

Department of Social Research
University of Helsinki

PRECARIOUS PREGNANCIES

ALCOHOL, DRUGS AND THE REGULATION OF RISKS

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ACADEMIC DISSERTATION

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CONTENTS

Contents.....	3
Acknowledgements.....	5
Summary.....	7
List of original publications	9
1 Introduction	11
1.1 Research Questions	14
1.2 Structure of the summary	14
2 Intensifying concern about alcohol and drug use during pregnancy	15
2.1 Prenatal alcohol and drug use in finland	16
2.2 Regulation of prenatal substance use.....	18
3 Theoretical framework: Sociologies of risk.....	21
3.1 Risk as a moral danger	21
3.2 Situated risk	22
3.3 Governing risks	24
3.4 Governing pregnancy	27
4 Research process, methods and materials.....	29
4.1 Multi-sited ethnography	29
4.2 Participant observation: daily life at the clinic.....	32
4.3 Interviews with women from the clinic.....	43
4.4 Medical and political discourses.....	45
4.5 Health education material	46

5	Results.....	47
5.1	The imperative of foetal health	47
5.2	Hybrid encounters	52
5.3	Between biomedical and others risks: Subjugated knowledge.....	57
6	Discussion.....	61
	References.....	67
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Anna Leppo

SUMMARY

Since the 1970s alcohol and drug use by pregnant women has gained the status of a serious social problem in the West and has become a target of political, professional and personal concern. The present study focuses on prenatal substance use and the regulation of risks by examining different kinds of societal responses to prenatal alcohol and drug use. The study analyses face-to-face encounters between professionals and service users at a specialised maternity clinic for pregnant women with substance abuse problems, medical and political discourses on the compulsory treatment of pregnant women as a means of FAS prevention and official recommendations on alcohol intake during pregnancy. Moreover, the study addresses the women's perspective by asking how women who have used illicit drugs during pregnancy perceive and rank the dangers linked to drug use. The study consists of five empirical sub-studies and a summary article. Sub-study I was written in collaboration with Dorte Hecksher and Sub-study IV with Riikka Perälä.

Theoretically the study builds on the one hand, on the socio-cultural approach to the selection and perception of risks and on the other on governmentality studies which focus on the use of power in contemporary Western societies. The study is based on an ethnographic approach and makes use of the principles of multi-sited ethnography. The empirical sub-studies are based on three different types of qualitative data: ethnographic field notes from a maternity clinic from a period of 7 months, documentary material (medical journals, political documents, health education materials, government reports) and 3) interviews from maternity clinics with clients and members of staff.

The study demonstrates that the logic of the regulation of prenatal alcohol use in Finland is characterised by "the rise of the foetus", a process in which the urgency of protecting the foetus has gradually gained a more prominent role in the discourses on alcohol-related foetal damage. An increasing unwillingness to accept any kinds of risks when foetal health is at stake is manifested in the public debate on the compulsory treatment of pregnant women with alcohol problems and in the health authorities' decision to advise pregnant women to refrain from alcohol use during pregnancy (Sub-studies I and II). Secondly, the study suggests that maternity care professionals have an ambivalent role in their mundane encounters with their pregnant clients: on the one hand professionals focus on the well-being of the foetus, but on the other, they need to take into account the women's needs and agency. The professionals' daily encounters with their clients are thus characterised by hybridisation: the simultaneous use of technologies of domination *and* technologies of agency (Sub-studies III and IV). Finally, the study draws attention to the women's understanding of the risks of illicit

drug during pregnancy, and shows that the women's understanding of risk differs from the bio-medical view. The study suggests that drug-using pregnant women can feel that their agency and moral worth is threatened by professionals' negative attitudes.

In conclusion, experts, authorities and policymakers should be better equipped not to sideline pregnant women with substance abuse problems with foetus-centred discourses. Too much emphasis on the protection of the foetus can lead to discourses that serve to demonise the pregnant woman. Particular attention should be paid to the cultivation of respectful and encouraging attitude towards pregnant women with substance abuse problems amongst health care and social service professionals. Increased dialogue between service providers and users would make more space for the service-users' agency and facilitate service use. Future studies on the perspectives of pregnant women with alcohol and drug issues would be very valuable.

LIST OF ORIGINAL PUBLICATIONS

This PhD study is based on the following sub-studies, indicated in the text with the roman numerals I—V as follows:

- I Leppo A. and Hecksher D. (2011) The Rise of the Total Abstinence Model. Recommendations regarding Alcohol Use during Pregnancy in Finland and Denmark. *Nordic Studies on Alcohol and Drugs*, 28, 1, 7-27.
- II Leppo A. (forthcoming) The Emergence of the Foetus: Discourses on Fetal Alcohol Syndrome Prevention and Compulsory Treatment in Finland. *Critical Public Health*.
- III Leppo A. (2008) Professional Interventions in Drug Use during Pregnancy at a Specialised Maternity Clinic. (This sub-study was published in Finnish in *Sosiaalilääketieteellinen aikakauslehti* [Finnish Journal of Social Medicine], 2008, 45, 1, 33-47. It has not been published in English)
- IV Leppo A. and Perälä R. (2009) User-involvement in Finland: the Hybrid of Control and Emancipation. *Journal of Health Organization and Management*, 2009, 23, 3, 359-371.
- V Leppo A. (Resubmitted to *International Journal of Drug Policy*) "Subutex is Safe": Women's Perceptions of Risk in Using Illicit Drugs during Pregnancy.

