem inevitable, natural, and unavoidable. For non-Indigenous women, the lack of focus on root causes presents maternal substance use as fixable and something that is out of the ordinary.

The 'burden' of FASD and the production of healthy citizens

In addition to transmitting dominant motherhood values, FASD public awareness-raising promotes certain ideals regarding the production of a healthy citizenry. Fetuses exposed to alcohol in utero are repeatedly referred to or represented as sick, abnormal, damaged, and disabled. Images of visibly disabled adults and children, warnings about social and physical difficulties, and photos of "FAS brains" are frequently employed to warn or scare women into abstinence. Although it is indisputable that FASD can present a unique set of challenges, Rutman (2013) argues that there is "tremendous heterogeneity in people's strengths and in the nature and degree of the harms and disabilities experienced by those living with FASD" (p. 107). With the exception of one document, produced by the Vancouver Aboriginal Friendship Centre Society (2K, 1998), which emphasizes the strengths that individuals with FASD have while acknowledging the potential difficulties, the documents are nearly universal in their bleak and homogenous

characterization of FASD. This characterization enforces narratives of FASD babies as less worthy than their non-alcohol-affected counterparts, and is supported by accounts that suggest spending is "disproportionately allocated to prevention over supports for those living with FASD (including supported housing, work programs, mentoring projects, and the list continues") (Stewart, 2016, p. 55). It also inflicts further shame and stigma on biological mothers for having imposed on their children a 'preventable' condition of disability.

These types of narratives do not affect women and children indiscriminately. As Oldani (2009) points out, FASD diagnosis often follows a racialized script, wherein Indigenous children are more likely to fall into discourses of FASD diagnosis while White children fall into those of ADHD. Those children diagnosed with FASD are also more likely to have negative interactions with police and the justice system (Stewart, 2016), and their mothers are viewed as "more different, with greater disdain, and more to blame" than mothers of children with other serious mental illnesses (Corrigan et al., 2017, p. 1171). Thus, characterizing FASD as a disability—a preventable, thus especially damning, disability—not only has the power to create stigma for women who use substances while pregnant and their children, but particularly for women and children who are Indigenous, racialized, and living in poverty.

As noted in the literature review, FASD is frequently cited, particularly in the research literature and by the government (Di Pietro & Illes, 2013; Health Canada, 2006; Tough et al., 2005), as a cost to taxpayers and as an 'unnecessary' and 'preventable' burden. FASD public awareness-raising supports this characterization by explicitly labelling FASD as individually preventable and in some instances by explicitly

advertising the economic costs associated with the disorder: "The estimated financial cost for the lifespan of an individual living with FAS is approximated at 1.5 million dollars" (2K, 1998). While employing this economic angle may be a means of encouraging pregnant women to abstain, it is also revealing of public interests. Salmon (2011) argues that the presence of neoliberal ideology in FASD prevention can have value in that it attracts political support for prevention initiatives, but also that it undermines social justice concerns by positioning some women (e.g., Indigenous women and poor women) as economic drains on society because they are portrayed as more—or most—likely to consume alcohol while pregnant.

Promoting the 'Rights' and Health of the Fetus

FASD public awareness-raising overwhelmingly positions the fetus as a life baby and fully formed human being. Sometimes this positioning is purely symbolic but other times the fetus is presented as exhibiting varying degrees of sentience. Featherstone (2008) argues that beginning in the 19th century, conceptualizations of the fetus began to shift from a relatively unproblematized part of a woman's body to an unborn baby, "almost but not quite a child" (p. 453). This shift from fetus to 'unborn child' works to assert the moral and legal status of the fetus:

> The phrase 'moral status,' means that human beings have obligations to protect to an entity, to protect and promote its interests. 'Legal status' means that state power should be used to enforce such obligations … Children have moral status; parents, healthcare professionals, and other human beings have substantive obligations to protect and promote the health-related and myriad other interests of children, i.e., living, ex utero, offspring of human beings. (McCullough & Chervenak, 2008, p. 35)

Positioning the fetus as an unborn baby, sometimes to the degree that it can think and speak in utero, works as a rhetorical strategy to not only convince pregnant women to

abstain, but to shift the cultural discourse and invite others to be involved in their abstention, too. These strategies work to highlight the culturally understood bond between mother and baby in order to strengthen a pregnant woman's conviction to abstain from alcohol. The elevation of the fetus's status to baby also strengthens its need for protection from its mother, conversely (and only rhetorically) elevating the mother's ability to harm via alcohol consumption and other behaviours. As Bell et al. (2015b) warn, positioning pregnant women as the ultimate protectors of, and risks to, their fetuses makes women less likely to disclose drinking to healthcare providers because of stigma; can deepen health inequities experienced by marginalized women who cannot simply make 'good choices'; and "may actually lead to diminished interest in undertaking environmental or societal changes that could prevent FASD" (p. 19) due to the presentation of maternal substance use as an individualized issue—and therefore individual problem—to be solved.

Attempts to elevate the fetus to legal personhood status in Canada are rooted in both morality and science, and are the product of decades of efforts of conservative and anti-choice political maneuvering, as well as increasing technologies and scientific advancements (e.g., ultrasound, genetic testing, fetal photography, and even fetal surgery) (Lupton, 2012). In tandem with this progression has been the intensification and proliferation of intensive parenting and pregnancy discourses concerned with fetal and child health, which encourage 'risk management' through an ever-widening scope of behaviours like diet, chemical and stress avoidance, exercise, sleep, and so on (Kukla, 2008; Romagnoli & Wall, 2012). The cultural push to elevate the fetus to legal personhood status, combined with increasingly prescriptive pregnant risk management

behaviours (and a failure to fulfill them), can effect a powerful stigma, which Bell et al. (2009) note, "tends to be exercised upon the most stigmatised and powerless groups, such as immigrants and the poor or dispossessed" (p. 163); in other words, those least likely to have the ability to perform the increasingly all-encompassing dominant and prescribed motherhood behaviours and values.

Some FASD public awareness-raising reproduces and perpetuates this view of the fetus as a realized person by attributing it with human characteristics. In the documents this is done by utilizing actual images and illustrations of babies, using fear-provoking images and illustrations of 'damaged' babies and children, and by centring pregnant women's bellies. Of course, whether a fetus is a human being at conception, or at what point a fetus becomes a human being, is not the focus of this discussion. Rather, it is to make the point that the documents employ the rhetorical strategy of framing the fetus as a thinking, feeling baby in order to motivate women to alter their behaviour.

The documents also consistently encourage abstinence-based behaviour throughout the time periods, with messages of harm reduction beginning to emerge only in 2010. By advocating primarily for abstinence-only prevention, FASD public awareness-raising generally fails to recognize the difficulty that some women may have with complete abstention. Messages of abstinence, and even those of harm reduction that portray maternal alcohol consumption as negative, run in contrast to contemporary scientific evidence that suggests that occasionally consuming small amounts of alcohol may not present serious concern (Underberg et al., 2012). This is important, because as Richardson and colleagues (2014) write:

> Although those who drink heavily during pregnancy can endanger their children, the risks of moderate drinking [are] overstated by policy-makers … warnings

> about alcohol during pregnancy made in inappropriate contexts still cause pregnant women to suffer social condemnation and to agonize over an occasional sip. (p. 132)

In this case, the stress and anxiety caused by warnings to abstain (warnings that may not realistically be able to be heeded) might be worse than the harms posed by consuming small quantities of alcohol. Further, these messages are unlikely to affect behaviour changes among a higher-risk population. So, while these messages may contribute to awareness-raising among the general public, they also pose potential to cause harm and contribute to stigma must also be considered.

Chapter 6: Conclusion

In the previous chapters, I deconstructed discourses of motherhood as found in FASD public awareness documents produced from 1979 to 2015. For example, the "woman's choice" discourse, wherein maternal substance use is positioned as an individual choice (and one that pregnant women are solely responsible for) rather than a complex action that is linked to structural inequalities and social determinants of health. In the literature review, I explored how cultural motherhood norms have drawn boundaries between 'good' and 'bad' mothering, the origins of FASD, and the state of FASD public awareness-raising in Canada. In the methodology chapter, I outlined Foucault's definition of discourse and centred my project within the feminist poststructuralist tradition, as well as outlined the process of data collection. In the data analysis chapter, I explored how maternal substance use and FASD were problematized and what assumptions enabled representations of 'the problem' to be repeated over time. Data analysis revealed that documents utilized certain frames (e.g., duty to the fetus, an Indigenous woman's duty to her community) to encourage women to abstain, and that some women (e.g., those who binge drink or who are racialized and/or poor) were constructed as more problematic than others. Finally, in the discussion chapter I connected the apparatus of FASD public awareness-raising to neoliberal regimes of self-governance and revealed it as a means for promoting certain dominant cultural values over others; as well as located FASD prevention discourses within the larger context of the fetal rights movement.

As I demonstrated through my discourse analysis of the documents, FASD prevention has and continues to uphold the health and well-being of the fetus above

pregnant women. FASD prevention has been critiqued for promoting narratives of blame and shame, and while some documents in recent decades have been framed in more supportive ways (e.g., by utilizing a harm reduction lens), overall there is still an overwhelming tendency to blame women for substance use that occurs during pregnancy. In future, producers of FASD public awareness documents should consider creating documents that "meet women where they are at" and that focus on service linkage, are inclusive, and resist promoting narratives of 'blame and shame.'

References

Aase, J. M. (1994). Clinical recognition of FAS: Difficulties in detection and diagnosis. *Alcohol health and research world, 18*(1), 5.

Abel, E. L. (1995). An update on incidence of FAS: FAS is not an equal opportunity birth defect. *Neurotoxicology and Teratology, 17*(4), 437–443.

Abel, E. L., & Hannigan, J. H. (1995). Maternal risk factors in fetal alcohol syndrome: Provocative and permissive influences. *Neurotoxicology and Teratology, 17*(4), 445–462.

Ahmed, S. (2012). *On being included: Racism and diversity in institutional life*. Durham and London, UK: Duke University Press.

Alfred, T. & Corntassel, J. (2005). Being Indigenous: Resurgences against contemporary colonialism. *Government and Opposition, 40*, 597–614.

Anderson, K. (2000). *A recognition of being: Reconstructing native womanhood.* Toronto, ON: Sumach Press.

Armstrong, E. M. (1998). Diagnosing moral disorder: The discovery and evolution of fetal alcohol syndrome. *Social Science & Medicine, 47*(12), 2025–2042.

Armstrong, E. M. (2003). *Conceiving risk, bearing responsibility: Fetal Alcohol Syndrome and the diagnosis of moral disorder.* Baltimore, MD: Johns Hopkins University Press.

Armstrong, E. M., & Abel, E. L. (2000). Fetal alcohol syndrome: The origins of a moral panic. *Alcohol & Alcoholism, 35*(3), 276–282.

Asante, K. O., & Nelms-Matzke, J. (1985). Survey of children with chronic handicaps and fetal alcohol syndrome in the Yukon and Northwest B.C. Ottawa. Unpublished report, Canada: Haland Welfare.

Astley, S. J., Bailey, D., Talbot, C., & Clarren, S. K. (2000). Fetal alcohol syndrome (FAS) primary prevention through FAS diagnosis: II. A comprehensive profile of 80 birth mothers of children with FAS. *Alcohol & Alcoholism, 35*(5), 509–519.

Avalos, L. A., Roberts, S. C. M., Kaskutas, L., Block, G., & Li, D. (2014). Volume and type of alcohol during early pregnancy and risk of miscarriage. *Substance Use & Misuse, 49*, 1437–1445.

Bacchi, C. (2009). *Analysing policy: What's the problem represented to be?* French Forest, Australia: Pearson.

Badry, D., & Wight Felske, A. (2013). An examination of the social determinants of health as factors related to health, healing and prevention of foetal alcohol spectrum disorder in a northern context – the brightening our home fires project, Northwest Territories, Canada. *International Journal of Circumpolar Health, 72,* 1–6.

Ballard, M., Sun, M., & Ko, J. (2012). Vitamin A, folate, and choline as a possible preventive intervention in fetal alcohol syndrome. *Medical Hypotheses*, 78, 489–493.

Basford, D. L., Thorpe, K., William, R., & Cardwell, K. (2004). *State of evidence: Fetal alcohol spectrum disorder (FASD) prevention.* Alberta Centre for Child, Family & Community Research, Lethbridge: AB.

BC Centre for Excellence in Women's Health. (2014). *Young women, alcohol and pregnancy: Information for service providers.* Retrieved from http://bccewh.bc.ca/wp-content/uploads/2014/08/FASD-Sheet-8_Young-Women-Alcohol-and-Pregnancy_27-March-2014.pdf

BC Women's Hospital & Health Centre. (2018). *Pregnancy, drugs & alcohol.* Retrieved from http://www.bcwomens.ca/our-services/pregnancy-prenatal-care/pregnancy-drugs-alcohol

Becker, H. S. (1963*). Outsiders: Studies in the sociology of deviance*. New York, NY: The Free Press of Glencoe.

Bell, E. (2015, October 21). Campaigns hopes to lower FASD. *630 Ched.* Retrieved from http://630ched.com/2015/10/21/campaigns-hopes-to-lower-fasd/

Bell, E., Andrew, G., Di Pietro, N., Chudley, A. E., Reynolds, J. N., & Racine, E. (2015a). It's a shame! Stigma against fetal alcohol spectrum disorder: Examining the ethical implications for public health practices and policies. *Public Health Ethics,* 1–13.

Bell, E., Zizzo, N., & Racine, E. (2015b). Caution! Warning labels about alcohol and pregnancy: Unintended consequences and questionable effectiveness. *The American Journal of Bioethics, 15*(3), 18–20.

Bell, K., McNaughton, D., & Salmon, A. (2009). Medicine, morality and mothering: Public health discourses on foetal alcohol exposure, smoking around children and childhood overnutrition. *Critical Public Health, 19*(2), 155–170.

Bennett, M. (2009). *FASD literature review: A scan of the literature, FASD best practice models and service standards.* First Nations Child & Family Caring Society of Canada. Retrieved from https://fncaringsociety.com/sites/default/files/docs/Literature_Review_FASD_2009_MB.pdf

Bourassa, C., McKay-McNabb, K., & Hampton, M. (2004). Racism, sexism and colonialism: The impact on the health of Aboriginal women in Canada. *Canadian Women Studies, 24*(1), 23–29.

Bowen, A., Bowen, R., Butt, P., Rahman, K., & Muhajarine, N. (2012). Patterns of depression and treatment in pregnant and postpartum women. *Canadian Journal of Psychiatry, 57,* 161–167.

Boyd, S. (1999). *Mothers and illicit drugs: Transcending the myths.* Toronto, ON: University of Toronto Press.

Boyd, S. (2003). *Child custody, law, and women's work*. Toronto, ON: Oxford University Press.

Boyd, S. (2007). Drug scares and practice: Socio-historical considerations. In S. C. Boyd & L. Marcellus (Eds.), *With child: Substance use during pregnancy, a woman-centred approach* (20–27). Winnipeg, MB: Fernwood Publishing.

Boyd, S. (2015). *From witches to crack moms: Women, drug law, and policy* (2nd ed.). Durham, NC: Carolina Academic Press.

Boyd, S., & Marcellus, L. (Eds.). (2007). *With child: Substance-use during pregnancy, a woman-centred approach*. Winnipeg, MB: Fernwood Publishing.

Boyd, S., & NAOMI Patients Association. (2013). Yet they failed to do so: Recommendations based on the experiences of NAOMI research survivors and a call for action. *Harm Reduction Journal, 10*(6).

Brady, M. (2000). Alcohol policy issues for Indigenous people in the United States, Canada, Australia and New Zealand. *Contemporary Drug Problems, 27*(3), 435–509.

Bray, D. L., & Anderson, P. D. (1989). Appraisal of the epidemiology of fetal alcohol syndrome among Canadian Native Peoples. *Canadian Journal of Public Health, 80*(1), 42–45.

Burgoyne, W. (2006). *What we have learned: Key Canadian FASD awareness campaigns.* Ottawa, ON: Public Health Agency of Canada.

Calhoun, F., & Warren, K. (2007). Fetal alcohol syndrome: Historical perspectives. *Neuroscience and Biobehavioural Reviews, 31,* 168–171.

