

I DRANK BECAUSE I WANTED TO DEAL WITH THE FRUSTRATION": EXPLAINING ALCOHOL CONSUMPTION DURING PREGNANCY IN A LOW-RESOURCE SETTING – WOMEN'S, PARTNERS AND FAMILY MEMBERS' NARRATIVES

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Understanding the explanatory narratives that women, partners and family members provide for consuming alcohol during pregnancy is essential in interventions. This paper reports on the stories of 25 participants in a low-resource area. Explanations included lack of partner support (not providing financially, being unfaithful, denying paternity), stress (HIV diagnosis, unwanted pregnancy, poverty), trauma (rape, death and crime), and a drinking culture (unregulated taverns, availability of liquor, peer pressure). Interventions should work with the gender norms; provide services or referrals for trauma; provide non-judgmental counselling; and target drinking in general in the community so as to reduce drinking culture.

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**Key words:** pregnancy, alcohol, narratives, support, interventions, South Africa



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### **BACKGROUND**

Drinking during pregnancy can result in children experiencing lifelong developmental delays, disabilities, mental deficiencies and physical anomalies which are collectively referred to as foetal alcohol spectrum disorders (FASDs). FASD has been recognised as a public health concern in South Africa, with rates being among the highest in the world. For example, in a study conducted in 17 towns across three provinces (Western Cape, Gauteng and Northern Cape), a rate of 29 to 290 per 1 000 live births across these settings was found (Olivier, Viljoen & Curfs, 2016).

Research conducted on alcohol use during pregnancy has identified various risk factors, including maternal characteristics, behavioural factors, drinking exposure, socio-cultural factors, and environmental factors (May & Gossage, 2011). Most of these studies have, however, been quantitative. Their emphasis, as a result, has not been on articulating and contextualising the manner in which pregnant women navigate drinking (Olusanya & Barry, 2015). Qualitative research is required to understand the meaning women ascribe to drinking during pregnancy in order to inform interventions. This is particularly important in the light of Myers & Vythilingum’s (2012:77) observation that “female substance users often have more complex and varied treatment needs than their male counterparts”

A qualitative study, conducted in the Western Cape, revealed that women used alcohol to cope with stress, to retain social connection, or because of addiction (Watt Eaton, Choi, Velloza, Kalichman, Skinner & Sikkema, 2014). In the light of these findings, which suggest the social embeddedness of drinking during pregnancy, the meanings that family members or partners ascribe to women drinking during pregnancy could assist in providing nuancing understandings of such drinking behaviour. However, very little research has concentrated on the views of the family members or partners of women who drink alcohol during pregnancy (Kelly & Ward, 2017).

In line with Olusanya and Barry’s (2015) call for more qualitative research on this topic in South Africa, this study investigated the narratives of women who have consumed alcohol during their pregnancies, as well as the narratives of the partners and family members of such women. The study took place in low-resource area in Buffalo City, South Africa. In this paper we home in on themes relating to how the participants justified or explained the drinking.

## METHOD

We employed a qualitative, explorative research design in this study, with narrative theory underpinning our interview approach. The research question driving the study was: How do women who have consumed alcohol during pregnancy, as well as the partners and family members of such women, narrate the journey of the pregnancy?

Individual interviews were conducted with (1) women who drank alcohol during their pregnancies; and (2) the partners or family members of such women. Participants were recruited through a non-governmental organisation (NGO) dealing with alcohol use during pregnancy. Convenience and purposive sampling were used to select women, >18 years old who drank during a previous pregnancy, and partners/family members of women who had consumed alcohol at any time during their pregnancies; the partner/family member had to have obtained consent from the woman prior to participation. A total of 25 participants were recruited for the study: 12 women, 12 partners/family members, and one participant who fitted both profiles (Khethiwe).

Once sub-sessions 1 and 2 of the interviews (see discussion below) were completed, the alcohol use of each of the women during their pregnancies was assessed using a modified version of the Alcohol Use Disorders Identification Test for Consumption (AUDIT-C) to assess reported drinking during pregnancy. Only those with scores of 3 and above were included. A score of 3 is considered to represent moderate drinking, but still potentially harmful during pregnancy. A score of 4-7 (females) indicates a risky pattern of drinking in general, while a score of 8+ (both females and males) indicates a high-risk pattern of drinking (Phelps and Hassed, 2012). Tables 1 and 2 provide information about the participants' age, relationship and employment status, languages spoken, level of education and AUDIT-C scores.