1 INTRODUCTION

What should be done when pregnant women consume alcohol or other substances in ways that may be harmful to the foetus? What in fact is harmful? Who should take the initiative and what would be the best course of action? What can professionals do for pregnant women in order to help them minimise risks? How do pregnant women themselves view the dangers related to prenatal substance use? The present study sets out to explore these questions which address the regulation of substance use during pregnancy in Finland today. The study consists of five sub-studies and this summary article. Sub-study I was written in collaboration with Dorte Hecksher, PhD, from the University of Århus and sub-study IV was written with a fellow PhD student, Riikka Perälä, from the University of Helsinki. I am the first author of sub-study I while the two authors each had an equal role in the creation of sub-study IV.

The term Fetal Alcohol Syndrome (hereafter FAS) was invented in the early 1970's by American researchers (Armstrong 2003, see also Golden 2005). Despite initial criticism of the theory that heavy alcohol consumption is the sole cause of FAS, the existence of the syndrome and the causal link came to be accepted as fact in the medical community (Armstrong 2003). Despite many uncertainties surrounding the diagnosis and incidence of FAS it is perceived today as a significant public health problem (Armstrong 2003, Mäkelä 2009). Societal efforts to regulate substance use in pregnancy have been particularly strict and punitive in the United States, especially in the case of drug use, and this punitive approach has been criticised by feminist scholars (Young 1994, Armstrong 2003).

FAS was mentioned for the first time in Finnish medical journals in 1979, and the first specialised and publicly provided treatment facility for pregnant women with alcohol problems was opened in 1983. The Finnish societal response to prenatal alcohol abuse and later on drug abuse during the last three decades could be characterised as an education and treatment approach based on broad health education campaigns and the provision of specialised public services. However, in Finland and the other mainland Nordic countries there has been political controversy about what modes of intervention are efficient and ethically sound and whether coercive measures should be used (Hecksher 2009, Mäkelä 2009, Leppo 2009, Søvig 2007).

The risk of alcohol- and drug-related foetal harm poses a genuine dilemma for contemporary liberal societies. What can and should be done about it? What should the expert recommendation be about alcohol intake during pregnancy? Is punishment or treatment the way to go? Can women be forced into treatment? The problem of how to square individual freedom with the public good is by no means a novel issue as historical analyses of "enforcement of health" have shown (e.g. Porter and Porter 1988, Mattila

1999). The question of the rights of the individual against the state, however, is further complicated when it comes to prenatal substance use because the mother's rights to autonomy are juxtaposed vis-à-vis the rights of the foetus – whether these rights are of a legal or moral kind – and also because the issue tends to provoke intense moral reactions.

Biomedical knowledge about the effects of alcohol or drug use during pregnancy cannot be used to produce a formula for tackling the problem. Despite evidence of the potential risks of prenatal substance use, many pregnant women will continue to consume alcohol or illicit drugs. Debates about the right of the pregnant women to autonomy versus the rights of the foetus to protection are inconclusive and provide no solution. The hypothesis of the present study is that the reason for the limited value of these approaches for understanding or solving the problem is that dealing with prenatal alcohol and drug use is essentially a question of values, power and justification of that power. These are the areas that need to be examined in order to understand the regulation of prenatal substance use in contemporary societies.

Theoretically, the study draws on two traditions. Regulation of substance use in pregnancy touches upon important theoretical debates in sociology in the areas of risk and power. On the one hand, the socio-cultural approach to risk based on the seminal work by Mary Douglas underlined the nature of risk as a moral danger that binds a community together and establishes its boundaries; Douglas emphasised the distinction between the self and the other as a central feature of any culture (Douglas and Wildawsky 1982, Douglas 1992). On the other hand, recent socio-cultural studies on risk inspired by Douglas and the “cultural turn” in social sciences have focused on the meanings and significance of risk for “non-experts” (Caplan 2000, Tulloch and Lupton 2003, Boholm and Corvellec 2010). Paralleling Douglas's work this perspective “acknowledges that understandings about risk, and therefore the ways in which risk is dealt with and experienced in everyday life, are inevitably developed via membership of cultures and subcultures as well as through personal experience.” (Tulloch and Lupton 2003, 1).