Canada Without Poverty. (2017). *Just the facts*. Retrieved from http://www.cwp-csp.ca/poverty/just-the-facts/

Canadian Broadcasting Corporation. (2014, September 22). Nunavut FASD posters provoke strong reaction. *CBC*. Retrieved from http://www.cbc.ca

Carabine, J. (2001). Unmarried motherhood 1830-1990: A genealogical analysis. In M. Wetherell, S. Taylor, S. J. Yates (Eds.), *Discourse as data: A guide for analysis* (pp. 267–310). London, UK: Sage Publications.

Carter, C. S. (1997). Ladies don't: A historical perspective on attitudes toward alcoholic women. *Affilia, 12*(4), 471–485.

Centers for Disease Control and Prevention. (2012). Alcohol use and binge drinking among women of childbearing age – United States, 2006-2010. *Morbidity and Mortality Weekly Report, 61*(28), 534–538.

Centers for Disease Control and Prevention. (2014). *Social determinants of health: Definitions*. Retrieved from http://www.cdc.gov/nchhstp/socialdeterminants/definitions.html

Chasnoff, I. J., Landress, H. J., & Barrett, M. E. (1990). The prevalence of illicit-drug or alcohol use during pregnancy and discrepancies in mandatory reporting in Pinellas County, Florida. *The New England Journal of Medicine, 322*(17), 1202–1206.

Chudley, A. E., Conry, J., Cook, J. L., Loock, C., Rosales, T., & LeBlanc, N. (2005). Fetal alcohol spectrum disorder: Canadian guidelines for diagnosis. *Canadian Medical Association Journal, 172*(5), S1–S21.

Clarren, S., Lutke, J., & Sherbuck, M. (2011). The Canadian guidelines and the interdisciplinary clinical capacity of Canada to diagnose fetal alcohol spectrum disorder. *Journal of Population Therapeutics and Clinical Pharmacology, 18*(3), e494–e499.

Clarren, S., Salmon, A., & Jonsson, E. (2011). Introduction. In S. Clarren, A. Salmon & E. Jonsson (Eds.), *Prevention of fetal alcohol spectrum disorder: Who is responsible?* Weinheim, Germany: Wiley Blackwell.

Cobb, C. (2015, September 16). FASD: The often invisible brain injury suffered by kids whose mothers drank while pregnant. *The Ottawa Citizen.* Retrieved from http://ottawacitizen.com/

Cohen, L., Chavez, V., & Chehimi, S. (Eds.). (2007). *Prevention is primary: Strategies for community well-being*. San Francisco, CA: John Wiley and Sons.

Cook, J. L., Green, C. R., Lilley, C. M., Anderson, S. M., Baldwin, M. E., Chudley, A. E., ... Canada Fetal Alcohol Spectrum Disorder Research Network. (2016). Fetal alcohol spectrum disorder: A guideline for diagnosis across the lifespan. *CMAJ, 188*(3), 191–197.

Corrigan, P. W., Lara, J. L., Shah, B. B., Mitchell, K. T., Simmes, D., & Jones, K. L. (2017). The public stigma of birth mothers of children with fetal alcohol spectrum disorders. *Alcoholism: Clinical and Experimental Research, 41*(6), 1166–1173.

Coulter, R. W. S., Blosnich, J. R., Bukowski, L. A., Herrick, A. L., Siconolfi, D. E., & Stall, R. D. (2015). Differences in alcohol use and alcohol-related problems between transgender- and nontransgender-identified young adults. *Drug and Alcohol Dependence, 154*, 251–259.

Crawford, R. (1994). The boundaries of the self and the unhealthy other: Reflections on health, culture and aids. *Social Science & Medicine, 38*(10), 1347–1365.

Cull, R. (2006). Aboriginal mothering under the state's gaze. In D. M. Lavell-Harvard & J. Corbiere Lavell, (Eds.), *"Until our hearts are on the ground": Aboriginal mothering, oppression, resistance and rebirth* (141–156). Toronto, ON: Demeter Press.

Daniels, C. (2009). *At women's expense: State power and the politics of fetal rights.* Cambridge, MA: Harvard University Press.

Davies, B. (1991). The concept of agency: A feminist poststructural analysis. *Social Analysis: The International Journal of Social and Cultural Practice, 30,* 42–53.

Day, J., Savani, S., Krempley, B. D., Nguyen, M., & Kitlinska, J. B. (2016). Influence of paternal preconception exposures on their offspring: Through epigenetics to phenotype. *American Journal of Stem Cells, 5*, 11–18.

Dell, C. A., & Roberts, G. (2005). *Research update, alcohol use and pregnancy: An important Canadian public health and social issue*. Ottawa, ON: Public Health Agency of Canada.

Dej, E. (2011). What once was sick now is bad: The shift from victim to deviant identity for those diagnosed with Fetal Alcohol Spectrum Disorder. *Canadian Journal of Sociology, 36*, 137–160.

Derrida, J. (1981). *Dissemination*. Chicago, IL: University Press.

DeVault, M., & Gross, G. (2012). Feminist qualitative interviewing: Experience, talk, and knowledge. In S. N. Hesse-Biber (Ed.), *Handbook of Feminist Research: Theory and Praxis* (2nd ed., pp 206-236). Thousand Oaks, CA: Sage.

DeVille, K. A., & Kopelman, L. M. (1998). Substance abuse in pregnancy: Moral and social issues regarding pregnant women who use and abuse drugs. *Obstetrics & Gynecology Clinics of North America, 25*(1), 237–254.

Diduck, A. (1993). Legislating ideologies of motherhood. *Social & Legal Studies, 2,* 461–485.

Di Pietro, N. C., & Illes, J. (2013). Disparities in Canadian Indigenous research on neurodevelopmental disorders. *Journal of Developmental and Behavioral Pediatrics, 35*(1), 74–81.

Dubriwny, T. N. (2010). Television news coverage of postpartum disorders and the politics of medicalization. *Feminist Media Studies, 10*(3), 285–303.

Duncan, S. (2007). What's the problem with teenage parents? And what's the problem with policy? *Critical Social Policy, 27*(3), 307–334.

Ebrahim, S. H., Luman, E. T., Floyd, R. L., Murphy, C. C., Bennett, E. M., & Boyle, C. A. (1998). Alcohol consumption by pregnant women in the united states during 1988–1995. *Obstetrics & Gynecology, 92*(2), 187–192.

Eni, R., & Phillips-Beck, W. (2013). Teenage pregnancy and parenthood perspectives of First Nation women. *The International Indigenous Policy Journal, 4*(1), 1–23.

Ethen, M. K., Ramadhani, T. A., Scheuerle, A. E., Canfield, M. A., Wyszynski, D. F., Druschel, C. M., ... National Birth Defects Prevention Study. (2009). Alcohol consumption by women before and during pregnancy. *Maternal and Child Health Journal, 13,* 274–285.

Ermine, W., Sinclair, R., Jeffery, B., & Indigenous Peoples' Health Research Centre. (2004). *The ethics of research involving Indigenous Peoples.* Retrieved from http://iphrc.ca/pub/documents/ethics_review_iphrc.pdf

Fairclough, N. (1992). *Discourse and social change.* Cambridge, UK: Polity Press.

Featherstone, L. (2008). Becoming a baby? The foetus in late nineteenth-century Australia. *Australian Feminist Studies, 23*(58), 451–465.

Ferguson, L. (1997). *Deconstructing fetal alcohol syndrome: A critical inquiry into the discourse around alcohol, women, ethnicity, Aboriginals and disease* (Master's Thesis). Retrieved from National Library of Canada (0-612-22077-X).

Fine, M. (1998). Working the hyphens: Reinventing Self and Other in qualitative research. In N. Denzin & Y. Lincoln. (Eds.), *Handbook of qualitative research* (pp. 130–155). Thousand Oaks, CA: Sage.

Finnegan, L. (2013). *Licit and illicit drug use during pregnancy: Maternal, neonatal, and early childhood consequences*. Ottawa, ON: Canadian Centre on Substance Abuse.

Fiske, J. (1993). Child of the state mother of the nation: Aboriginal women and the ideology of motherhood. *Culture, 1,* 17–35.

Fiske, J., & Browne, A. J. (2006). Aboriginal citizen, discredited medical subject: Paradoxical constructions of Aboriginal women's subjectivity in Canadian health care policies. *Policy Sciences, 39*, 91–111.

Foucault, M. (1970/1981). The order of discourse. In R. Young (Ed.), *Untying the text: a post-structural anthology*, 48–78. Boston, MA: Routledge & Kegan Paul.

Foucault, M. (1971/1986). The discourse on language. In H. Adams & L. Searle (Eds.), *Critical Theory Since 1965* (pp. 148–162). University of Press of Florida.

Foucault, M. (1972). *The archaeology of knowledge and the discourse on language* (A. M. Sheridan Smith Trans.). New York, NY: Harper.

Foucault, M. (1979). *Discipline and punish: The birth of the prison* (A. M. Sheridan Smith Trans.). New York, NY: Random House.

Fournier, S., & Crey, E. (1997). *Stolen from our embrace: The abduction of First Nations children and the restoration of Aboriginal communities.* Vancouver, BC: Douglas & McIntyre.

France, K., Donovan, R., Bower. C., Elliott, E. J., Payne, J. M., Antoine, H. D., & Bartu, A. E. (2014). Messages that increase women's intentions to abstain from alcohol during pregnancy: Results from quantitative testing of advertising concepts. *BMC Public Health, 14*(1), 30.

Fraser, S. L., Muckle, G., Abdous, B. B., Jacobson, J. L., & Jacobson, S. W. (2012). Effects of binge drinking on infant growth and development in an Inuit sample. *Alcohol, 46*(3), 277–283.

Fusch, P. I., & Ness, L. R. (2015). Are we there yet? Saturation in qualitative research. *The Qualitative Report, 20*(9), 1408–1416.

Gabe, J., Harley, K., Calnan, M. (2015). Healthcare choice: Discourses, perceptions, experiences and practices. *Current Sociology Monograph, 63*(5), 623–635.

Gattis, M. N., Sacco, P., & Cunningham-Williams, R. M. (2012). Substance use and mental health disorders among heterosexual identified men and women who have same-sex partners or same-sex attraction: Results from the National Epidemiological Survey on Alcohol and Related Conditions. *Archives of Sexual Behavior, 41*(5), 1185–1197.

Gavaghan, C. (2009). "You Can't Handle the Truth": Medical paternalism and prenatal alcohol use. *Journal of Medical Ethics, 35*(5), 300–303.

Gavey, N. (1989). Feminist poststructuralism and discourse analysis: Contributions to feminist psychology. *Psychology of Women Quarterly, 13*, 459–475.

Gelb, K., & Rutman, D. (2011). *Substance using women with FASD and FASD prevention.* Research Initiatives for Social Change Unit. Retrieved from http://www.uvic.ca/hsd/socialwork/assets/docs/research

George, A. (2001). *The effects of prenatal exposure to alcohol, tobacco, and other risks on children's health, behaviour, and academic abilities*. Thesis (PhD). University of British Columbia.

Gladstone, J., Levy, M., Nulman, I., & Koren, G. (1997). Characteristics of pregnant women who engage in binge alcohol consumption. *CMAJ, 156*(6), 789–794.

Golden, J. (2005). *Message in a bottle: The making of fetal alcohol syndrome.* Cambridge, MA: Harvard University Press.

Government of Alberta. (2013). *Alberta's FASD Service Network Program: A new model for FASD prevention and service delivery.* Retrieved from http://fasd.alberta.ca/documents/3-Overview_Year_5_Evaluation_of_FASD_10_Year_Strategic_Plan.pdf

Grant, M. (2017, October 5). Rapist brothers who 'didn't stand a chance' will learn their fate next year. *CBC News*. Retrieved from http://www.cbc.ca/news/canada/calgary/cody-corey-manyshots-rape-kidnap-taradale-sentencing-fasd-1.4328883

Grbich, C. (2004). *New approaches in social research.* Gateshead, UK: Athenaeum Press.

Greaves, L., & Poole, N. (2004). Victimized or validated? Responses to substance-using pregnant women. *Canadian Woman Studies, 24*(1), 87–92.

Greaves, L., Varcoe, C., Poole, N., Morrow, M., Johnson, J., Pederson, A., & Irwin, L. (2002). *A motherhood issue: Discourses on mothering under duress*. Ottawa, ON: Status of Women in Canada.

Green, C. R., Cook, J. L., Racine, E., & Bell, E. (2016). *Stigma, discrimination and fetal alcohol spectrum disorder*. Canada FASD Research Network. Retrieved from https://canfasd.ca/wp-content/uploads/sites/35/2016/05/Stigma-and-FASD-Final.pdf

Hall, S. (1997). (Ed.). *Representation: Cultural representations and signifying practices*. London, UK: Routledge.

Hammer, R., & Inglin, S. (2014). 'I don't think it's risky, but…': Pregnant women's risk perceptions of maternal drinking and smoking. *Health, Risk & Society, 16*(1), 22–35.

Hankivsky, O. (Ed.). (2012). *An intersectionality-based policy analysis framework*. Vancouver, BC: Institute for Intersectionality Research and Policy, Simon Fraser University.

Hartman, D. M., & Golub, A. (1999). The social construction of the crack epidemic in the print media. *Journal of Psychoactive Drugs, 31*(4), 423–433.

Harvey, D. (2005). *A brief history of neoliberalism.* Oxford, UK: Oxford University Press.

Hayman, B., Wilkes, L., Halcomb, E., & Jackson, D. (2013). Marginalised mothers: Lesbian women negotiating heteronormative healthcare services. *Contemporary Nurse, 44*(1), 120–127.

Hays, S. (1996). *The cultural contradictions of motherhood.* New Haven, CT: Yale University Press.

Health Canada. (1997). *It takes a community*. Ottawa, ON: Minister of Public Works and Government Services Canada.

Health Canada. (2006). *It's your health: Fetal alcohol spectrum disorder.* Minister of Health. Retrieved from the Health Canada website: http://www.hc-sc.gc.ca/hl-vs/alt_formats/pacrb-dgapcr/pdf/iyh-vsv/diseases-maladies/fasd-etcaf-eng.pdf

Hesse-Biber, S. N. (2012). Feminist research: Exploring, interrogating, and transforming the interconnections of epistemology, methodology, and method. In S. N. Hesse-Biber (Ed.), *Handbook of Feminist Research: Theory and Praxis* (2nd ed.) (2–26). Thousand Oaks, CA: Sage.

Hesse-Biber, S. N., Leavy, P., & Yaiser, M. (2004). Feminist approaches to research as a process: Reconceptualizing epistemology, methodology and method. In S. N. Hesse-Biber, M. Yaiser & P. Leavy (Eds.), *Feminist perspectives on social research* (pp. 3–26). New York: Oxford University Press.

Hill Collins, P. (1994). Shifting the center: Race, class, and feminist theorizing about motherhood. In Nakano Glenn, G. Chang, & L. Rennie Forcey, (Eds.), *Mothering: Ideology, Experience and Agency* (45-65). New York, NY: Routledge.

Hill Collins, P. (2000). *Black feminist thought:* Knowledge, consciousness, and the politics of empowerment. New York, NY: Routledge.

Holland, K., McCallum, K., & Walton, A. (2016). 'I'm not clear on what the risk is': Women's reflexive negotiations of uncertainty about alcohol during pregnancy. *Health, Risk & Society, 18*(1–2), 38–58.

Holmila, M., & Raitasalo, K. (2005). Gender differences in drinking: Why do they still exist ? *Addiction, 100*(12), 1763–1769.

Hook, D. (2001). Discourse, knowledge, materiality, history. *Theory and Psychology, 11*(4), 521–547.

Huber, Anna-Maria. (1998). *Fetal alcohol syndrome in the Canadian press: A discourse analysis* [unpublished master's thesis], University of Victoria, Victoria, BC, Canada.

Hunting, G. (2011). *A call for a policy paradigm shift: An intersectionality-based analysis of FASD policy.* Institute for Intersectionality Research & Policy, Simon Fraser University.

Hunting, G. & Browne, A. (2012). Decolonizing policy discourse: Reframing the 'problem' of fetal alcohol spectrum disorder. *Women's Health and Urban Life, 11*(1), 35–53.

Ikemoto, L. C. (1992). The code of perfect pregnancy: At the intersection of the ideology of motherhood, the practice of defaulting to science, and the interventionist mindset of law. *Ohio State Law Journal, 53*(5), 1205–1306.

Indigenous Foundations. (2009). *Indian status.* Retrieved from http://indigenousfoundations.web.arts.ubc.ca/indian_status/

Jomeen, J. (2010). *Choice, control and contemporary childbirth.* Abingdon, UK: Radcliffe Publishing Ltd.