**TABLE 1**  
**DEMOGRAPHIC INFORMATION OF WOMEN PARTICIPANTS**

Pseudonym	Age	Relationship Status	Language(s) Spoken	Level of Education	Employment Status	AUDIT-C Score
Cindy	23	Single	IsiXhosa	Matric	Unemployed	4
Dineo	20	Single	IsiXhosa	High School	Unemployed	5
Hope	23	Married	IsiXhosa	High School	Unemployed	5
Khethiwe	48	Widowed	IsiXhosa	Primary School	Unemployed	6
Lola	27	Single	IsiXhosa; English	High School	Unemployed	10
Lucy	36	Single	IsiXhosa	High School	Unemployed	7
Morongwa	32	Married	IsiXhosa	High School	Unemployed	4
Nina	25	Single	IsiXhosa	High School	Unemployed	8
Nonny	24	Single	IsiXhosa	High School	Unemployed	4
Nono	43	In a relationship	IsiXhosa; English; Afrikaans	Matric	Unemployed	7
Pearl	40	Single	IsiXhosa	High School	Unemployed	10
Pretty	27	In a relationship	IsiXhosa	High School	Unemployed	6
Rosey	22	In a relationship	IsiXhosa	High School	Unemployed	10

**TABLE 2**  
**DEMOGRAPHIC INFORMATION OF PARTNER OR FAMILY MEMBER**  
**PARTICIPANTS**

Pseudonym (relation to woman)	Age	Relationship Status	Language(s) Spoken	Level of Education	Employment Status	AUDIT-C Score
Luvo (husband)	57	Married	IsiXhosa	Primary School	Unemployed	8
Khaya (husband)	45	Married	IsiXhosa	High School	Unemployed	3
Jonga (husband)	37	Married	IsiXhosa	Matric	Employed	10
Sizwe (husband)	33	Married	IsiXhosa	High School	Employed	6
Lunga (husband)	48	Separated	IsiXhosa	High School	Unemployed	9
Khethiwe (mother)	48	Widowed	IsiXhosa	Primary School	Employed	7
Linda (mother)	45	Married	IsiXhosa	High School	Unemployed	11
Lisa (niece)	32	In a relationship	IsiXhosa	None	Unemployed	6
Lumka (mother)	48	Married	IsiXhosa	High School	Unemployed	3
Lulu (sibling)	23	In a relationship	IsiXhosa	High School	Unemployed	11
Liso (aunt)	32	Married	IsiXhosa	Matric	Unemployed	12
Kuhle (mother)	57	Married	IsiXhosa	Primary School	Unemployed	6
Jade (daughter)	38	Married	IsiXhosa	High School	Unemployed	12

The interview followed Wengraf's (2001) method of narrative interviewing. In the first or main interview, two sub-sessions took place. In the first sub-session, the interviewers posed one narrative question (or what Wengraf (2001) calls a Single Question aimed at Inducing Narrative (SQUIN)). During this session, as well as in the second sub-session, two researchers were present. One asked the SQUIN, while the co-researcher quietly took notes. The SQUIN used for this study was as follows: "Please tell me the story of your [partner's or family member's] pregnancy from before you were [she was] pregnant through to when the child was born, including the events and experiences that were important to you during this time". Prior to the second sub-session of the main interview (i.e. the narrative follow-up), the interviewee was asked to leave the room and the researcher and her co-researcher spent 15 minutes composing questions to ask the interviewee based on the notes taken by the co-researcher (Wengraf, 2001). The second interview took place after the data from the first interview (the first and second sub-sessions) had been transcribed (verbatim) and read over (Wengraf, 2001). In this session, the interviewer asked further questions that emerged from what was said or not said in the first interview (Wengraf, 2001).

The second and third authors, who are bilingual, translated the data from isiXhosa to English and validated each other's translations to ensure accuracy. The data were analysed using thematic analysis. Thematic analysis offers a systematic method of organising, identifying and reporting patterns or themes within the dataset (Braun & Clark, 2006). The thematic analysis carried out for this study involved i) reading and re-reading interview material in order to identify potential themes; ii) reviewing the identified themes using thematic mind-maps; and iii) re-reading the interview material again to refine and define existing themes. Ethical clearance was obtained through the Department of Psychology Research Projects and Ethics Review Committee (RPERC), as well as the Rhodes University Ethical Standards Committee (RUESC).