Once something has been collectively designated as a risk, risk management strives to exclude the risk and to keep the valued object-at-risk in, that is, secure; adequate risk management regimes are developed for these purposes (Boholm and Corvellec 2010, 6). In order to understand how risks are handled, the present study draws on a foucauldian approach to power and the “conduct of conduct” in contemporary society. This approach emphasises the freedom of those who are being governed (Miller and Rose 1990, Rose 1999). Peter Miller and Nikolas Rose (1990, 2) have suggested that in advanced liberalism political power is characterised by “indirect” and “at a distance” mechanisms for aligning people's conduct with socio-political objectives. Such “action at a distance” mechanisms rely upon “expertise” and the self-regulating capacities of subjects (ibid). In a similar manner, in the

context of lifestyle risks Pekka Sulkunen (2009) posits that the increased freedom of choice over one's life-course in today's affluent societies has posed a new problem for social coordination: how does a society that places a high value on freedom of choice deal with the consequences of unhealthy or otherwise risky lifestyles? Not so long ago, the strong Nordic welfare states had the moral authority to employ harsh measures in regulating individual lives: reproduction was regulated by sterilising deviant women (Mattila 1999, Meskus 2009) and alcohol abuse was controlled by long-term incarcerations of alcoholics (Sulkunen 2009). Since the 1960s and 1970s, however, such normative state control has lost its mandate, which, according to Sulkunen (2011), has led to "the victory of the principle of individual autonomy" over the authoritarian and normative state.

The present study builds on ethnography (Honkasalo 2008) and follows the methodological principles of multi-sited ethnography (Marcus 1995, Hannerz 2003). Multi-sited ethnography moves out of the single site of conventional ethnography and draws on a problem that is not confined to a single place. Such a design examines multiple sites of activity and, significantly, the associations between the different sites. The present study traces the controversies that frame the regulation of prenatal substance use at the following locations or sites: Firstly, I analyse medical and political discourses on FAS risk prevention. Secondly I scrutinise institutional face-to-face encounters in which health professionals interfere in prenatal drug use at a maternity clinic. Thirdly I give a voice to the targets of these interventions, namely women who have struggled with drug problems during pregnancy. The study focuses on the regulation of both prenatal alcohol and drug use, which, however, are socially and culturally very different kinds of phenomena (on the cultural meanings ascribed to alcohol and illicit drugs, see Bancroft 2009). In Finnish society alcohol is defined simultaneously as a socially problematic substance as well as a socially acceptable substance, while illicit drug use is marginalised, illicit and heavily stigmatised (Partanen 2002).

An analysis of the regulation of prenatal substance use provides useful insights into the dilemmas of how risks are selected and regulated and how power can be exercised in contemporary societies. The title of the present study labels pregnancies affected by alcohol or drug use as "precarious", which means "dangerous", "uncertain" or "dubious". Depending on the perspective, prenatal alcohol or drug use may appear to be downright dangerous or it may be a grey area characterised by uncertainties. Furthermore, depending on the viewer, the nature of the danger, doubt or uncertainty may vary as the sub-studies will demonstrate.

1.1 RESEARCH QUESTIONS

A variety of perspectives and discussions has marked the research process. I approach prenatal substance use from three perspectives and ask the following research questions:

1. In the discourses that seek to regulate the risks of prenatal alcohol use, how is the pregnant woman constructed? What is her place with regards to the foetus? (Sub-studies I and II)

2. How is the pregnant woman approached in institutional face-to-face practices that seek to regulate the risks of prenatal drug use? How is professional power used? Is the pregnant substance-using woman regarded as an autonomous agent or as a target for interventions? (Sub-studies III and IV)

3. What do women who have used illicit drugs during pregnancy make of the dangers of prenatal drug use? Do they share the dominant biomedical risk perception or reject it? (Sub-study V)

1.2 STRUCTURE OF THE SUMMARY

In the next chapter I will sketch out the background to the study as a whole by looking at previous studies on the regulation of prenatal substance abuse and introducing the Finnish context. In chapter three I will present the theoretical framework. The fourth chapter introduces the method, research process, data and analysis. The fifth chapter is divided into three sections in which I will present the main findings of the five sub-studies. At the end of each section I will discuss the findings in a wider context and draw links between the different sub-studies. The sixth and last chapter closes with a consideration of important topics for future research and policy implications.

2 INTENSIFYING CONCERN ABOUT ALCOHOL AND DRUG USE DURING PREGNANCY

Beliefs about femininity and motherhood have a key role in punitive societal responses to drinking or drug use among women, particularly pregnant or parenting women (e.g. Humphries 1999, Campbell 2000). In the past the intoxication of women has been a morally dense topic (Warner 1997, Plant 1997) and it continues to be so, as the subject is still linked to sexual recklessness (Demant 2007, Törrönen and Maunu 2007) and other types of disorderliness (Day, Gough and McFadden 2004, Hutton 2004). In cultural images of alcohol and intoxication women bear the responsibility for the family and women's intoxication thus triggers moral concern (Järvinen and Rosenqvist 1991, Järvinen 1991, Holmila 1992, Sulkunen et al. 1997, Bogren 2008). Fiona Measham (2002) notes that, although young mothers linked their recreational drug use to the experience of pleasure and the achievement of a desired gender identity, for many of those interviewed excessive intoxication resulted in a perceived failure to fulfil (traditional) femininity; the women, for instance, felt guilty about the loss of self-control or the neglect of family responsibilities.