Jones, K. L., & Smith, D. F. (1973). Recognition of the fetal alcohol syndrome in early infancy. *The Lancet, 302*(7836), 999–1001.

Jones, K. L., Smith, D. W., Ulleland, C. N., & Streissguth, A. P. (1973). Pattern of malformation in offspring of chronic alcoholic mothers. *The Lancet, 301*(7815), 1267–1271.

Kaplan, E. A. (1992). *Motherhood and representation: The mother in popular culture and melodrama*. New York, NY: Routledge.

Koopman, C. (2008). Foucault's historiographical expansion: Adding genealogy to archaeology. *Journal of the Philosophy of History, 2*, 338–362.

Kowalsky, L. O., & Verhoef, M. (1999). Northern community members' perceptions of FAS/FAE: A qualitative study. *The Canadian Journal of Native Studies, 19*(1), 149–168.

Kukla, R. (2008). Measuring mothering. *International Journal of Feminist Approaches to Bioethics, 1*(1), 67–90.

Kukla, R. (2010). The ethics and cultural politics of reproductive risk warnings: A case study of California's Proposition 65. *Health, Risk & Society, 12*(4), 323–334.

Lassi, Z. S., Majeed, A., Rashid, S., Yawar Yakoob, M., & Bhutta, Z. A. (2013). The interconnections between maternal and newborn health – evidence and implications for policy. *The Journal of Maternal-Fetal & Neonatal Medicine, 26*(S1), 3–53.

Lavell-Harvard, D. M., & Corbiere Lavell, J. (Eds.). (2006). *"Until our hearts are on the ground": Aboriginal mothering, oppression, resistance and rebirth.* Toronto, ON: Demeter.

Lemoine, P., Harousseau, H., Borteyru, J. P., & Menuet, J. C. (1968). Les enfants de parents alcooliques: Anomalies observes a propos de 127 cas [Children of alcohol parents: Abnormalities observed in 127 cases]. *Ouest méd, 21,* 476–482.

Leppo, A. (2012). The emergence of the foetus: Discourses on foetal alcohol syndrome and compulsory treatment in Finland. *Critical Public Health, 22,* 179–191.

Lewis, P. T., Shipman, V. C., & May, P. A. (2011). Socioeconomic status, psychological distress, and other maternal risk factors for fetal alcohol spectrum disorders among American Indians of the northern plains. *American Indian and Alaska Native Mental Health Research, 17*(2), 1–21.

Loewen, C. (2000). *FAS/E in the Aboriginal community: A woman's perspective.* (Unpublished master's thesis). The University of Manitoba, Winnipeg, MB, Canada.

Logan, E. (1999). The wrong race, committing crime, doing drugs, and maladjusted for motherhood: The nation's fury over "Crack Babies". *Social Justice, 26*(1), 115–138.

Loppie, C. (n.d.). Racism as a social determinant of health for Indigenous peoples [PowerPoint slides]. Retrieved from http://www.fnha.ca/eventsContent/Documents/FNHA-BCPSQC-Webinar-Racism-as-a-Social-Determinant-of-Health-for-Indigenous-Peoples.pdf

Loppie Reading, C., & Wein, F. (2009). Health inequalities and social determinants of Aboriginal peoples' health. *National Collaborating Centre for Aboriginal Health.* Prince George, BC.

Luce, J. (2002). *Making choices/taking chances*. Vancouver, BC: BC Centre of Excellence for Women's Health.

Lupton, D. (2012). 'Precious cargo': Foetal subjects, risk and reproductive citizenship. *Critical Public Health, 22,* 329–340.

Machado, J. (2015, August 10). What to expect when you're drinking while pregnant. *Broadly.* Retrieved from https://broadly.vice.com/en_us/article/what-to-expect-when-youre-drinking-while-pregnant

Maki, K. (2011). Neoliberal deviants and surveillance: Welfare recipients under the watchful eye of Ontario Works. *Surveillance & Society, 9*(1/2), 47–63.

Mamo, L. (2007). *Queering reproduction: Achieving pregnancy in the age of technoscience.* Durham, NC: Duke University Press.

Marcellus, L. (2007). Using feminist ethics to inform practice with pregnant women who use substances. In S. C. Boyd & L. Marcellus (Eds.), *With child: Substance use during pregnancy, a woman-centred approach* (28-37). Winnipeg, MB: Fernwood Publishing.

Markey, A. (2010). The English governess, her wild Irish pupil, and her wandering daughter: Migration and maternal absence in Georgian children's fiction. *Eighteenth-Century Ireland, 25,* 161–176.

Marmot, M. (2004). *Status syndrome: How your social standing directly affects your health.* London, UK: Bloombury.

Marquis, G. (2005). From beverage to drug: Alcohol and other drugs in 1960s and 1970s Canada. *Journal of Canadian Studies, 39*(2), 57–79.

Masotti, P., George, M. A., Szala-Meneok, K., Morton, M. A., Loock, C., Van Bibber, M., ... & MacLeod, S. (2006). Preventing fetal alcohol spectrum disorder in Aboriginal communities: A methods development project. *PLoS Medicine, 3*(1), 0024–0029.

May, P. A., Blankenship, J., Marais, A. S., Gossage, P., Kalberg, W. O., Joubert, B., … Seedat, S. (2013). Maternal alcohol consumption producing fetal alcohol spectrum disorders (FASD): Quantity, frequency, and timing of drinking. *Drug and Alcohol Dependence, 133*(2), 502–512.

May, P. A., & Gossage, J. P. (2011). Maternal risk factors for fetal alcohol spectrum disorders: Not as simple as it might seem. *Alcohol Research & Health, 34*, 15–26.

May, P. A., Hamrick, K. J., Corbin, K. D., Hasken, J. M., Marais, A., Blankenship, J., … Gossage, J. P. (2016). Maternal nutritional status as a contributing factor for the risk of fetal alcohol spectrum disorders. *Reproductive Toxicology, 59,* 101–108.

McCullough, B. M., & Chervenak, F. A. (2008). A critical analysis of the concept and discourse of 'Unborn Child.' *The American Journal of Bioethics, 8*(7), 34–39.

McDaniel, S. A. (2002). Women's changing relations to the state and citizenship: Caring and intergenerational relations in globalizing Western democracies. *The Canadian Review of Sociology and Anthropology, 39*(2), 125–150.

McGarrity, L. A. (2014). Socioeconomic status as context for minority stress and health disparities among lesbian, gay, and bisexual individuals. *Psychology of Sexual Orientation and Gender Diversity, 1*(4), 383–397.

Mennella, J. A. (1995). Mother's milk: A medium for early flavor experiences. *Journal of Human Lactation, 11*(1), 39–45.

Meurk, C., Lucke, J., & Hall, W. (2014). A bio-social and ethical framework for understanding fetal alcohol spectrum disorders. *Neuroethics, 7*(3), 337–344.

Mihesuah, D. A. (2003). *Indigenous American women: Decolonization, empowerment, activism.* Lincoln, IL: University of Nebraska Press.

Mikkonen, J., & Raphael, D. (2010). *The social determinants of health: The Canadian facts.* Toronto, ON York University School of Health Policy and Management.

Million, D. (2013). *Therapeutic nations: Healing in an age of Indigenous human rights.* Tucson, AZ: University of Arizona Press.

Ministerial Advisory Council on Rural Health. (2002). *Rural health in rural hands: Strategic directions for rural, remote, northern and Aboriginal communities*. Health Canada. Retrieved from http://www.ruralontarioinstitute.ca/file.aspx?id=29b5ba0b-c6ce-489f-bb07-2febfb576daa

Mitchell, M. (2010). Risk, pregnancy and complementary and alternative medicine. *Complementary Therapies in Clinical Practice, 16*(2), 109–113.

Modh, C., Lundgren, I., & Bergbom, I. (2011). First time pregnant women's experiences in early pregnancy. *International Journal of Qualitative Studies in Health and Well-being, 6*(2), 1–11.

Mold, A., & Berridge, V. (2013). The history of health promotion. In L. Cragg, M. Davies & W. Macdowell (Eds.), *Health promotion theory* (2nd ed). Berkshire, UK: Open University Press.

Moosa-Mitha, M. (2005). Situating anti-oppressive theories within critical and difference-centered perspectives. In Brown, L., & Strega, S. (Eds.), *Research as Resistance* (pp. 37–72). Toronto, ON: Canadian Scholars Press.

Morgan, J., & Zimmer, L. (1997). The social pharmacology of smokeable cocaine: Not all it's cracked up to be. In C. Reinarman & H. Levine (Eds.), *Crack in America: Demon drugs and social justice*. Berkeley, CA: University of California Press.

Morrison, K. (2006). *Marx, Durkheim, Weber: Formations of modern social thought.* London, UK: Sage Publications.

Moss, W., & Gardner-O'Toole, E. (1991). *Aboriginal people: History of discriminatory laws.* BP-175E. Ottawa, ON: Parliamentary Research Branch, Library of Parliament.

Moynihan, R., Heath, I., & Henry, D. (2002). Selling sickness: The pharmaceutical industry and disease mongering. *British Medical Journal, 324,* 886–891.

Muir, N., & Bohr, Y. (2014). Contemporary practice of traditional Aboriginal child rearing: A review. *First Peoples Child & Family Review, 9*(1), 66–79.

Nakano Glenn, E. (1994). Social constructions of mothering: A thematic overview. In E. Nakano Glenn, G. Chang, & L. Rennie Forcey, (Eds.), *Mothering: Ideology, Experience and Agency* (1-32). New York, NY: Routledge.

Nanson, J. (1997). Binge drinking during pregnancy: Who are the women at risk? *CMAJ, 156*(6), 807–808.

Naples, N. A. (Ed.). (2003*). Feminism and method: Ethnography, discourse analysis, and activist research.* New York, NY: Routledge.

Nathoo, T., Poole, N., Bryans, M., Dechief, L., Hardeman, S., Marcellus, L., ... Taylor, M. (2013). Voices from the community: Developing effective community programs to support pregnant and early parenting women who use alcohol and other substances. *First Peoples Child & Family Review, 8*(1), 93–106.

National Collaborating Centre for Aboriginal Health. (2011). *Our babies, our future: Aboriginal birth outcomes in British Columbia.* Retrieved from http://www.nccah-ccnsa.ca/docs/fact sheets/child and youth/Our Babies, Our Future %28English - Web%29.pdf

National Collaborating Centre for Aboriginal Health. (2012). *The sacred space of womanhood: Mothering across the generations.* Retrieved from https://www.ccnsa-nccah.ca/docs/health/RPT-SacredSpaceWomanhood-Bckgrnd-EN.pdf

National Institute on Alcohol Abuse and Alcoholism. (1979). *The fetal alcohol syndrome public awareness campaign, 1979: Progress report concerning the advance notice of proposed*

rulemaking on warning labels on containers of alcoholic beverages and addendum. United States. Bureau of Alcohol, Tobacco, and Firearms, Department of the Treasury.

Norris, C. (Narrator). (2014, September 26). Ontario only province without a FASD strategy, advocates say [Radio broadcast episode]. In G. Graves (Producer), *The Morning Edition K-W.* Kitchener-Waterloo, ON: Canadian Broadcasting Corporation (CBC).

O'Hanlan, K. A., & Isler, C. M. (2007). Health care of lesbians and bisexual women. In I. H. Meyer & M. E. Northridge (Eds.), *The health of sexual minorities: Public health perspectives on lesbian, gay, bisexual, and transgender populations* (pp. 506–522).

Oldani, M. (2009). Uncanny scripts: Understanding pharmaceutical emplotment in the Aboriginal context. *Transcultural Psychiatry, 46*(1), 131–156.

O'Neill, J. (1986). The disciplinary society: From Weber to Foucault. *The British Journal of Sociology, 37*(1), 42–60.

Ordean, A., & Kahan, M. (2011). Comprehensive treatment program for pregnant substance users in a family medicine clinic. *Canadian Family Physician, 57*(11), e430–e450.

O'Reilly, A. (2006). *Rocking the cradle: Thoughts on motherhood, feminism, and the possibility of empowered mothering.* Toronto, ON: Demeter.

O'Reilly, A. (2010a). Introduction. In A. O'Reilly (Ed.), *21st century motherhood: Experience, identity, policy, agency* (1-20). New York, NY: Columbia University Press.

O'Reilly, A. (2010b). *Encyclopedia of motherhood.* Thousand Oaks, CA: SAGE Publications.

Osborne, T. (1997). On health and statecraft. In A. Petersen & R. Bunton (Eds.), *Foucault, Health and Medicine* (pp. 173–188).

Peele, S., Brodsky, A., & Arnold, M. (1991). *The Truth About Addiction and Recovery.* New York, NY: Simon & Schuster.

Perry, M., Chase, M., Jacob, J. R., Jacob, M. C., & Von Laue, T. H. (2012). *Western civilization: Ideas, politics, and society.* Boston, MA: Wadsworth.

Philip, M. (2007, February 3). A slap in the face of every Canadian. *The Globe and Mail.* Retrieved from http://theglobeandmail.com

Poole, N. (2000). *Evaluation report of the Sheway project for high-risk pregnant and parenting women.* Retrieved from http://bccewh.bc.ca/wp-content/uploads/2012/05/2000_Evaluation-Report-of-the-Sheway-Project.pdf

Poole, N. (2003). *Mother and child reunion: Preventing fetal alcohol spectrum disorder by promoting women's health*. British Columbia Centre of Excellence for Women's Health, Vancouver: BC.

Poole, N. (2007). A women-centred framework for the prevention of Fetal Alcohol Spectrum Disorder. In N. Poole & L. Greaves (Eds.), *Highs & lows: Canadian perspectives on women and substance use* (289-298). Toronto, ON: Centre for Addiction and Mental Health.

Poole, N. (2008a). Conceiving risk, bearing responsibility: FASD as a social construction. [Review of the book *Conceiving risk, bearing responsibility: Fetal alcohol syndrome and the diagnosis of moral disorder*, by E. Armstrong]. *CrossCurrents, 12*(2), 19

Poole, N. (2008b). *Fetal alcohol spectrum disorder (FASD) prevention: Canadian Perspectives.* Public Health Agency of Canada, Ottawa, ON.

Poole, N. (2011). Bringing a women's health perspective to FASD prevention. In E. P. Riley, S. Clarren, J. Weinberg, & E. Jonsson (Eds.), *Fetal Alcohol Spectrum Disorder: Management and policy perspectives of FASD.* Weinheim, Germany: Wiley-Blackwell.

Poole, N., Gelb, K., & Trainor, J. (2008). *Substance use treatment and support for First Nations and Inuit women at risk of having a child affected by FASD*. Vancouver, BC: British Columbia Centre of Excellence for Women's Health.

Poole, N., Schmidt, R. A., Green, C., & Hemsing, N. (2016). Prevention of fetal alcohol spectrum disorder: Current Canadian efforts and analysis of gaps. *Substance Abuse: Research and Treatment, 10*(S1).

Popova, S., Lange, S., Probst, C., Gmel, G., & Rehm, J. (2017). Estimation of national, regional, and global prevalence of alcohol use during pregnancy and fetal alcohol syndrome: A systematic review and meta-analysis. *Lancet Global Health, 5*(3), e290–e299.

Popova, S., Lange, S., Probst, C., Parunashvili, N., Rehm, J. (2017). Prevalence of alcohol consumption during pregnancy and fetal alcohol spectrum disorders among the general and Aboriginal populations in Canada and the United States. *European Journal of Medical Genetics, 60*(1), 32–48.

Price, K. J., & Miskelly, K. J. (2015). Why ask why? Logical fallacies in the diagnosis of Fetal Alcohol Spectrum Disorder. *Ethics & Behavior, 25*(5), 418–426.

Public Health Agency of Canada. (2005). *Fetal alcohol spectrum disorder (FASD): A framework for action*. Ottawa, ON: Ministry of Health.

Rasmussen, C., Andrew, G., Zwaigenbaum, L., & Tough, S. (2008). Neurobehavioural outcomes of children with fetal alcohol spectrum disorders: A Canadian perspective. *Paediatrics & Child Health, 13*(3), 185–191

Reid, C., Greaves, L., & Poole, N. (2008). Good, bad, thwarted or addicted? Discourses of substance-using mothers. *Critical Social Policy, 28*(2), 211–234.

Rich, A. (1986). *Of woman born* (2nd ed.). New York, NY: W. W. Norton & Company.

Richardson, S. (1740). *Pamela, or Virtue Rewarded.* London, UK: J. B. Pratt.