## FINDINGS: EXPLAINING DRINKING

Despite a few isolated examples of misunderstandings, most participants knew, and indicated that others knew, about the dangers of drinking during pregnancy, with knowledge coming from various sources, including 'Xhosa culture'. Despite this, drinking continued. Some women mentioned trying to stop, some mentioned taking "temporary breaks". Participants also referred to a number of social problems that are common features of their lives. Crime was mentioned frequently. Indeed, life in low-income urban communities in South Africa is characterized by a cycle of crime and violence

(Hinsberger, Sommer, Kaminer, Holtzhausen, Weierstall, Seedat, Madikane & Elbert, 2016). It is within this context that we outline themes in which participants either explained or justified women's drinking during pregnancy. These explanations included: the lack of partner support; stress in relation to being diagnosed with HIV; carrying an unwanted pregnancy, poverty; trauma as a result of crime or death of close ones; and a drinking culture in the community fuelled by peer pressure.

### **Lack of partner support**

Many of the women in this study indicated that they drank as a result of their partners being unsupportive and unreliable. This revolved around three issues: the partner not providing for the pregnancy and, subsequently, the child; cheating/being unfaithful; and the denial of paternity. (Intimate partner violence is discussed under the trauma heading).

Participants indicated that financial support for neither the pregnancy nor the child was forthcoming from their partners: "*But he never gave me money ... I had to ask my mother for money to take care of everything*" (Lucy). In an environment where unemployment is high, this places significant stress on pregnant women and their partners: "*I was so frustrated when I got pregnant because my partner did not have a job and was not educated so ... so ... it was very hard for him to find a job. ... you must know that I drank because I wanted to deal with the frustration.*" (Nonny)

Unfaithfulness was also mentioned. For example, Morongwa stated: "*The main thing that made me drink that time [when I was pregnant] was not getting the truth from him [my partner] [about making the other woman pregnant], you see?*" (Morongwa). Rosey implied that she would not have drunk alcohol if she had not been abandoned: "*If he stayed and did not leave me, I wouldn't be talking like this ... I wouldn't have drank because alcohol was never my thing.*"

Denial of paternity, rejection and complete abandonment were mentioned by family members and women alike: "*I saw a message, she sent a message to her boyfriend telling him she was pregnant. I saw a response message saying, 'I did not get you pregnant'*" (Kuhle, family member); "*I denied the pregnancy and kicked her out*" (Khaya, partner). Partners rationalised their rejection through reference to women's bad behaviour and rumours: "*I heard rumours that it was not my child, and this bothered me.*" (Sizwe, Partner)

These women's experiences are located within the gender dynamics operating within the country. Father absence, for example, is well documented in South Africa and persists for a number of reasons, including rural-urban labour migration and denied responsibility of fatherhood (Padi, Nduna, Khunou & Kholopane, 2014). Infidelity and lack of condom use mark many heterosexual relationships (Pettifor, Macphail, Anderson & Maman, 2012), and fear of infidelity drives some unhealthy practices (Parker, Pettifor, Maman, Sibeko & Macphail, 2014).

### **Stress**

Family members, partners and women reported that stress was a major factor in the women's drinking. Three of the women who took part in this study shared that they were diagnosed with HIV during their pregnancies, which came as shocking news to them: "*I couldn't believe that I was pregnant and HIV positive, so the alcohol helped me forget about this, sis!*" (Hope); "*It [the HIV-positive diagnosis] affected me so much because I ate [took] poison, but it did not kill me*" (Lulu). The stress of such a diagnosis was confirmed by family members: "*What bothered her and made her drink, she got tested while pregnant. She found out she was HIV positive and that made her drink too much alcohol.*" (Lisa family member). The continued stigma surrounding HIV exacerbated the stress: "*I drank for a long time because I thought about who I was going to tell about this*" (Pretty); "*She did not tell anyone that she was HIV positive.*" (Lisa, family member). Given the high rate of intimate partner violence (IPV) in South Africa (Mokwena & Adeoti, 2014), disclosure to a partner may be very difficult: "*He will see that I have this [HIV] and he would say I infected him. There is a high number of men killing women here ... Maybe he will end up killing me.*" (Lulu)

The shock of discovering an unplanned pregnancy was described by some women: “*I asked them to please test me again because I didn’t believe [that I was pregnant]*” (Nina). Some of these unplanned pregnancies remained unwanted. Three of the women spoke about drinking during their pregnancies in order to induce an abortion: “*I spoke to a friend who was in a similar situation who told me that she drank alcohol ... she said she drank shots of brandy so that she could take the tummy out [have an abortion] so I did this too but nothing happened*” (Pretty); “*I asked around in the community how a baby is taken out [aborted], and they said ...take a shot of brandy and drink it so that the baby comes out of your stomach.*” (Nina)

Poverty was indicated as a clear stress factor. For example, Pearl said: “*Because I was from a poor family ... and we have no money and I did not know who the father of my child was, during my pregnancy, I was always worried about where my child was going to get the things he/she needed.*” Here Pearl connects poverty with lack of partner support, drawing from the understanding of males as bread winners.