The term Fetal Alcohol Syndrome (FAS) was coined in three articles published in the medical journal *The Lancet* in 1973 and 1974 (Armstrong 2003, see also Golden 2005). These articles systematically delineated and labelled the association between chronic maternal alcoholism and a specific configuration of severe birth defects (Armstrong 2003.) A diagnosis of Fetal Alcohol Syndrome indicated a triad of dysmorphic facial features, impaired growth and central nervous system abnormalities caused by heavy alcohol exposure in utero (Golden 2005). In the decades preceding these findings, doctors regarded drinking during pregnancy "as a benign activity with no serious long-term consequences" ; from the 1960's until the early 1980s alcohol was commonly prescribed therapeutically to arrest preterm labour (Armstrong 2003, 72-73, see also Golden 2005).

Initially, the FAS diagnosis was questioned on the grounds that the syndrome could be explained by other maternal characteristics such as social class and nutritional status, for example, but the scepticism was soon overwhelmed by arguments that promoted the straightforward causal link between heavy drinking and foetal harm (Armstrong 2003). In her sociological account of the evolution of medical knowledge about the effects of alcohol on foetal development Elisabeth Armstrong (2003, 86) compares this process to the manner in which social problems are constructed and then subsequently expand: the diagnosis of FAS expanded from alcoholics to alcohol use in general and from FAS to less serious problems.

During the 1980s and 1990s new terms were invented for to less severe manifestations of prenatal alcohol exposure. These terms include “fetal alcohol effect” (FAE) or “partial FAS” (PFAS), “alcohol-related birth defects” (ARBD) and “alcohol-related neurodevelopmental disorder” (ARND). Since 2003, the umbrella term “fetal alcohol spectrum disorder” (FASD) has been used to describe all of the above mentioned conditions, that is, a continuum of permanent birth defects, which are understood to be caused by maternal consumption of alcohol during pregnancy (Sokol et al. 2003). It is often assumed that FASD incidence is about nine times that of FAS incidence (Mäkelä 2009).

Armstrong (2003, 6) argues that, “although FAS and its kindred syndromes are often presented as clearly established diagnostic paradigms ... considerable uncertainty pervades our understanding of the relationship between alcohol and reproductive outcome”. Further, according to Armstrong (2003, 4), there is little evidence substantiating such diagnoses as FAE, PFAS, ARBD or ARND. Not only social scientists but also epidemiologists have been sceptical about the way the perceived problem has expanded from heavy alcohol consumption to low-to-moderate consumption. In their recent discussion of the effects of prenatal alcohol exposure on neurodevelopment, Gray et al. (2009) call into question the evidence base for the increased concern that prenatal alcohol exposure may result in ARND at low-to-moderate alcohol consumption. In the view of these researchers, it seems clear that heavy alcohol consumption during pregnancy can result in FAS, but the effects of drinking at low-to-moderate levels are much less clear (see also Henderson et al. 2007; Abel 2009).¹ To make matters even more complicated, there is recent evidence suggesting that low alcohol intake during pregnancy can actually be beneficial to the development of the foetus (Kelly et al. 2009).

2.1 PRENATAL ALCOHOL AND DRUG USE IN FINLAND

In Finland over the last several decades there has been a significant increase in women’s alcohol consumption. In 1968 women drank twelve per cent of the total amount of alcohol consumed in Finland (Metso et al. 2002), while in 2006 women’s consumption had risen to approximately thirty per cent of total consumption (Tigerstedt 2006). The increase in women’s alcohol consumption is reflected in a similar increase in the number of women who have sought professional help for substance abuse problems (Nuorvala et al.

¹ Low-to-moderate alcohol consumption is defined as a maximum of 84 grams of alcohol per week, which, in the UK, for instance, is up to 10.4 “standard units” per week and in the US amounts to seven “standard drinks” per week. The UK “standard unit” contains 8 grams of alcohol, while the US “standard drink” contains 12 grams of alcohol (Gray et al. 2009).

2008). This massive transformation in the relationship between women and alcohol has been attributed to the changes that have taken place in women's social roles in late-modernity, including de-traditionalisation, individualisation, urbanisation and increased gender equality in the labour-market, family roles and so on (Nätkin 2006ab).

In Finnish medical journals FAS was mentioned for the first time in a review article in 1979 (Sub-study II). The article stated that heavy alcohol consumption during pregnancy is linked to FAS but added that it has not been ruled out whether "moderate" or "irregular" alcohol intake during pregnancy would be harmful to the foetus. The problem was thus defined very broadly. The authors identified two key missions: preventing FAS and conducting prevalence studies in order to determine how commonplace the problem was. Prevention was to take place by providing information to all pregnant women about the dangers of heavy alcohol intake during pregnancy (Sub-study II). The Finnish press discovered FAS in the early 1980s, and media coverage increased from the late 1980's after the first Finnish medical studies on FAS were published (Nätkin 2006b). The first specialised prenatal clinic for women with alcohol problems was opened up in 1983 as a part of public maternity hospital, and in 1990 the first residential institution to be based on a psycho-social approach and provide services for pregnant women and mothers with alcohol problems came into existence in 1990 (Leppo 2008).