Richardson, S. S., Daniels, C. R., Gillman, M. W., Golden, J., Kukla, R., Kuzawa, C., & Rich-Edwards, J. (2014). Don't blame the mothers. *Nature, 512,* 131–132.

Richmond, C. (2009). Explaining the paradox of health and social support among Aboriginal Canadians. *Canadian Issues,* 65–71.

Riley, E. P., Infante, M. A., & Warren, K. R. (2011). Fetal alcohol spectrum disorders: An overview. *Neuropsychology Review, 21,* 73–80

Roberts, G., & Nanson, J. (2000). *Best practices: Fetal alcohol syndrome/fetal alcohol effects the effects of other substance use during pregnancy*. Ottawa, ON: Canada's Drug Strategy Division, Health Canada.

Robinson, G. C., Conry, J. L., & Conry, R. F. (1987). Clinical profile and prevalence of fetal alcohol syndrome in an isolated community in British Columbia. *Canadian Medical Association Journal, 137*(3), 203–207.

Robinson, G. C. (1992). *The epidemic of fetal alcohol syndrome in British Columbia*. Report on the symposium on fetal alcohol syndrome and fetal alcohol effects. Vancouver, BC: Health Canada.

Robinson, W. (2015, October 15). Deformed by their mother's alcoholism: The Indian territory where hundreds of children are suffering fetal alcohol syndrome because their pregnant moms won't stop drinking. *Daily Mail Online.* Retrieved from http://www.dailymail.co.uk/news/article-3273346/Deformed-mother-s-alcoholism-Indian-territory-hundreds-children-suffering-fetal-alcohol-syndrome-pregnant-moms-won-t-stop-drinking.html

Romagnoli, A., & Wall, G. (2012). 'I know I'm a good mom': Young, low-income mothers' expriences with risk perception, intensive parenting ideology and parenting education programmes. *Health, Risk & Society, 14*(3), 273–289.

Roskies, A. L. (2010). Neuroimaging and inferential distance. In S. José Hanson & M. Bunzl (Eds.), *Foundational Issues in Human Brain Mapping* (pp. 195–216).

Rutman, D. (2013). Voices of women living with FASD: Perspectives on promising approaches in substance use treatment, programs and care. *First Peoples Child & Family Review, 8*(1), 107–121.

Rutman, D., Callahan, M., Lundquist, A., Jackson, S., & Field, B. (2000). *Substance use and pregnancy: Conceiving women in the policy-making process.* Status of Women Canada, Ottawa.

Ryan, S., & Ferguson, D. L. (2006). The person behind the face of Fetal Alcohol Spectrum Disorder: Student experiences and professionals' perspectives on FASD. *Rural Special Education Quarterly, 25*, 32–40.

Salmon, A. (2004). "It Takes a Community": Constructing Aboriginal mothers and children with FAS/FAE as objects of moral panic in/through a FAS/FAE prevention policy. *Journal of the Association for Research on Mothering, 6*(1), 112–123.

Salmon, A. (2007). Adaptation and decolonization: Unpacking the role of "culturally appropriate" knowledge in the prevention of fetal alcohol syndrome. *Canadian Journal of Native Education, 30*(2), 257–274.

Salmon, A. (2011). Aboriginal mothering, FASD prevention and the contestations of neoliberal citizenship. *Critical Public Health, 21*(2), 165–178.

Salmon, A., & Clarren, S. (2011). Developing effective, culturally appropriate avenues to FASD diagnosis and prevention in northern Canada. *International Journal of Circumpolar Health, 70*(4), 428–433.

Schellenberg, C. (2012). *The social organization of mothers' work: Managing the risk and the responsibility for fetal alcohol spectrum disorder*. (Doctoral Dissertation). Retrieved from ProQuest Dissertations & Theses (NS28399).

Schrecker, T. (2016). 'Neoliberal epidemics' and public health: Sometimes the world is less complicated than it appears. *Critical Public Health, 26*(5), 477–480.

Scott, C. E. (2009). Foucault, genealogy, ethics. *Journal of Medicine and Philosophy, 34*, 350–367.

Shahram, S., Bottorf, J. L., Kurtz, D. L. M., Oelke, N. D., Thomas, V., & Spittal, P. M. (2017). Understanding the life histories of pregnant-involved young Aboriginal women with substance use experiences in three Canadian cities. *Qualitative Health Research, 27*(2), 249–259.

Shankar, I. (2011). *Discourses of fetal alcohol spectrum disorder in Alberta.* (Doctoral Dissertation). Retrieved from ProQuest Dissertations & Theses (NR89428).

Smith, D., Varcoe, C., & Edwards, N. (2005). Turning around the intergenerational impact of residential schools on Aboriginal people: Implications for health policy and practice. *Canadian Journal of Nursing Research, 37*(4), 38–60.

Spargo, J. (1914). *Socialism and motherhood.* New York, NY: B. W. Huebsch.

Stade, B., Ali, A., Bennett, D., Campbell, D., Johnston, M., Lens, C., Tran, S., & Koren, G. (2009). The burden of prenatal exposure to alcohol: Revised measurement of cost. *The Canadian Journal of Clinical Pharmacology, 16*(1), e91–e102.

Statistics Canada. (2016). *Aboriginal People: Fact sheet for Yukon*. Retrieved from http://www.statcan.gc.ca/pub/89-656-x/89-656-x2016012-eng.htm

Steckley, J. & Cummins, B. (2001). *Full circle: Canada's First Nations.* Toronto: Prentice Hall.

Stewart, M. (2016). Fictions of prevention: Fetal alcohol spectrum disorder and narratives of responsibility. *North American Dialogue, 19*(1), 55–66.

Strega, S. (2005). The view from the poststructural margins. In Brown, L., & Strega, S. (Eds.), *Research as Resistance* (pp. 97–126). Toronto, ON: Canadian Scholars Press.

Strega, S., Callahan, M., Rutman, D., & Dominelli, L. (2002). Undeserving mothers: Social policy and disadvantaged mothers. *Canadian Review of Social Policy, 49-50*, 175–197.

Tait, C. (2000). *A study of the service needs of pregnant addicted women in Manitoba*. Retrieved from the Government of Manitoba website: https://www.gov.mb.ca/health/documents/PWHCE_June2000.pdf

Tait, C. (2003a). *The tip of the iceberg: The making of fetal alcohol syndrome in Canada* (Doctoral Dissertation). Unpublished doctoral thesis. Montreal, QC: McGill University.

Tait, C. (2003b). *Fetal Alcohol Syndrome among Aboriginal people in Canada: Review and analysis of the intergenerational links to residential schools*. Ottawa, ON: The Aboriginal Healing Foundation.

Tait, C. (2008). Simmering outrage during an "epidemic" of fetal alcohol syndrome. *Canadian Woman Studies, 26*(3/4), 69–76.

Thanh, N. & Jonsson, E. (2009). Costs of fetal alcohol spectrum disorder in Alberta, Canada. *The Canadian Journal of Clinical Pharmacology, 16*(1), 380–390.

Thanh, N. X., Jonsson, E., Dennett, L., & Jacobs, P. (2011). Costs of FASD. In E. P. Riley, S. Clarren, J. Weinberg, & E. Jonsson (Eds.), *Fetal Alcohol Spectrum Disorder: Management and policy perspectives of FASD.* Weinheim, Germany: Wiley-Blackwell.

Thom, B. (1997). Women and alcohol: A 'policy dilemma.' *Policy Studies, 18*(1), 49–65.

Thomas, G. & Poole, N. (2014). *Alcohol and pregnancy: Warning signage information kit for local governments in British Columbia*. Retrieved from http://bccewh.bc.ca/wp-content/uploads/2014/09/FASD_WarningSignageInfoKit_Booklet_web.pdf

Thompson, S. R. (2014). What is health? In S. R. Thompson (Ed.), *The essential guide to public health and health promotion.* Oxon, UK: Routledge.

Thurmeier, R., Deshpande, S., Lavack, A., Agrey, N., & Cismaru, M. (2011). Next steps in primary prevention. In P. Riley, S. Clarren, J. Weinberg & E. Jonsson (Eds.), *Fetal alcohol spectrum disorder: Management and policy perspektives of FASD.* Germany: Wiley-Blackwell.

Timko, C., Sutkowi, A., Pavao, J., & Kimerling, R. (2008). Women's childhood and adult adverse experiences, mental health, and binge drinking: The California women's health survey. *Substance Abuse Treatment, Prevention, and Policy, 3*(1), 15–15.

Tough, S., Clarke, M., Hicks, M., & Clarren, S. (2005). Attitudes and approaches of Canadian providers to preconception counselling and the prevention of Fetal Alcohol Spectrum Disorders. *Journal of FAS International, 3*, 1–16.

Tough, S. C., & Jack, M. (2011). Frequency of FASD in Canada, and what this means for prevention efforts. In P. Riley, S. Clarren, J. Weinberg & E. Jonsson (Eds.), *Fetal alcohol spectrum disorder: Management and policy perspektives of FASD.* Germany: Wiley-Blackwell.

Toward Optimized Practice (2007). *Physicians for Fetal Alcohol Spectrum Disorder prevention: Project report.* Retrieved from http://www.health.alberta.ca/documents/Fetal-Alcohol-report-2007.pdf

Trans Student Educational Resources [TSER]. (2017). *LGBTQ+ Definitions*. Retrieved from http://www.transstudent.org/definitions

Tuhiwai Smith, L. (1999). *Decolonizing methodologies.* London, UK: University of Otago Press.

Underberg, M., Kesmodel, U. S., Landrø, N. I., Bakketeig, L., Grove, J., Wimberley, T., ... & Mortensen, E. L. (2012). The effects of low to moderate alcohol consumption and binge drinking in early pregnancy on selective and sustained attention in 5-year-old children. *BJOG: An International Journal of Obstetrics and Gynaecology, 119*(10), 1211–1221.

Uttal, W. R. (2011). *Mind and brain: A critical appraisal of cognitive neuroscience.* Cambridge, MA: MIT Press.

Vancouver Coastal Health. (2016). *Women's health and safety in the Downtown Eastside: paper to the Second Generation Strategy Design Paper.* Retrieved from http://dtes.vch.ca/wp-content/uploads/sites/6/2016/11/DTES_Womens_Companion_Paper_WEBFINAL.pdf

Varcoe, C., Hankivsky, O., & Morrow, M. (Eds.). (2007). *Women's health in Canada: Critical perspectives on theory & policy*. Toronto, ON: University of Toronto Press.

Wall, G. (2013). 'Putting family first': Shifting discourses of motherhood and childhood in representations of mothers' employment and child care. *Women's Studies International Forum, 40,* 162–171.

Warner, R. H., & Rosett, H. L. (1975). The effects of drinking on offspring: An historical survey of the American and British literature. *Journal of Studies on Alcohol, 36*(11), 1395–1420.

Weber, M. (1968). *Economy and Society: An outline of interpretive sociology.* New York, NY: Bedminster Press.

Weedon, C. (1987). *Feminist practice and poststructuralist theory*. New York, NY: Blackwell.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York, NY: Norton.

Whitley, R., & Kirmayer, L. J. (2008). Perceived stigmatisation of young mothers: An exploratory study of psychological and social experience. *Social Science & Medicine, 66*(2), 339–348.

Wilkinson Saldaña, Z. (2015). My path to trans motherhood. Retrieved from https://www.buzzfeed.com/zoewilkinsons/on-trans-motherhood?utm_term=.naDk10KJ8 - .epDlMQvjp

Williams, C., Alderson, P., & Farsides, B. (2001). Conflicting perceptions of the fetus: Person, patient, 'nobody', commodity? *New Genetics and Society, 20*(3), 225–238.

Williamson, L., Thom, B., Stimson, G. V., & Uhl, A. (2014). Stigma as a public health tool: Implications for health promotion and citizen involvement. *International Journal of Drug Policy, 25,* 333–335.

Winslow, C.-E. A. (1920). The untilled fields of public health. *Science, 51*(1306), 23–33.

Witt, W. P., Mandell, K. C., Wisk, L. E., Cheng, E. R., Chatterjee, D., Wakeel, F., ... & Zarak, D. (2015). Predictors of alcohol and tobacco use prior to and during pregnancy in the US: The role of maternal stressors. *Archives of Women's Mental Health, 18,* 523–537.

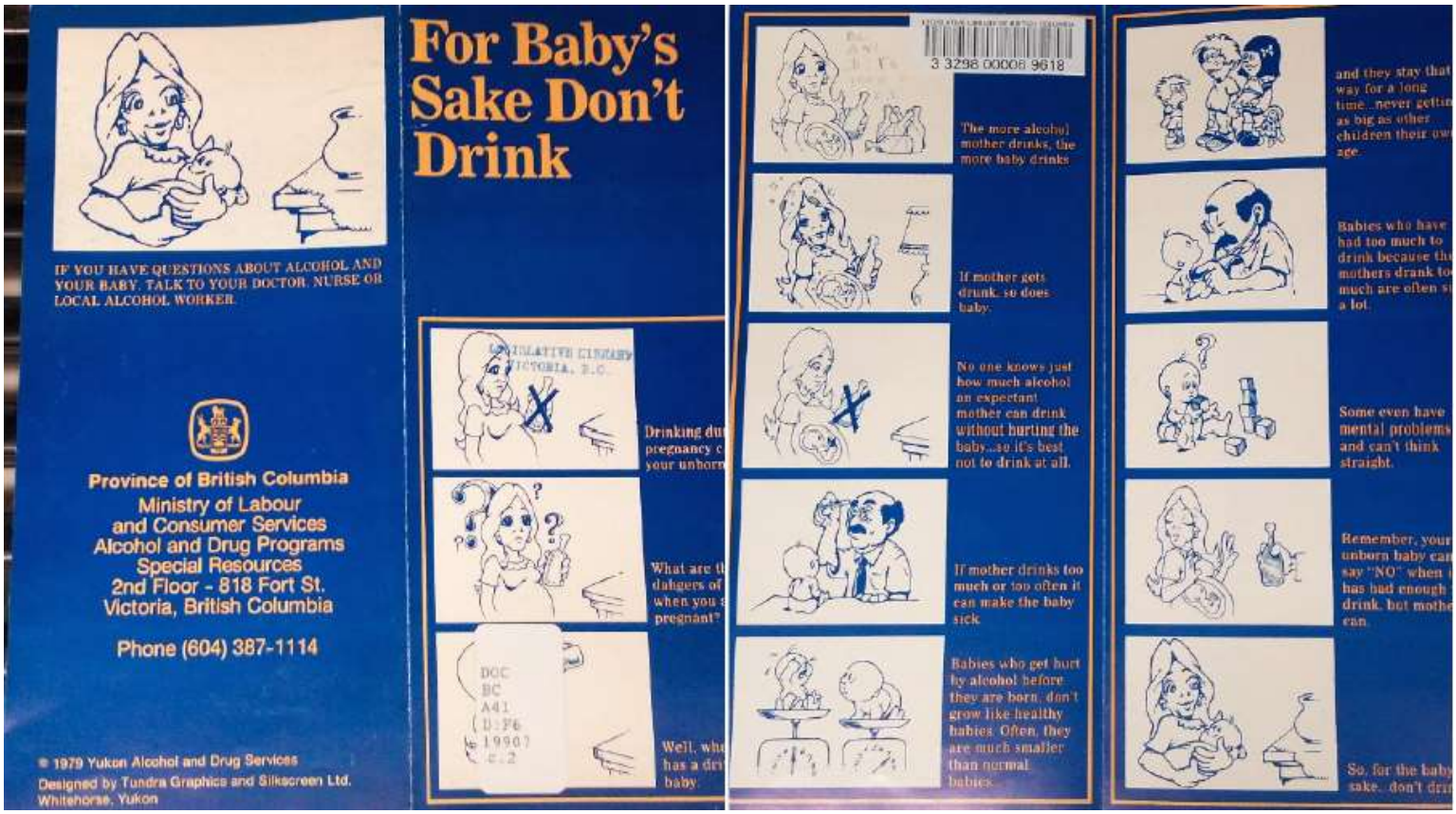
Women of Color Network. (2014). *Term: "Women of Color.*" Retrieved from http://www.wocninc.org/about-wocn/term-women-of-color/

World Health Organization. (1986). *Ottawa Charter for Health Promotion.* Ottawa, ON: WHO.

World Health Organization. (2005). The World Health Report 2005: Make every mother and child count. Geneva, Switzerland: WHO.