The association of stress with alcohol/substance use during pregnancy is confirmed in quantitative research conducted with women presenting at antenatal care. This study also revealed a high correlation between perceived stress and depression amongst these women, suggesting that depression, stress and alcohol use during pregnancy are interwoven (Vythilingum, Roos, Faure, Geerts & Stein, 2012).

## Trauma

Participants indicated that alcohol was used to cope with distressing intrusive memories of trauma. Traumas referred to by family members, partners and the women themselves included rape, losing loved ones during their pregnancies through tragic events such as murder, as well as intimate partner violence: “*She was raped by someone we know, who stays in our area. He raped her and ran. ... After reporting, [name], who was a police officer there, said to my sister she must follow him. ... Only to find out he raped her as well*” (Lulu, family member); “*When I was eight months [clears her throat], my father passed away after he was stabbed in another area.*” (Cindy)

Intimate partner violence was mentioned by many family members, partners and women: “*She found out that she was pregnant. Her man was beating her up.*” (Liso, family member). “*At that time, she was not listening and used to drink. ... Sometimes I would be so angry and end up beating her unintentionally*” (Luvo, partner). “*We used to fight and he used to beat me*” (Nono). “*One time he beat me because I didn’t want to drink, so after that day ... I ... I ... I decided that I would drink with him.*” (Lucy)

This association between trauma and substance use is confirmed in a study conducted amongst pregnant women in the Western Cape. This survey revealed that women who reported lifetime substance use had fourfold greater odds of reporting trauma exposure compared to women without substance use (Myers, Jones, Doherty, Kline, Key, Johnson & Wechsburg, 2015).

## Drinking culture

Participants reported that there are many *shebeens* (taverns) in their community, the majority of which are illegal: “*Yoh!! People drink so much here because we have MANY shebeens. ... and police do not go there to close them down*” (Jade, family member). Participants reported that the lack of compliance of *shebeens* with liquor regulations influenced alcohol use in pregnancy: “*People use alcohol beyond measures ... Young children at the age of 9-10 years can buy alcohol.*” (Lunga, Partner)

Participants also highlighted the role of others (e.g. friends) in influencing an individual’s drinking behaviour during their pregnancy: “*The reason [is that] I was forced by my friends, even when I told myself that I wasn’t going to drink ... they brought alcohol and they told me to come and drink and I also ended up going to drink.*” (Cindy). Cindy’s use of the word “forced” suggests the possibility of being excluded from her friendship circle should she refuse. This kind of exclusion can be seen in Lola’s statement: “*My friends, with whom I used to drink, had a problem with me not drinking. They said I was boring and making myself better than them.*”

Ferreira-Borges, Parry and Babor (2017) note that several studies have documented a movement towards a culture of public and binge drinking in not only South Africa but other sub-Saharan African countries. This, it is believed, is fuelled by marketing strategies that portray drinking alcohol as glamorous and an emblem of success.

## DISCUSSION

A major factor reported in participants' explanations of their drinking behaviour was the lack of support from partners. This took the form of lack of financial support, infidelity and paternal denial. Gearing, McNeill and Lozier (2005) argue that a fundamentally important, but frequently minimised and ignored factor, is the role of fathers in the issue of FASD. Lack of paternal involvement is associated with an increase in the use of alcohol (Aktas & Calik, 2015), as well as maternal depressive symptoms and emotional distress that may feed into alcohol use (Nduna & Jewkes, 2012). A recent South African literature review demonstrated that women's relative disempowerment in relationships with men reinforce unequal positions in families, societies and public domains (Fladseth, Gafos, Newell & McGrath, 2015).