A figure that is very often quoted when the magnitude of prenatal substance abuse is discussed in Finland comes from Marjukka Pajulo's (2001) survey research findings. According to Pajulo (2001), six per cent of pregnant Finnish women were dependent on alcohol or drugs. Other figures frequently used when the incidence of FASD is discussed state that approximately 520 to 600 Finnish children annually are born with FASD (520 children annually equals one in 110 newborns); these figures are based on prevalence studies conducted in the US (Autti-Rämö and Ritvanen 2005, Raskaana olevien päihdeongelmaisten... 2009). Like many other people, I have also quoted these figures uncritically (Sub-study I). Recently, however, these widely used figures have been criticised by a prominent Finnish alcohol researcher, Klaus Mäkelä (2009), who argued that the figures are uncertain and very likely too high. According to Mäkelä (2009), Pajulo's study did not measure alcohol or drug dependency *during* pregnancy; it measured risky alcohol and drug use *before or during* pregnancy in a sample of pregnant women. Further, Mäkelä (2009) points out that the 1:1000 FASD incidence estimate from the US cannot simply be exported to the Finnish context: there are social and racial factors that may result in FASD incidence in Finland being lower than in the US.

Prenatal alcohol intake dominated the expert and media accounts of prenatal substance abuse until the late 1990s at which time concern for prenatal drug use increased (Leppo 2008). No reliable estimates exist for the number of pregnant women with drug problems; in the experience of

professionals the problems started to increase in the late 1990s (ibid.). This development was linked to a substantial increase in the experimentation and problem use of illicit drugs in the Finnish society during the latter half of the 1990s (Partanen and Metso 1999, Hakkarainen and Tigerstedt 2005). It was estimated that in 2002, there were 16,000 to 21,000 problem drug users in Finland amongst 15 to 55 year olds, which equals 0,6 to 0,7 per cent of the population in this age group. The estimate for opioid users in 2002 was 4,200 to 5,900 and for amphetamine users 10,900 to 18,500. Poly-substance use was very common and the above figures refer to the “main substance” used (*pääpäihde* in Finnish). According to the estimates approximately 15 to 20 per cent of problem drug users who used amphetamine and 25 per cent of those who used opioids as their “main substance” were women (Rönkä et al. 2006).

Opioid substitution treatment (ST) aims to replace illicit opioid use by the medicinally-controlled oral use of a synthetic opioid, namely, methadone or buprenorphine. The increasing use of ST has, at least in Finland and France, resulted in a phenomenon called “pharmaceutical leakage” (Lovell 2006), in which buprenorphine leaks onto the illicit market. Buprenorphine is a synthetic opioid manufactured and sold under different trade names such as Subutex and Subuxone. In Finland, amongst problem opioid users who had sought professional help, the use of buprenorphine has increased steadily since the late 1990s and by 2005 buprenorphine had nearly replaced heroin as the cause for seeking drug treatment (Rönkä et al. 2006.). In my data from the maternity clinic, for example, 26 per cent of the service users were primarily opioid users, and with very few exceptions they used Subutex, which they purchased illicitly.

2.2 REGULATION OF PRENATAL SUBSTANCE USE

Elisabeth Ettorre (1997) has noted that the field of alcohol studies has been consistently resistant to gender-sensitive perspectives. Similarly, Fiona Measham and her colleagues have argued that in the UK, drug policy tends to be male-oriented in terms of provision of information, treatment and services (Measham et al. 2011). However, during the last twenty years prenatal alcohol and drug use has motivated a number of researchers and policy-makers. Policy reactions to FASD and prenatal drug use differ according to particular cultures of state interventions (Drabble et al. 2009). In 1981 the United States Surgeon General issued a recommendation that pregnant women should not drink alcohol. Moira Plant (1997, 160-163) has raised the question of why such a recommendation was issued at a time when there was scientific data only for the potential harmfulness of *heavy* drinking during pregnancy and the recommendation was thus not based on scientific evidence. A similar argument has been made by Lee-Ann Kaskutas (1995) in her study of the role of scientific knowledge in the formation of a law passed

by the US Congress in 1988; the law required a health warning on alcoholic beverage containers stating that pregnant women should not drink alcohol. According to Kaskutas (1995), there was no scientific evidence to back up the assumption that moderate alcohol consumption put the foetus at risk: the warning label policy was not justified in the light of existing evidence.