Yang, S., Lynch, J. W., Raghunathan, T. E., Kauhanen, J., Salonen, J. T., & Kaplan, G. A. (2006). Socioeconomic and psychosocial exposures across the life course and binge drinking in adulthood: Population-based study. *American Journal of Epidemiology, 165*(2), 184–193.

Appendix A: 1979–1989



1A, 1979.

Appendix B: 1990–1999

IF YOU NEED HELP CALL:

- Doctor
- Public Health Nurse
- Downtown Eastside Community Health Clinic: (604) 255-3151
- Healthiest Babies Possible: (604) 872-2511 (Pregnancy Outreach Program)
- Alcoholics Anonymous: (604) 434-3933
- Nicotine Anonymous: (604) 889-5335
- Cocaine Anonymous: (604) 660-9382
- Narcotics Anonymous: (604) 873-1018
- Provincial Medical Genetics Program: (604) 875-2157
  (If you've used alcohol or drugs during pregnancy and are concerned about your baby)
- Sunny Hill Hospital for Children: (604) 434-1331
- Aboriginal Friendship Centre: (604) 251-4844

The YWCA of Vancouver, a registered charity, is a resource for women, families and those seeking to improve the quality of their lives. From support for children & families to employment services, housing to health & wellness programs, leadership development to information & referral, the YWCA offers essential programs in more than 40 locations throughout Greater Vancouver.

YWCA CRABTREE CORNER

- FAS/NAS Prevention Project (Fetal Alcohol Syndrome/Neonatal Abstinence Syndrome)
- Peer support group for parents of children with FAS/NAS
- FAS/NAS Community Lending Library
- FAS/NAS pamphlets, posters and prevention guides
- Emergency/short-term daycare
- Women's drop-in centre
- Single Mothers/Family programming
- Special programs on preventing birth defects caused by alcohol and drugs
- Alcohol and drug information
- Pregnancy information (family planning)
- Support for pregnant women and family members
- Referrals to detox, doctors, treatment centres
- Support, information and advocacy

YWCA
of Vancouver

YWCA Crabtree Corner
101 E. Cordova Street
Vancouver, BC V6A 1K7
Tel: (604) 689-2808
Fax: (604) 689-5463
Website: www.ywcavan.org

Special thanks to the Vancouver Coastal Health Authority.

You can Make a Difference to Your CHILD'S HEALTH

PREVENT BIRTH DEFECTS CAUSED BY DRUGS & ALCOHOL

YWCA Crabtree Corner FAS/NAS Prevention & Support Services

ALCOHOL AND DRUGS CAUSE BIRTH DEFECTS

When you use drugs and alcohol while you are pregnant, you pass them on to your baby.

Birth defects can be caused by:

- beer
- wine
- ciders and coolers
- hard liquor

There is no known safe amount of alcohol for a pregnant women.

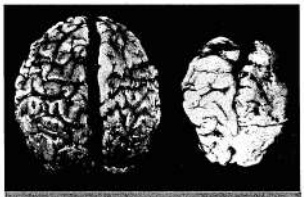
These drugs may also cause problems in newborns:

- cocaine
- heroin
- T's and R's
- marijuana
- prescription drugs
- solvents (sniffing things like glue and paint thinner)

Learning problems may show up as the child grows older

These things may also harm you and your baby:

- smoking
- caffeine (coffee, tea, soft drinks)
- poor eating habits
- stress



FETAL ALCOHOL SYNDROME (FAS)

WHAT IS IT?

FAS is a group of problems that can show up in babies whose mothers drank alcohol while pregnant, including:

- small size and not growing well
- small eye openings
- thin upper lip
- crowded teeth
- smaller brain
- learning slowly
- too active (hyper)
- problems getting along with others

Your baby will NOT outgrow Fetal Alcohol Syndrome

Babies whose mothers use drugs may be:

- born too soon
- small and weak
- very cranky
- cry for many hours
- hard to feed or may vomit (throw up) often
- sensitive to touch and not like to be held

BIRTH DEFECTS CAUSED BY DRUGS AND ALCOHOL CAN BE PREVENTED

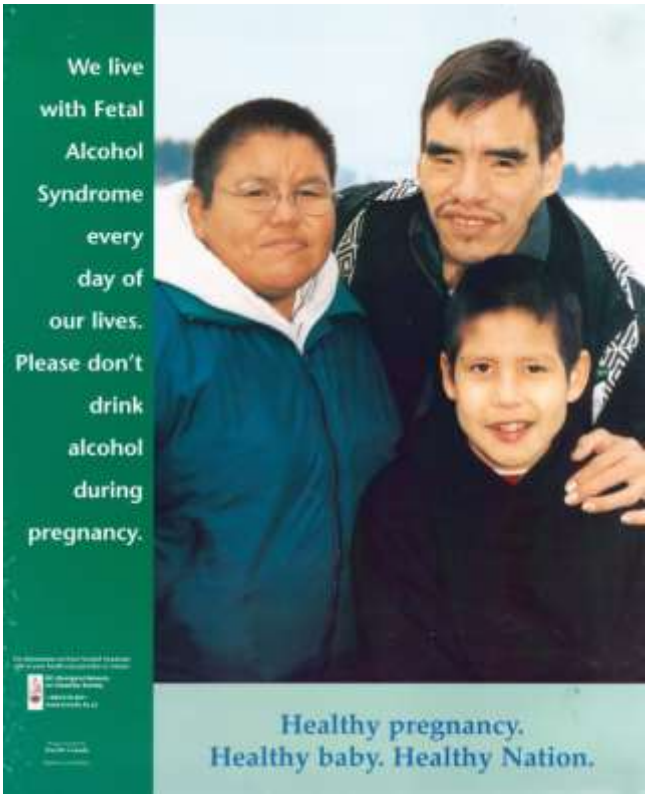
Stay away from alcohol, drugs and things that will harm you and:

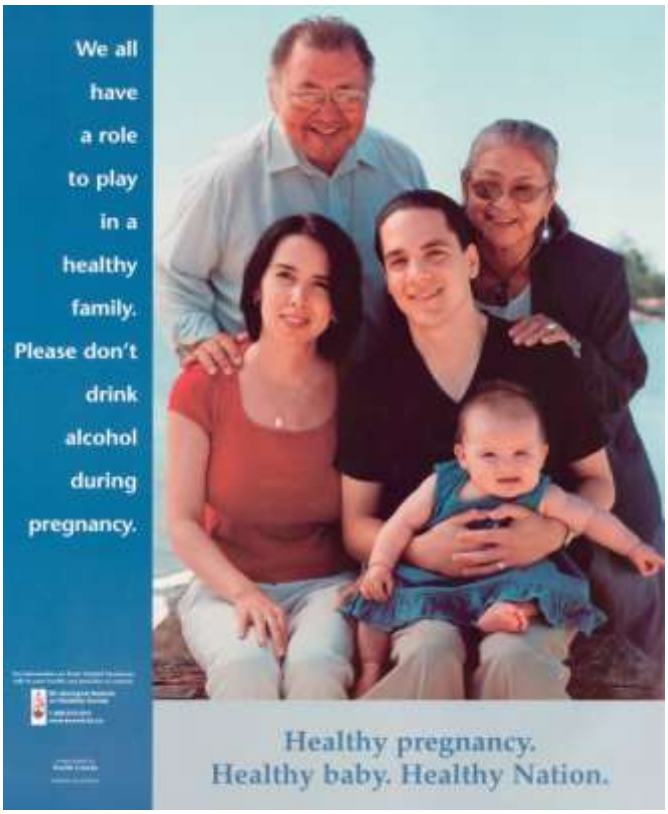
- get lots of rest
- eat healthy meals
- visit a doctor regularly
- go to prenatal classes

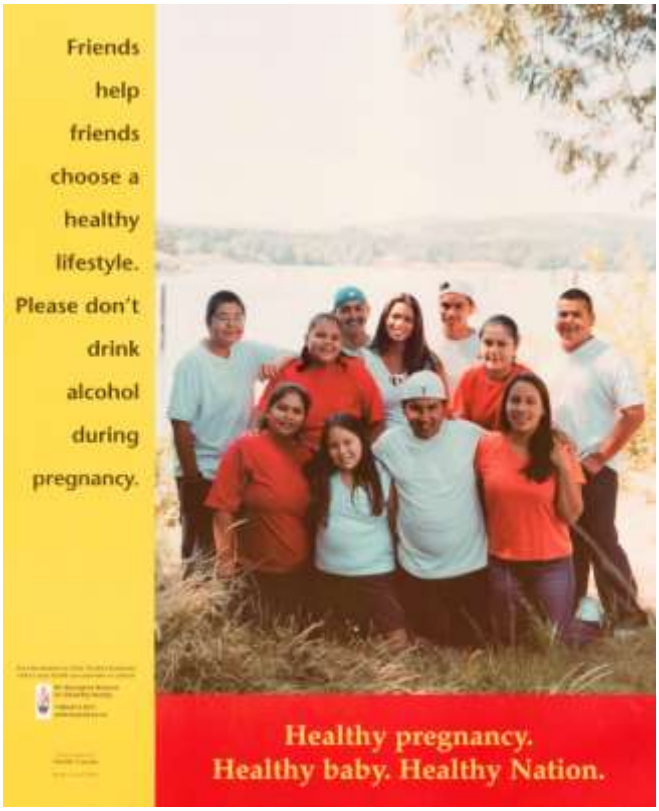
Take Care of Yourself and Your Baby

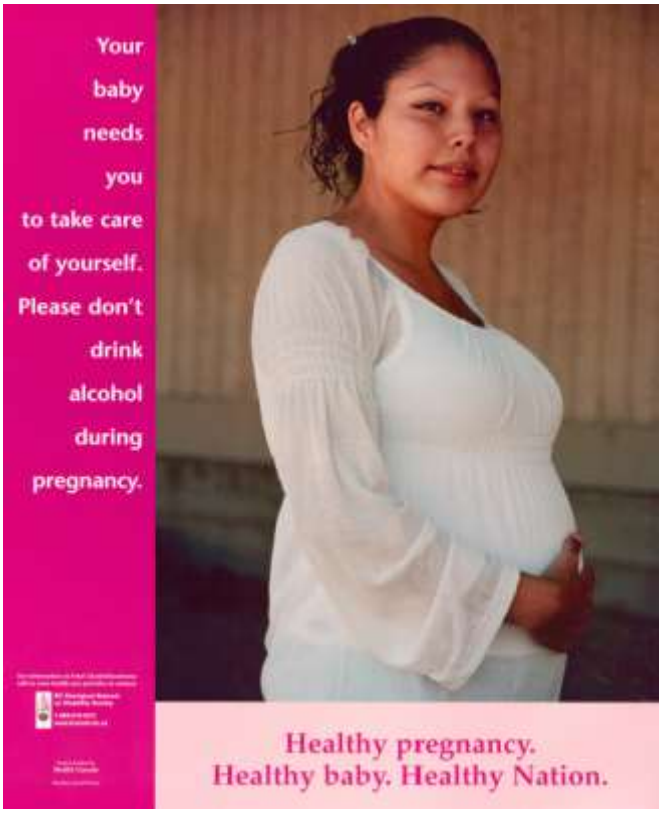
2A, 1998.

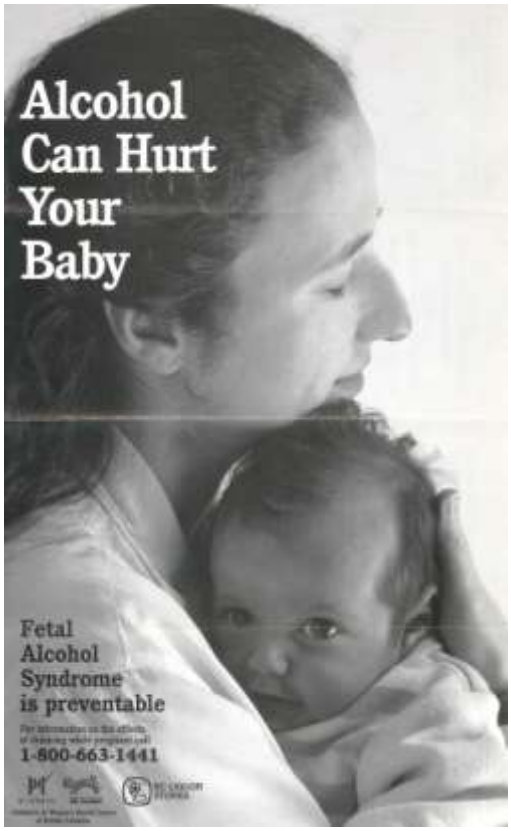
2B, 2C, 2D, 2E, 1997
(Clockwise from left)







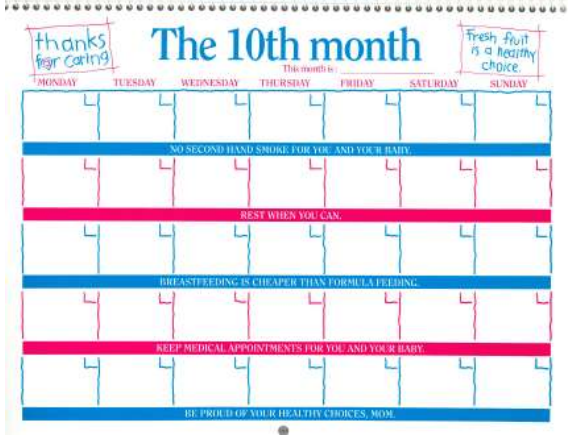


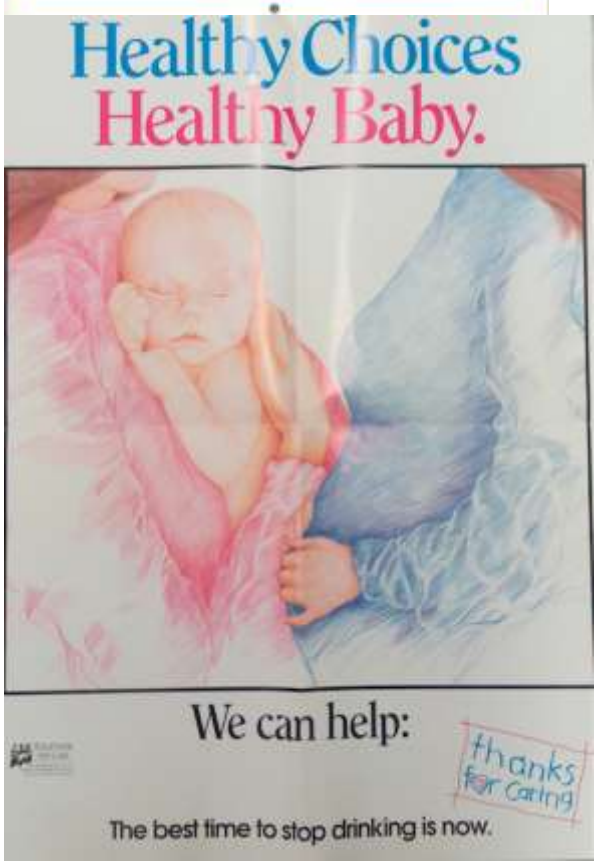


2F, 1999; 2G-1, 2G-3, 2G-2, 1993 (Clockwise from left)

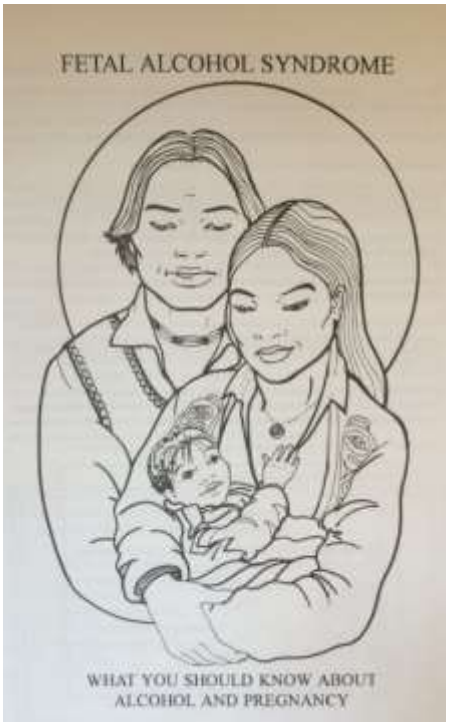
2G-4, 2G-5, 2G-7, 2G-6
1993 (Clockwise from left)

2G-8, 2G-9, 2H, 2G-10 1993
(Clockwise from left)

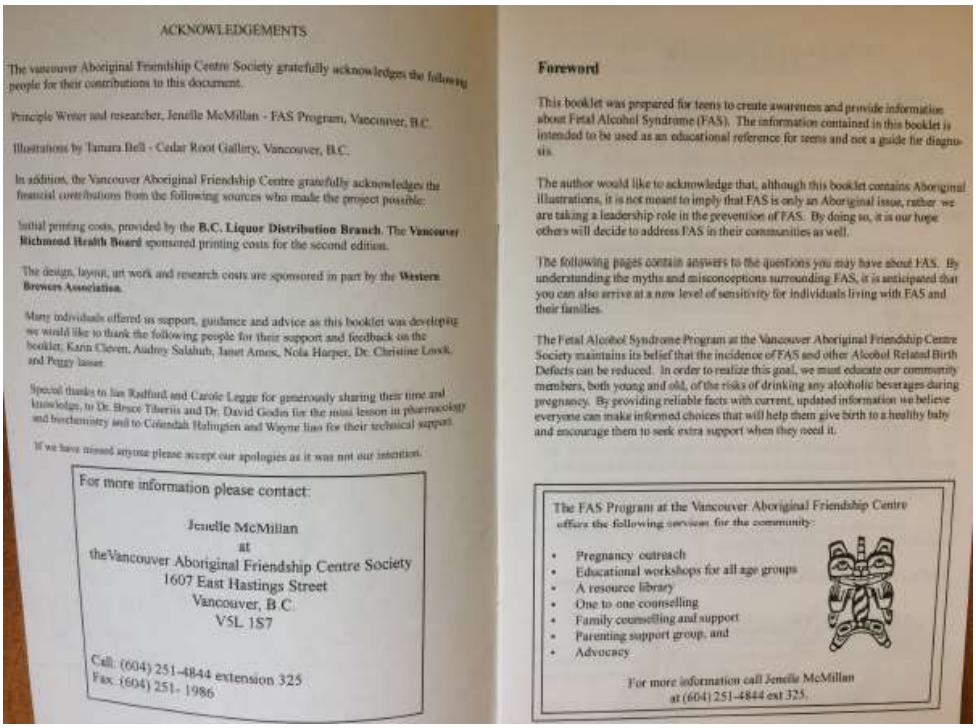




2I, 1993; 2L, 1999; 2J, 1998 (Clockwise from left)


FETAL ALCOHOL SYNDROME

WHAT YOU SHOULD KNOW ABOUT ALCOHOL AND PREGNANCY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If we have missed anyone please accept our apologies as it was not our intention.