Multiple stress factors were also mentioned as a major factor in drinking, including HIV diagnosis, unplanned pregnancies and poverty. Studies confirm that pregnant women turn to alcohol and/or drugs in an attempt to cope (Eaton, Pitpitan, Kalichman, Sikkema, Skinner, Watt & Cain, 2014; Watt *et al.*, 2014). This may be particularly pertinent for women who have been exposed to adverse economic and socio-political conditions for an extended period of time as a result of the legacy of apartheid (Cloete & Ramugondo, 2015).

The shock of being diagnosed with HIV during pregnancy and the concomitant reluctance to share this news with others is worrying. Walcott, Hatcher, Kwena and Turan (2013) argue that disclosure may be particularly crucial for pregnant women: without partner support, it is often difficult for women to adhere to HIV treatment and to breastfeed, both of which reduce transmission of HIV to their infants, and protect their own and their partner's health.

Trauma, mostly related to violence, was referred to by participants as leading to drinking in pregnancy. Murder of loved ones, rape and intimate partner violence were mentioned by participants. IPV was spoken of as being exacerbated by, but also causing, drinking. In their study, Choi, Abler, Watt, Eaton, Kalichman, Skinner and Sikkema (2014) found that pregnant women with prior experiences of IPV or childhood abuse tended to drink at elevated levels. Thus, it is not only present trauma that may contribute to drinking during pregnancy, but also past trauma.

Participants spoke about the drinking culture in their community and the operation of many illegal taverns. Kelly and Ward (2017) confirm that alcohol may form an important aspect of pregnant women's social lives. Indeed, in many parts of South Africa alcohol use and abuse have become normalised and socially acceptable (Cloete and Ramugondo, 2015; Watt *et al.*, 2014). Some women spoke about peer pressure to drink, implying that not to drink means foregoing social recognition in friendship circles.

## RECOMMENDATIONS FOR INTERVENTIONS

It is important to note that participants in this study knew about the dangers of drinking alcohol during pregnancy. This suggests that interventions focusing on knowledge only are bound to fail. Indeed, Russell, Eaton and Petersen-Williams (2013) argue that "the synergistic quality that clusters of health problems [alcohol use during pregnancy, intimate partner violence, HIV] create" needs to be acknowledged. Our study supports this claim, showing how various health and social problems are intertwined in complex ways in the lives of women who drink alcohol during pregnancy. Locating women's responses to drinking during pregnancy, and hence to interventions, within the context and their personal explanatory narratives is essential to a supportive, non-judgmental approach.

Lack of partner support featured as a major factor in the women's drinking. These patterns (lack of financial support, IPV and paternity denial - mentioned by women and confessed to by some partners) are embedded in gender norms and the social construction of particular types of masculinities in communities. As such, interventions need to work with the underlying gender dynamics that normalise and enable such behaviours. This means working with partners as well as the women themselves, and addressing the problematic understandings of masculinity that are pervasive in many social situations (Kaye, Kakaire, Nakimuli, Osinde, Mbalinda & Kakande, 2014).

While working with men and with couples is important, it is equally important to provide the support services to women who have experienced lack of partner support. Referral to, and encouragement to use, social services that assist women with, *inter alia*, restraining orders (in the case of IPV), maintenance and child support grant applications (in the case of lack of financial support) are important.

While an intervention dealing with alcohol use during pregnancy cannot hope to address the multiple stressors and traumas experienced by these women, providing space for them and their families or partners to speak through the stressors and/or trauma is important. Indeed, the response of all study participants to taking part in a non-judgmental narrative interview was overwhelmingly positive. Pearl, for example, described how she felt *a bit better* after taking part in this research: "*I felt alright ... it's a bit better ever since [I took part in this research]. I was able to speak about my problem[s], you understand? At least I am now a person who is a bit better. ... at least I do get some sleep*".

Having said this, particular stressors and trauma mentioned by participants could be given attention. The shock of receiving an HIV diagnosis during pregnancy was mentioned by a number of participants. This suggests that counselling for dealing with such a diagnosis, and support in disclosing the diagnosis to family and friends, are all important, not only in terms of potentially reducing drinking during pregnancy, but also for a range of other health-related issues.

Although some participants spoke about, on the one hand, being discouraged from drinking by community members, but on the other hand, they risked losing social recognition if they do not. The acceptance of drinking as a pastime and peer pressure to drink are well known in South Africa. Interventions targeting drinking in general in a particular community could assist in addressing the underlying drinking culture and peer pressure to drink. Better regulation of illegal taverns could also assist, along with providing leisure and social spaces where alcohol does not feature.

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