Responses to prenatal substance abuse have been particularly punitive in some parts of the US; in many states pregnant women with alcohol or drug problems can be prosecuted for child abuse (Young 1994, Gomez 1997, Campbell 2000). By contrast, the emphasis in Canada has been more on inclusive welfare policies and public service provision (Drabble et al. 2009, Greaves and Poole 2006). Iris Marion Young (1994) has divided policies on prenatal substance abuse into punishment and treatment approaches, which aptly captures a crucial point of tension in the discourses and practices around the efforts to prevent harm caused by prenatal alcohol and drug abuse.

A key argument in the North American social science literature on FASD is that the alarm generated by FAS/FASD has generated has many of the characteristics of a moral panic. A moral panic refers to the proliferation of concern about a certain threat, which overstates the actual danger posed by the subject of the panic (Cohen 1972). It has been argued that in the US, FAS quickly gained the status of “a major threat to public health” and a severe social problem in part because it resonated with broader social concerns in the 1970s and 1980s about alcohol's deleterious effect on American society and the perceived increase in child abuse and neglect (Armstrong and Abel 2000). Further, Armstrong and Abel (2000) posit that, as concern about FAS escalated beyond the level warranted by the existing evidence, FAS took on the status of a moral panic (see also Kaskutas 1995, Armstrong 2003, Golden 2005, Drabble et al. 2009). The moral panic has also been interpreted as a reaction to anxiety about women's increased freedom and less traditional role in the society (Armstrong 2003). A similar argument about the exaggerated nature of the societal reaction has been made in the context of prenatal drug use (e.g. Campbell 2000). Another key finding in previous research is that controversies frame the responses to prenatal substance use: a consensus about the best course of action in the regulation of prenatal substance use has been hard to obtain (e.g. Kaskutas 1995, Campbell 2000, Armstrong 2003).

While previous research in this area has been very much about the study of discourses and societal responses to prenatal substance, previous studies also include a few explorations of women's perspectives on prenatal drug use. These studies have identified pregnant women's risk perceptions about different substances, their fear of authorities and child removal (Murphy and Rosenbaum 1999, Friedman and Alicea 2001, Jessup et al. 2003, Roberts and Nuru-Jeter 2010) as well as mothers' experiences of recreational drug use (Measham 2002). To my knowledge there is no previous research that

examines what actually takes place in institutional settings between professionals and pregnant women who have substance abuse problems.

In Finland the societal response to prenatal alcohol use and later to drug use during the last two decades has been based on providing health education to the entire pregnant population and providing public health and social services (Sub-studies II, III and IV). Prenatal substance abuse problems in Finland, as well as in the other Nordic countries, have been framed as a health and social welfare issue: there has been no debate on or incidents of the use of criminal justice to tackle the problem. This is not to say, however, that "treatment" and the provision of services are free of control and domination; the term drug or alcohol "management" is in this respect better than drug or alcohol "treatment" because it leaves open how care and control may be intertwined in service provision (Lovell, forthcoming).

In Finland, very few social science studies have been conducted on prenatal substance use. Nätkin (2006ab) has analysed the media reaction to FAS while Virokannas (2011) demonstrated that mothers with drug problems have suffered from negative attitudes from social work professionals and from fear of authorities (also Väyrynen 2007). Mäkelä (2009) has critically examined the Finnish FASD prevalence figures and their political use, as mentioned above.

The idea of compulsory treatment for pregnant women with substance abuse problems has been in the last decades debated in Finland and Denmark while Norway and Sweden already use compulsory measures (Mäkelä 2009, Hecksher 2009, Runqvist 2009, Stenius 2009, Leppo 2009). In 1996, after several attempts and amidst political controversy, the Norwegian Parliament accepted compulsory treatment for pregnant women when it appears probable that the substance abuse will cause damage to the foetus and when voluntary treatment is deemed insufficient (Søvig 2007, Lundeberg et al. 2010). In Finnish debates the advocates of compulsory measures have used Norway as a positive example. In Sweden compulsory treatment for pregnant substance-abusing women can only take place when the substance abuse seriously risks the woman's *own wellbeing*, i.e., Swedish legislation does not allow compulsory treatment on the grounds of a risk to the foetus (Runqvist 2009).

These examples of the uncertainties surrounding scientific evidence about FASD and the societal responses to it in the United States and the Nordic countries demonstrate that the regulation of alcohol and drug use in pregnancy poses a genuine dilemma for contemporary liberal societies. What should the expert recommendation be concerning alcohol intake during pregnancy? Is punishment or treatment the way to go if a woman continues to use substances? The problem of how to balance individual freedom with the public good of is by no means easy and becomes even more complicated when the foetus is added to the equation.

3 THEORETICAL FRAMEWORK: SOCIOLOGIES OF RISK

In all historical times and socio-cultural contexts people have developed ways of dealing with danger, hazard and fear. Risk has become a focus for much contemporary research in sociology and across the social sciences (e.g. Lupton 1999a, Caplan 2000, Zinn and Taylor-Gooby 2006). It is not, however, always clear what is meant by "risk". In fact, different approaches to risk have very little in common and define the term differently (Garland 2003). The present summary draws theoretical inspiration from two different perspectives on the construction and regulation of risk. Mary Douglas's anthropological approach to risk and the more recent socio-cultural approaches facilitate the understanding of why prenatal substance use has become such a prominent issue and why the risks related to it are understood differently by different actors. Secondly, the governmentality approach is useful in thinking about how risks are regulated and how power can be used in contemporary societies.