For more information please contact:

Jenelle McMillan
at
theVancouver Aboriginal Friendship Centre Society
1607 East Hastings Street
Vancouver, B.C.
V5L 1S7

Call: (604) 251-4844 extension 325
Fax: (604) 251- 1986

Foreword

This booklet was prepared for teens to create awareness and provide information about Fetal Alcohol Syndrome (FAS). The information contained in this booklet is intended to be used as an educational reference for teens and not a guide for diagnosis.

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

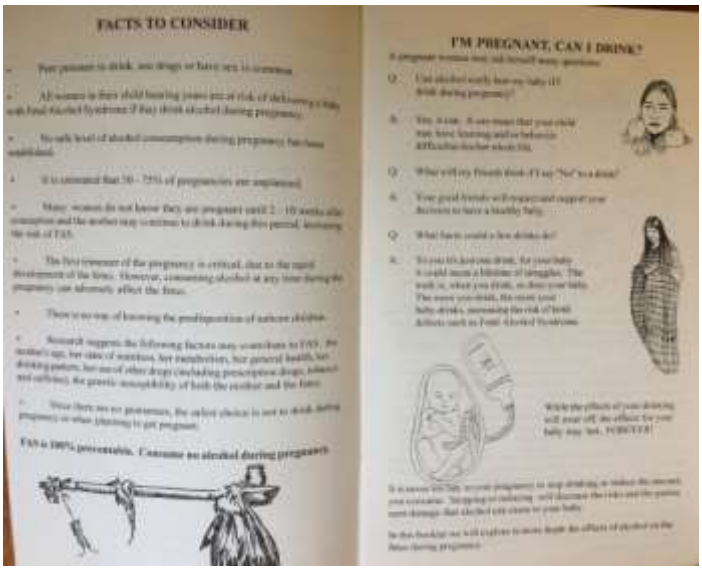
The following pages contain answers to the questions you may have about FAS. By understanding the myths and misconceptions surrounding FAS, it is anticipated that you can also arrive at a new level of sensitivity for individuals living with FAS and their families.

The Fetal Alcohol Syndrome Program at the Vancouver Aboriginal Friendship Centre Society maintains its belief that the incidence of FAS and other Alcohol Related Birth Defects can be reduced. In order to realize this goal, we must educate our community members, both young and old, of the risks of drinking any alcoholic beverages during pregnancy. By providing reliable facts with current, updated information we believe everyone can make informed choices that will help them give birth to a healthy baby and encourage them to seek extra support when they need it.

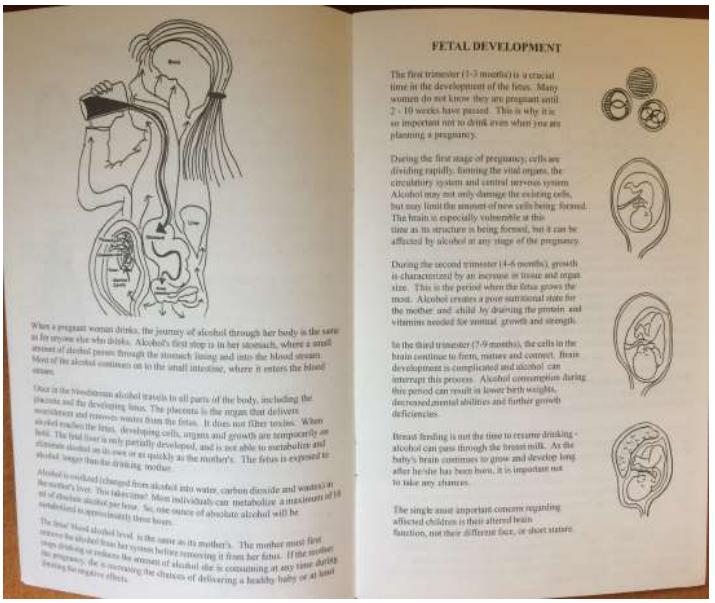
The FAS Program at the Vancouver Aboriginal Friendship Centre offers the following services for the community:

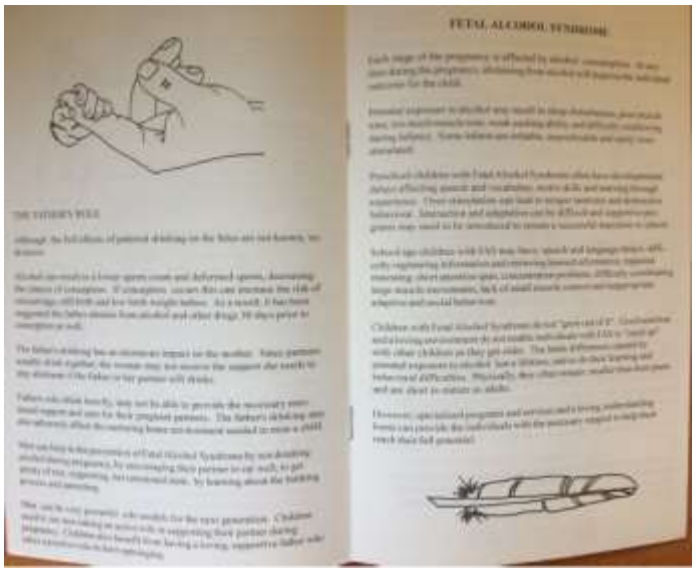
- Pregnancy outreach
- Educational workshops for all age groups
- A resource library
- One to one counselling
- Family counselling and support
- Parenting support group, and
- Advocacy

For more information call Jenelle McMillan at (604) 251-4844 ext 325.

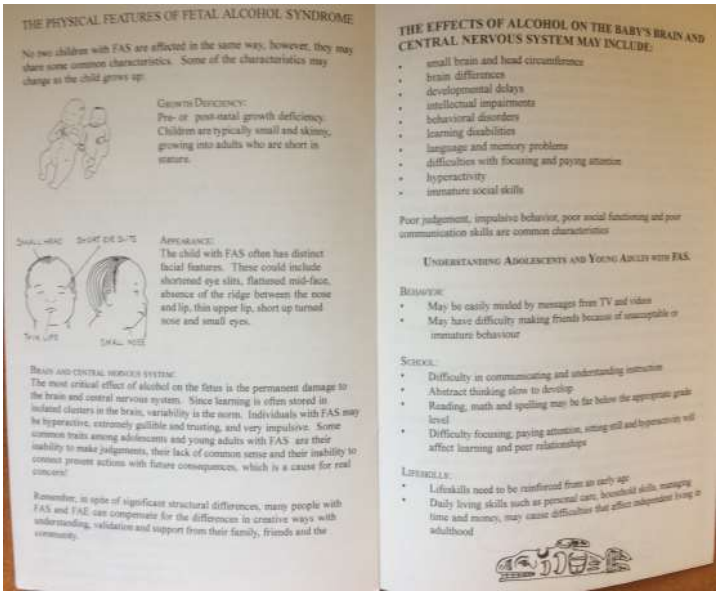

FACTS TO CONSIDER

I'M PREGNANT, CAN I DRINK?


FETAL DEVELOPMENT


FETAL ALCOHOL SYNDROME

2K, 1998
(continued on page 176)



THE PHYSICAL FEATURES OF FETAL ALCOHOL SYNDROME

No two children with FAS are effected in the same way, however, they may share some common characteristics. Some of the characteristics may change as the child grows up.

Growth Deficiency:
Pre- or post-natal growth deficiency. Children are typically small and skinny, growing into adults who are short in stature.

Appearance:
The child with FAS often has distinct facial features. These could include shortened eye slits, flattened mid-face, absence of the ridge between the nose and lip, thin upper lip, short up turned nose and small eyes.

Brain and Central Nervous System:
The most critical effect of alcohol on the fetus is the permanent damage to the brain and central nervous system. Since learning is often stored in isolated clusters in the brain, variability is the norm. Individuals with FAS may be hyperactive, extremely gullible and trusting, and very impulsive. Some common traits among adolescents and young adults with FAS are their inability to make judgements, their lack of common sense and their inability to connect present actions with future consequences, which is a cause for real concern!

Remember, in spite of significant structural differences, many people with FAS and FAE can compensate for the differences in creative ways with understanding, validation and support from their family, friends and the community.

THE EFFECTS OF ALCOHOL ON THE BABY'S BRAIN AND CENTRAL NERVOUS SYSTEM MAY INCLUDE:

- small brain and head circumference
- brain differences
- developmental delays
- intellectual impairments
- behavioral disorders
- learning disabilities
- language and memory problems
- difficulties with focusing and paying attention
- hyperactivity
- immature social skills

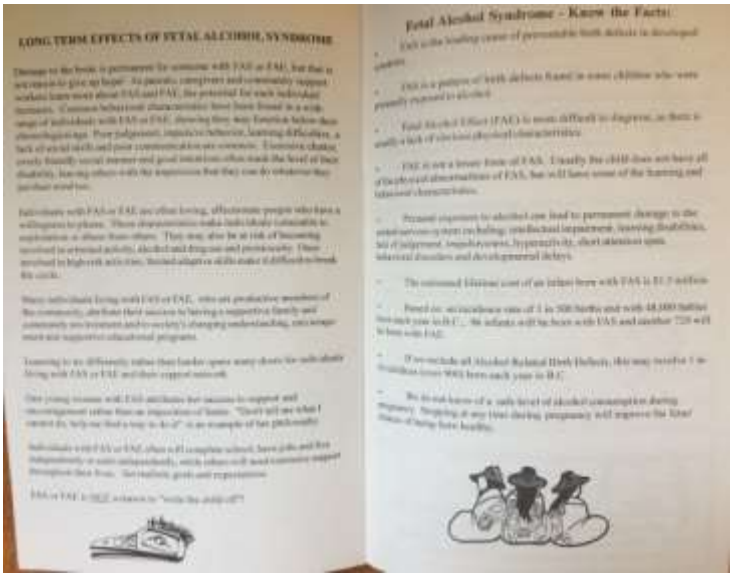
Poor judgement, impulsive behavior, poor social functioning and poor communication skills are common characteristics

Understanding Adolescents and Young Adults with FAS

Behavior:
- May be easily misled by messages from TV and video
- May have difficulty making friends because of unacceptable or immature behaviour

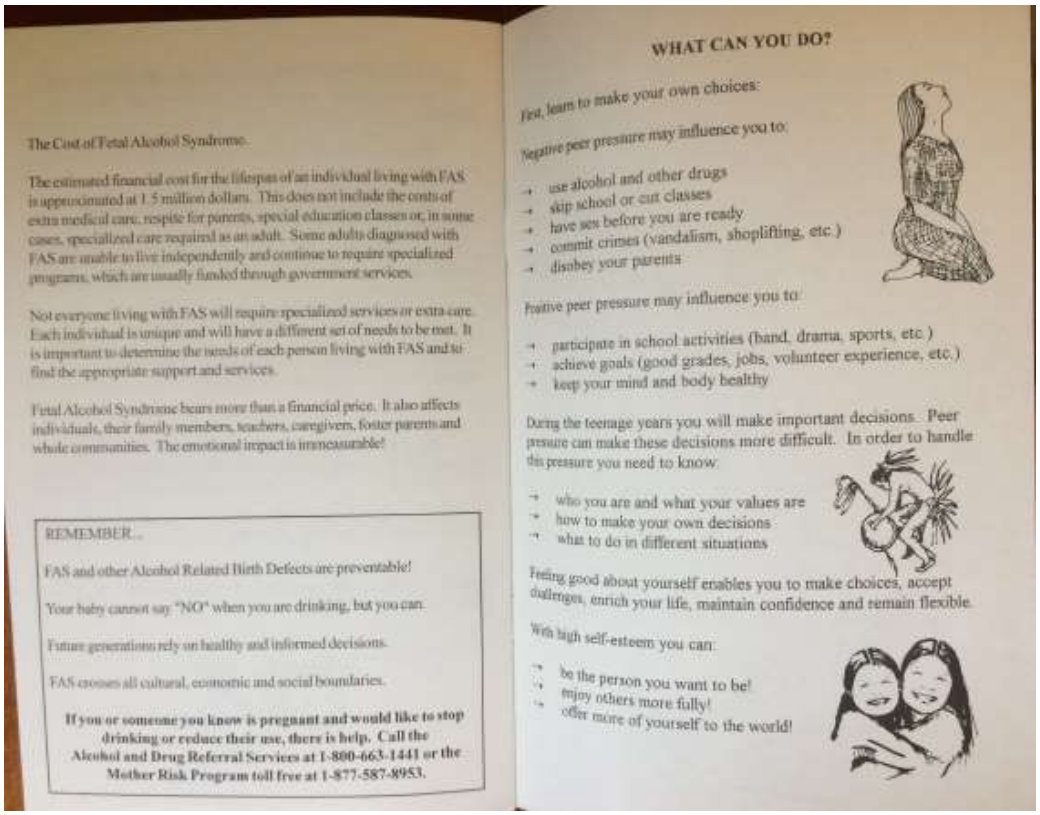
School:
- Difficulty in communicating and understanding instruction
- Abstract thinking slow to develop
- Reading, math and spelling may be far below the appropriate grade level
- Difficulty focusing, paying attention, sitting still and hyperactivity will affect learning and peer relationships

Lifeskills:
- Lifeskills need to be reinforced from an early age
- Daily living skills such as personal care, household skills, managing time and money, may cause difficulties that affect independent living in adulthood



LONG TERM EFFECTS OF FETAL ALCOHOL SYNDROME

Fetal Alcohol Syndrome - Know the Facts:



The Cost of Fetal Alcohol Syndrome.

The estimated financial cost for the lifespan of an individual living with FAS is approximated at 1.5 million dollars. This does not include the costs of extra medical care, respite for parents, special education classes or, in some cases, specialized care required as an adult. Some adults diagnosed with FAS are unable to live independently and continue to require specialized programs, which are usually funded through government services.

Not everyone living with FAS will require specialized services or extra care. Each individual is unique and will have a different set of needs to be met. It is important to determine the needs of each person living with FAS and to find the appropriate support and services.