3.1 RISK AS A MORAL DANGER

The way in which pregnant women's use of substances has triggered intense moral concern or moral panic is best understood in light of the cultural theorising about the symbolic functions of risks. Douglas introduced her novel perspective to risk theorising in the 1980s, at a time when analysis of risk was dominated by technical-scientific and cognitive-rational approaches. Douglas asked why "risk" had become so prominent, replacing "danger" in the vocabulary of the western countries, and found the answer in the idea that "risk could have been custom-made. Its universalising terminology, its abstractness, its power of condensation, its scientificity, its connection with objective analysis, make it perfect" (Douglas 1992, 15). In other words, "risk" in the western context is a more convincing term for things deemed potential hazards than the terms "threat" or "danger", which lack the aura of scientific objectivity. Douglas did not, however, deny the reality of dangers; she emphasised that her cultural approach is not about the reality of dangers but about how only certain issues are politicised and considered worthy of our attention (Douglas 1992).

According to Douglas, debate on risk "always links some real danger and some disapproved behaviour, coding the danger in terms of a threat to a valued institution." (1992, 29). No one can worry about all potential risks at the same time, and therefore dangers need to be ranked. But there are no value-free processes for choosing between risky alternatives; however detailed information there may be about the probability of different risks.

“Selection” of risk is always a political and moral issue. In politics, Douglas (1992, 46) argues, the notion of “danger” would in fact be sufficient and actually more appropriate than “risk” because political decisions between different types of risks are not made solely on the basis of probability calculations and scientific evidence, even when such evidence exists. In fact, Douglas uses the concept of “risk” as an equivalent for “danger”, and her point in choosing that term seems to be that she wants to underline how contemporary societies like the illusion that they are approaching threats objectively and rationally, on the basis of scientific evidence and calculability.

Douglas, in collaboration with Aaron Wildavsky, underlined the nature of risk as a moral danger that binds a community together and draws its boundaries. She drew attention to the distinction between the self and the other as a central feature of any culture (Douglas and Wildavsky 1982, Douglas 1992). Douglas’s analysis of risk in modern secularised societies is equivalent to her understanding of the symbolic functions of dangers in more primitive societies. Zinn (2008, 169) sums up Douglas’s outlook on the symbolic function of dangers in a given community as follows:

Concerns regarding dirt and pollution are less about bacteria, viruses or pollutants than about socio-symbolic disorder and the lack of control of a group’s boundaries. The control of the body and its margins serves as a symbol for controlling the rules which constitute a social group. Dangers become important for a community as a threat to its boundaries, orders and values.

Ian Hacking (2003) writes in a similar vein about risk in the context of crime: the risk of crime is not only about actual loss, but also entails central values such as the sanctity of property, privacy and liberty. According to Hacking, reaction to crime thus extends beyond the actual harm done and includes punishment of symbolic pollution to sustain a sense of purity. In order for a given danger to be viewed as a major risk, it needs to be viewed as pollution, that is, a threat to purity.

3.2 SITUATED RISK

Douglas’s and Wildavsky’s (1982, 8) notion of how “common values lead to common fears” underlines the intertwined nature of shared moral values and perception of dangers. Douglas approached risk from the opposite direction compared to the then-dominant paradigms of mainstream cognitive psychology and economics: she moved from societal structures to the level of the individual, rather than the other way around (Douglas and Wildavsky 1982). According to Douglas, the selection of dangers and the strategies for managing them are not objective, but rather the results of social and cultural processes: “between private subjective perception, and public physical science there lies culture, a middle area of shared beliefs and values”

(Douglas and Wildavsky 1982, 194). Whilst Douglas's cultural theory of risk perception has been highly influential it has also been criticised for being overtly functionalist, inconsistent, and not particularly useful for empirical research (Boholm 1996).

Research on how lay-people understand risk is generally known as risk perception research. The notion of "risk perception", however, originated in psychology and has been criticised by social scientists for first of all building on the dichotomy between objective and subjective notions of risk, and further, for treating people as atomised individuals, equating cognitive judgements with emotional or other responses and ignoring the specific social contexts in which people face and deal with risks (Horlick-Jones and Prades 2009, Wilkinson 2001). Sociological studies on risk perception seek to overcome these shortcomings by addressing the social dynamics of risk perception. Many researchers in this area have drawn attention to the differences or even to a "gulf" between expert and lay understandings of risk (Horlick-Jones and Prades 2009).