Fetal Alcohol Syndrome bears more than a financial price. It also affects individuals, their family members, teachers, caregivers, foster parents and whole communities. The emotional impact is immeasurable!

REMEMBER...

FAS and other Alcohol Related Birth Defects are preventable!

Your baby cannot say "NO" when you are drinking, but you can.

Future generations rely on healthy and informed decisions.

FAS crosses all cultural, economic and social boundaries.

If you or someone you know is pregnant and would like to stop drinking or reduce their use, there is help. Call the Alcohol and Drug Referral Services at 1-800-663-1441 or the Mother Risk Program toll free at 1-877-587-8953.

WHAT CAN YOU DO?

First, learn to make your own choices:

Negative peer pressure may influence you to:

- use alcohol and other drugs
- skip school or cut classes
- have sex before you are ready
- commit crimes (vandalism, shoplifting, etc.)
- disobey your parents

Positive peer pressure may influence you to:

- participate in school activities (band, drama, sports, etc.)
- achieve goals (good grades, jobs, volunteer experience, etc.)
- keep your mind and body healthy

During the teenage years you will make important decisions. Peer pressure can make these decisions more difficult. In order to handle this pressure you need to know:

- who you are and what your values are
- how to make your own decisions
- what to do in different situations

Feeling good about yourself enables you to make choices, accept challenges, enrich your life, maintain confidence and remain flexible.

With high self-esteem you can:

- be the person you want to be!
- enjoy others more fully!
- offer more of yourself to the world!

HOW TO THINK POSITIVELY ABOUT YOURSELF

Make a point to be your own best friend. This means giving yourself:

- **Acceptance:** Identify your personal strengths and weaknesses. Everyone has them!
- **Goals:** Set realistic goals for yourself. Meet these expectations by learning new skills and developing your abilities.
- **Take Time Out:** Be alone with your thoughts and feelings regularly. Get involved in activities you can do alone. Learn to enjoy your own company.
- **Trust:** Pay attention to your thoughts and feelings. Act on what you believe is right. Do what makes you feel happy and fulfilled.
- **Respect:** Don't try to be someone else. You are unique, be proud of who you are. Appreciate your specialness.
- **Encouragement:** Have a "can do" attitude. Set reasonable expectations for your goals and give yourself encouragement along the way.
- **Praise:** Take pride in your achievements, both small and great alike.
- **Love:** Learn to love the unique person you are. Accept and learn from your mistakes. Accept your successes and shortcomings—those who love you do!

Appendix C: 2000–2009

People with FAS or "partial FAS" often have:

- difficulty in school and social situations
- mental health concerns
- problems living on their own or working at a job
- their own alcohol or drug challenges

Remember...

Effects of drug and alcohol use are different for every pregnancy and every baby, depending on:

- amount used
- if other drugs are used, and which ones
- when in the pregnancy the drugs are used
- mother's general health
- other risks in the baby's environment

It helps you and your baby if you cut back or stop using alcohol at any point in your pregnancy.

Adapted with permission from Vancouver Island Health Authority, South Island Prevention Services

Revised by:
Fir Square Family Education - June 2004

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For more information about the effects of alcohol use during pregnancy, call:

- your doctor
- a public health nurse
- an alcohol and drug counsellor
- Motherrisk infoline (confidential counselling) Toll Free 1-877-327-4636

Sheway
533 East Hastings Street, Vancouver, B.C.
Phone: 604-216-1699

A/D Information Line
Phone: 604-660-9382
1-800-663-1441

Detox Access Line
Phone: 604-658-1250

Pender Clinic
59 West Pender, Vancouver, B.C.
Phone: 604-669-9181

3-Bridges Community Health Centre
1292 Hornby Street, Vancouver, B.C.
Phone: 604-736-9844

Community Aboriginal Health Advocate:
Phone: 604-873-1833

Mental Health Liaison Worker
Phone: 604-872-6723

BCW#736

Alcohol Use During Pregnancy

Effects on Mother and Baby

4500 Oak Street,
Vancouver, B.C.
V6H 3N1

3A, 2003

How does alcohol work?

Alcohol, the most popular drug in Canada, is called a drug because it slows down the central nervous system.

Alcohol rapidly enters the bloodstream. It may have dangerous effects on all organs of the body.

Alcohol goes through the placenta to the developing baby. When you drink, your baby's blood alcohol is the same as yours. There is NO known safe level of drinking during pregnancy so experts recommend No alcohol during this time.

What are the effects of alcohol for the pregnant woman?

Effects of alcohol include:

- loss of appetite, resulting in a slow weight gain
- anemia (low red blood cells) and tiredness
- increased risk of miscarriage in the first three months
- rapid (really fast) labour (hard for the baby)
- low blood sugars
- premature (early labour)

If you suddenly stop drinking, it can cause withdrawal symptoms for you and your baby. If you want to quit, tell your doctor so that you and your baby can be kept safe.

What are the effects of prenatal alcohol exposure on the baby?

If you drink a lot of alcohol while pregnant (either bingeing or drinking regularly), you increase your risk of having a baby with lasting birth defects.

Alcohol can harm the baby at any time during the pregnancy.

In the first three months you are pregnant, alcohol can cause physical problems in the baby. In the last few months, it can slow down the baby's growth. The baby's brain, which develops all through the pregnancy, can be damaged at any time.

Right after birth, babies exposed to alcohol in the womb can have signs of withdrawal. Babies may:

- be jittery (shaky)
- cry more than usual
- have problems feeding
- have problems sleeping
- have "floppy" muscle tone
- be sensitive to noise or touch

Some babies need medication to help them with their withdrawal.

What about breastfeeding?

Alcohol goes into breastmilk. Heavy drinking can lower the amount of milk you make. To keep your baby safe while you are breastfeeding:

- don't drink alcohol or drink small amounts occasionally
- breastfeed before having a drink so there will be less alcohol in your breastmilk the next time you breastfeed
- have safe "alcohol-free" breastmilk stored for your baby if you plan to drink large amounts of alcohol

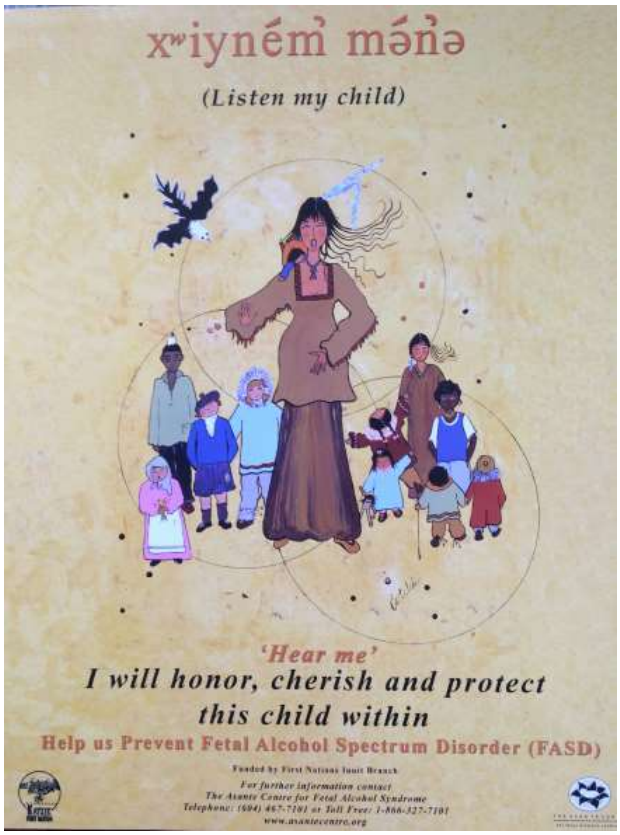
What are the outcomes for children?

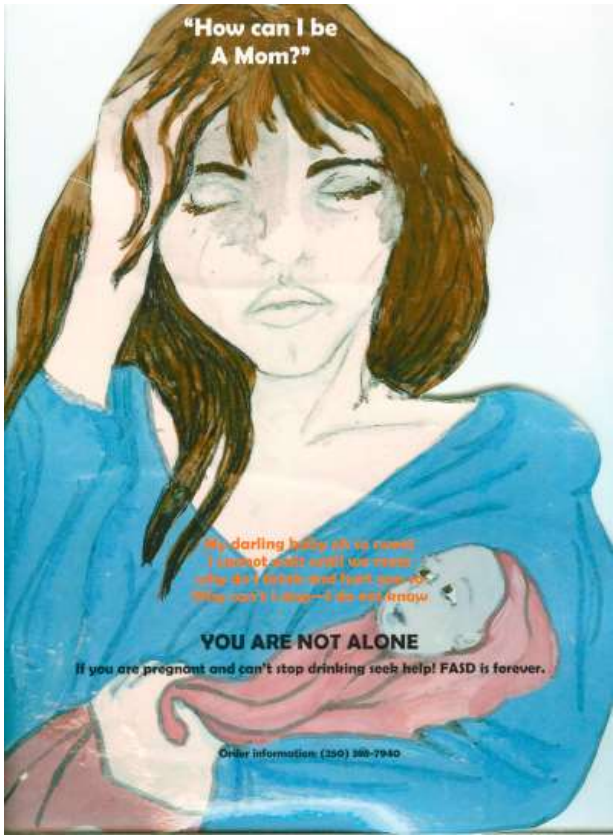
When you drink during pregnancy, your baby is at risk of Fetal Alcohol Syndrome (FAS). This is especially true with heavy drinking. People with FAS:

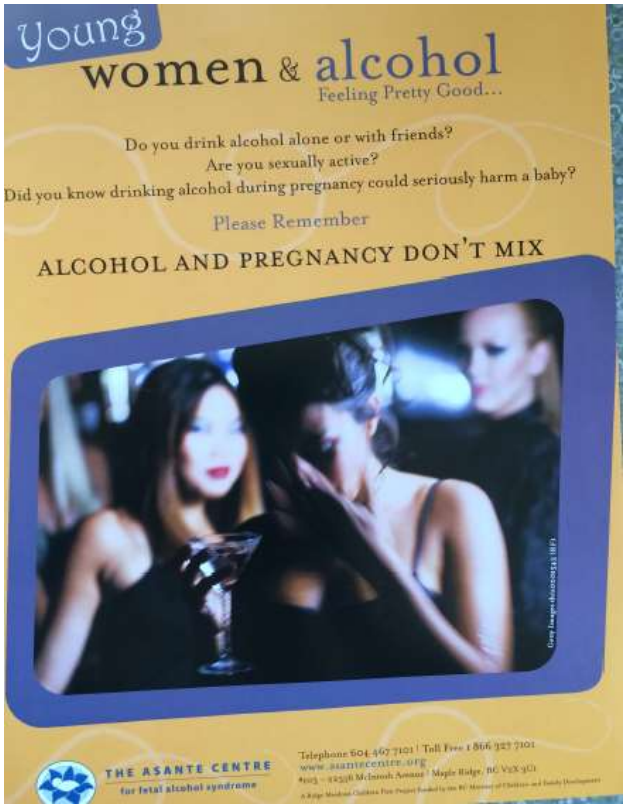
- smaller all their lives
- have central nervous system damage resulting in learning problems, short attention span, hyperactivity, poor muscle tone and coordination
- have facial abnormalities (i.e., small eye openings, drooping eyelids, flat wide nose bridge, thin upper lip, flattened area between nose and lip)

Those with just a few of those characteristics have "partial FAS", and may have other problems such as heart defects or skeleton/other body organ problems.

3C, 3E, 2006
(3C left, 3E
below)







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3H, 2006; 3G, 2006
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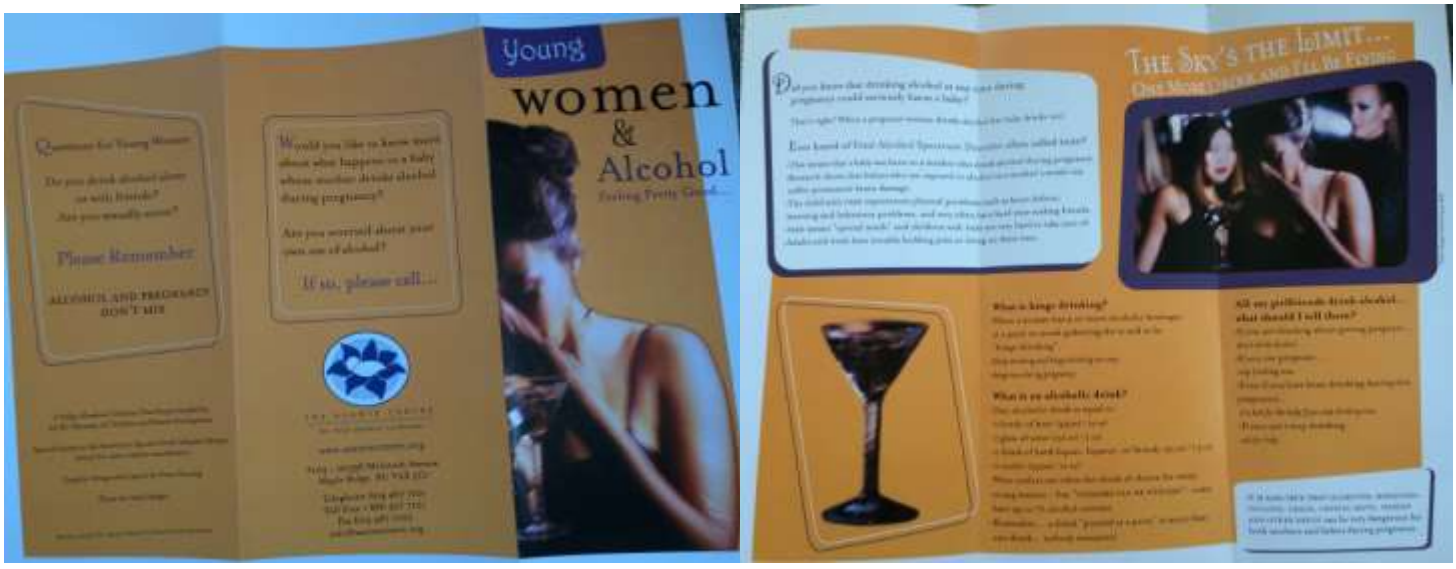
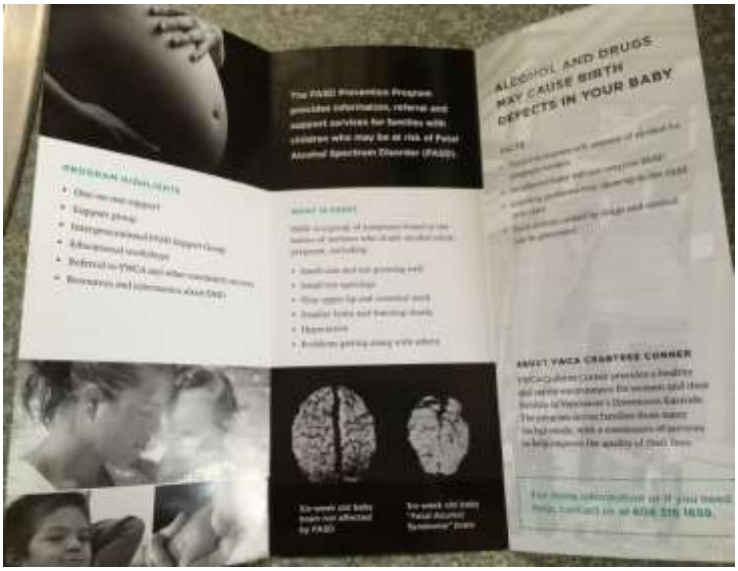
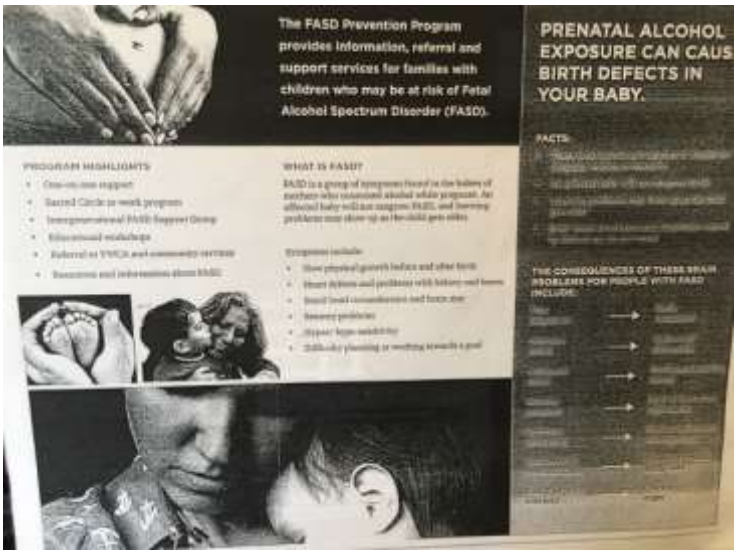
3I, 3J, 3K, 2005 (3I below,
3J middle, 3K bottom)







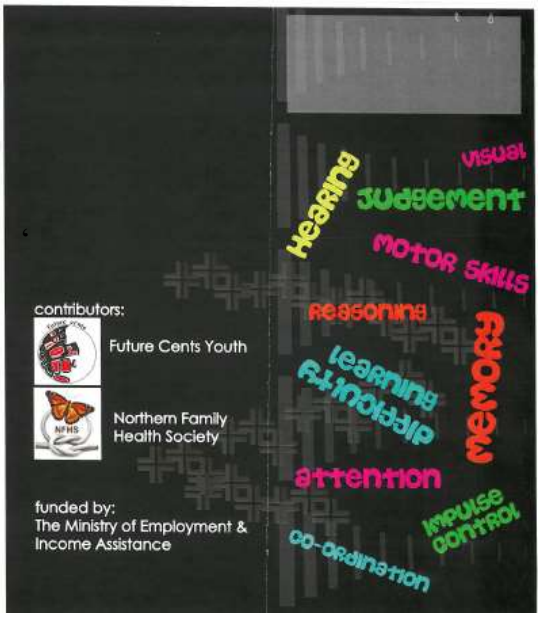
Appendix D: 2010–2015

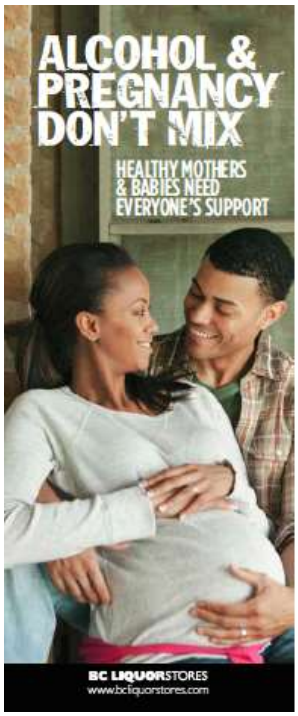
4A, 2011; 4B, 2015

with
Alchohol & Pregnancy

No safe time...
No safe amount

Prevent FASD
Always use protection





Drinking alcohol when you're pregnant can cause your baby to be born with many lifelong physical and mental health problems. The effect of drinking alcohol during your pregnancy on the developing brain can mean that your child can have learning difficulties, and problems with memory, reasoning and judgment. The health problems caused by drinking alcohol in pregnancy are called **Fetal Alcohol Spectrum Disorder (FASD).**

ARE THERE ANY SAFE TIMES FOR PREGNANT WOMEN TO DRINK ALCOHOL?
Drinking alcohol can be harmful at any point during pregnancy. The baby's brain and nervous system develops throughout the entire pregnancy.

IS THERE A SAFE AMOUNT TO DRINK WHEN PREGNANT?
There is no known safe level of alcohol use during pregnancy, so it is safest not to drink at all when women are pregnant or planning to become pregnant.

Drinking more than two drinks per day and drinking regularly are most harmful to the developing baby. Every step women take to stop drinking and be healthy during pregnancy is helpful.

BC WOMEN'S HOSPITAL + HEALTH CENTRE

WHAT IF I WAS DRINKING BEFORE I KNEW I WAS PREGNANT?
Having a small amount of alcohol before you knew you were pregnant is not likely to harm your baby. Quitting now and looking after your own health are the best ways to ensure that your baby is healthy.

It is never too late to quit or cut down on your drinking. As well as avoiding alcohol, pregnant women benefit from:

- Lots of rest
- Regular medical care (doctor, nurse or midwife)
- Healthy food
- Supportive friends and family members
- Healthy recreation and physical activities
- It is best to avoid cigarettes and other drugs during pregnancy as well as alcohol

TIPS FOR PARTNERS AND FRIENDS OF PREGNANT WOMEN
Women need support to avoid alcohol and have healthy pregnancies:

- Cut down or take a break from drinking to support her or avoid drinking around her
- Take part in social activities that don't involve drinking
- Encourage women who are pregnant not to drink
- Participate in recreation and physical activities with your pregnant friend or partner
- Ask her how to help reduce stress in her life
- Have a non-alcohol drink option at parties or gatherings

WHERE CAN I GET MORE INFO AND HELP?
If you need help to cut down or stop drinking, be sure to talk to someone. Friends, family, or a doctor, midwife, nurse or counsellor can help.

BC Association of Pregnancy Outreach Programs
Provides a listing of local support programs for pregnant women. www.bcapop.ca/

24-hour BC Alcohol & Drug Information & Referral Service
Lower Mainland/Greater Vancouver:
(604) 660-9382
Outside Lower Mainland, Toll-free in BC:
1-800-663-1441

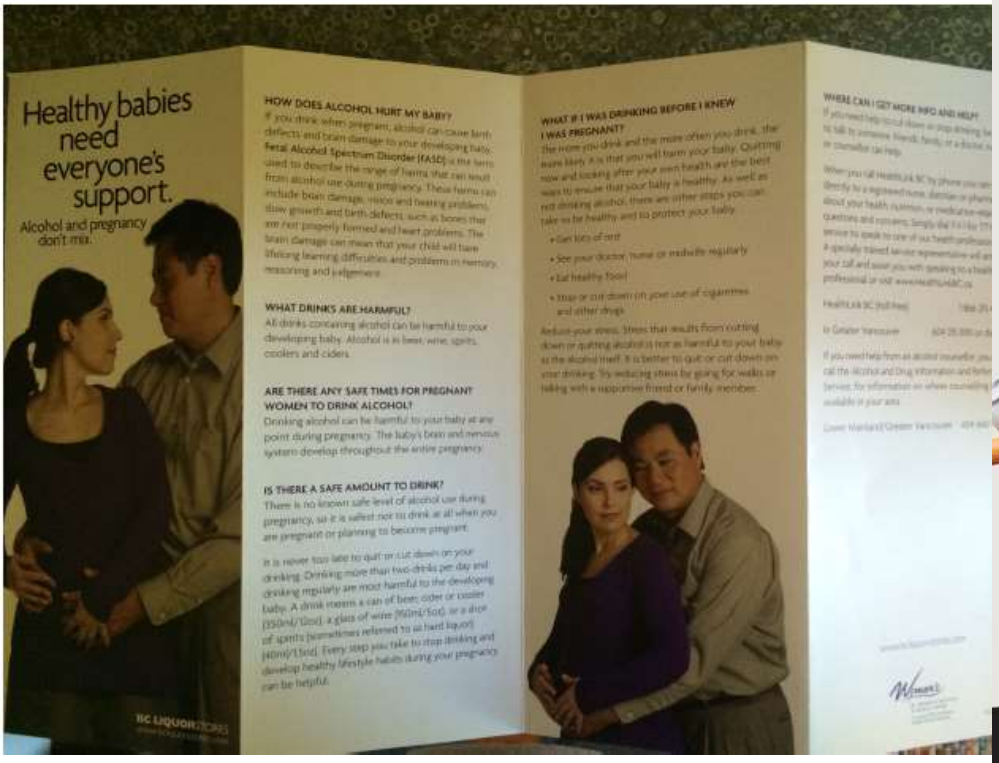
HealthLink BC
Non-emergency health information and services 24/7: Dial 8-1-1 (for TTY dial 7-1-1)
www.healthlinkbc.ca/

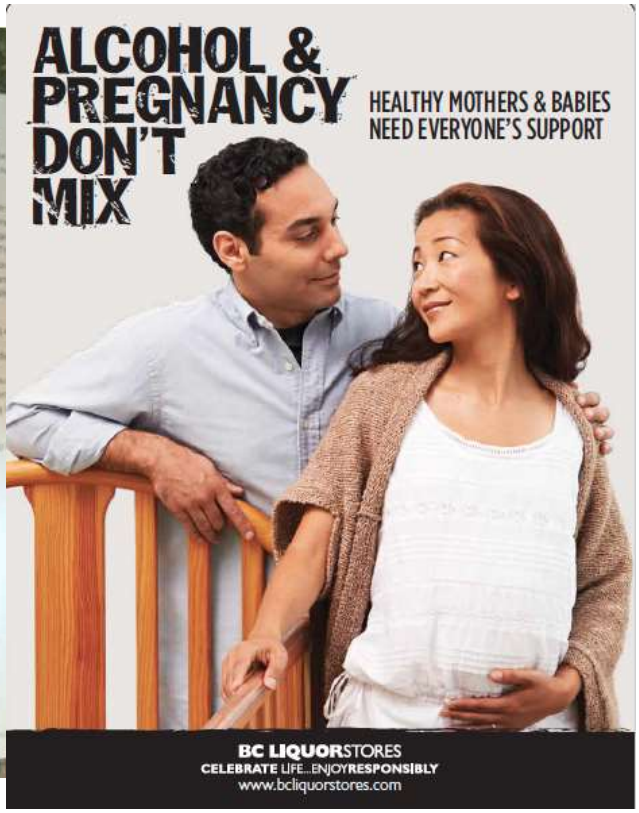
Your Local Public Health Unit
Ask for the mental health and addictions team.
Contact information at:
www.Health.gov.bc.ca/socsec

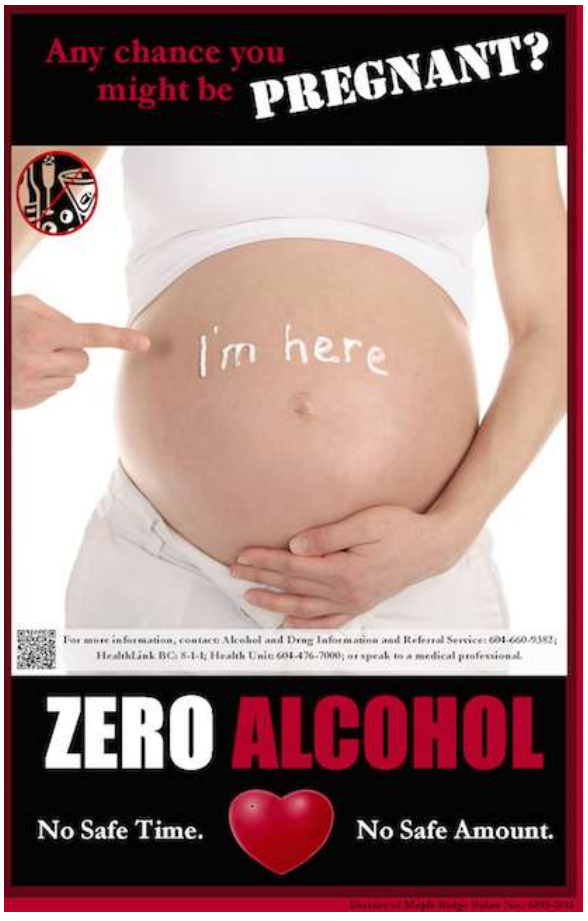
QuitNow Services
You can get help to quit smoking:
Toll-free: 1-877-455-2233 www.Quitnow.ca
See also resources at www.expectingtoquit.ca

Learn More
About Low-Risk Drinking Guidelines:
http://ccsa.ca/Resource%20Library/2012-Canada-Low-Risk-Alcohol-Drinking-Guidelines-Brochure-en.pdf

About Alcohol and Women's Health:
http://bccewh.bc.ca/wp-content/uploads/2014/07/WomenAndAlcoholResource2014.pdf







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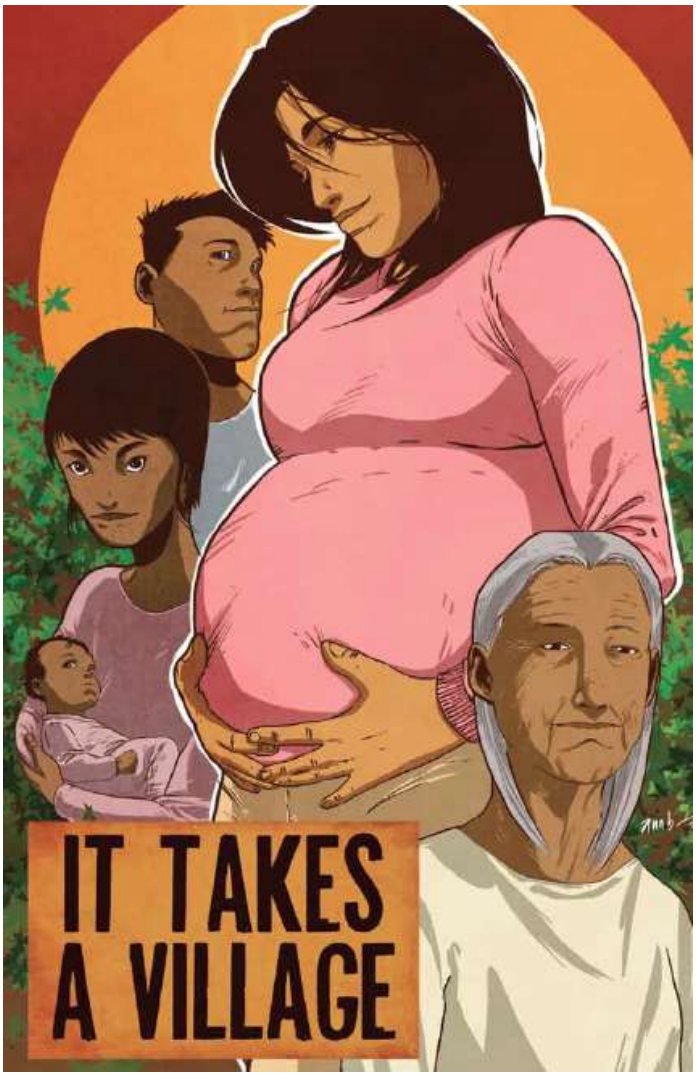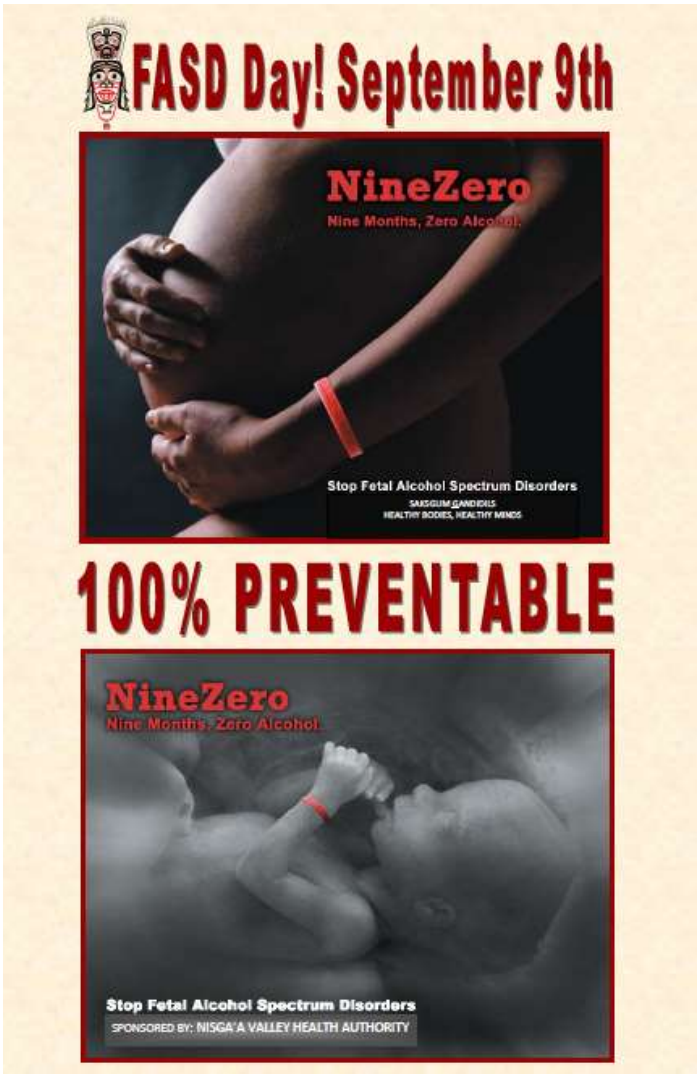
4F, 2012; 4H, 2013 (4F left, title page only, does not feature comic pages; 4H right)