Recent constructionist studies on risk perception inspired by Douglas's work and the so-called cultural turn in social sciences have focused on the meanings and significance of risk for "non-experts" or "lay-people" (Caplan 2000, Tulloch and Lupton 2003, Horlick-Jones and Prades 2009). This perspective "acknowledges that understandings about risk, and therefore the ways in which risk is dealt with and experienced in everyday life, are inevitably developed via membership of cultures and subcultures as well as through personal experience." (Tulloch and Lupton 2003, 1). According to Zinn (2008, 182), risk research inspired by the cultural turn prioritises "thick descriptions" of everyday sense making of the world.

Åsa Boholm (1996, 2003) points out that an analytical distinction guiding many of the early studies on risk since the 1970s was the division between "objective risks" (based on statistical calculations of the probabilities of adverse events) and "perceived risk" (how people understand such adverse events). Boholm (2003, 165), however, posits that an alternative is needed for the "sterile dichotomy" between "objective" and "subjective"/"culturally constructed" risks, and argues that risks are not simply objective nor subjective.

In search of a characterisation of risk that acknowledges the amalgamation of objective and subjective, Boholm turns to sociologist Gene Rosa's definition of risk as "a situation or event where something of human value (including humans themselves) has been put at a stake and where the outcome is uncertain" (Rosa 1998, 28, quoted in Boholm 2003, 166). In other words, "the concept of risk addresses situations when people are aware that there is a possibility of threat to something that is of value" (Boholm 2003, 166). From this perspective, Boholm suggests, it makes sense to ask how people identify, understand and manage uncertainty. Further, "there is no simple translation from the way in which experts define and estimate risks ...

to “situated risk”, that is to say, risks as they are actually understood and contextualised by people in social settings” (ibid., 166).

With the concept of “situated risk” Boholm (2003) sought to put risk in a specific context and underline that risk is not an intrinsic property of things: our notions of risk are shaped by social and power relations, cultural beliefs, trust in institutions and science, knowledge, experience, discourses, practices and collective memories. In a more recent “relational theory of risk” that builds on Boholm’s earlier work, Boholm and Corvellec (2010, 9) argue that risk is a matter of connecting things: a “risk object” is an artefact that is designated “dangerous” (natural phenomena, manufactured products, cultural representations or behaviours) because a causal relationship has been established by an observer (e.g. a scientist, local resident, patient, or journalist) between the risk object and an “object at risk”, which is something that is considered to be of worth and, moreover, is something perceived as being vulnerable and in need of protection (Boholm and Corvellec 2010). What we understand as a risk comes into being in the *relationships* established between risk objects and objects at risk; what is a risk object for one person may be an object at risk for another (ibid.). Once an individual’s behaviour has been defined as constituting a risk, what should be done about it in order to protect the valued object at risk? Boholm and Corvellec (2010, 9) posit that risk definitions “introduce moral orders of blame and a corresponding order of governmentality.”

3.3 GOVERNING RISKS

Studies building on the notion of government analyse “the shifting ambitions and concerns of all those social authorities that have sought to administer the lives of individuals and associations” (Miller and Rose 1990, 1). Government, or the “conduct of conduct”, refers to all more or less rationalised endeavours to shape and guide the conduct of others so as to achieve certain ends; it also involves the ways in which one is urged and educated to govern oneself (Rose 1999, 3, Helén 2000). A starting point for studies of government was the notion that political power cannot be reduced to the actions of the state, but attention needs to be drawn to the diversity of powers and knowledges that tries to regulate the lives of individuals and populations (Miller and Rose 1990, Helén 2000).

Government is not only a matter of representation, but also of intervention: “political rationalities” render reality into the domain of thought, while “technologies of government seek to translate thought into the domain of reality, and to establish ‘in the world of persons and things’ spaces and devices for acting upon those entities of which they dream and scheme.” (Miller and Rose 1990, 8). In other words, “technology” refers to the instrumentalisation of government, the activity of ruling through mundane

activities such as the schoolroom, techniques of calculation, the invention of devices such as surveys and so on (ibid., Rose 1999).

Studies following this tradition tend to analyse programmatic statements, policy documents, pamphlets and the like and to look back in history, tracing the genealogy of the ways in which certain issues are problematised and acted on. Governmentality studies prioritise the study of language and discourse, because "it is through language that governmental fields are composed, rendered thinkable and manageable." (Miller and Rose 1990, 7).

Miller and Rose (1990, 2) have suggested that in advanced liberalism political power is characterised by "indirect" and "at a distance" mechanisms for aligning people's conduct with socio-political objectives. Such "action at a distance mechanisms" rely upon "expertise" and the self-regulating capacities of subjects (ibid.). Expertise refers here to "the social authority ascribed to particular agents and forms of judgement on the basis of their claims to possess specialized truths and rare powers." (ibid., 2). Further, "the self-regulating capacities of subjects, shaped and normalized in large parts through the powers of expertise, have become key resources for modern forms of government and have established some crucial conditions for governing in a liberal democratic way." (ibid, 2).

Not so long ago, the strong Nordic welfare states had the moral authority to regulate such things as family life, reproduction and alcohol use with interventionist and/or harsh measures such as detailed advice about parenting, sterilisation of deviant women and long-term incarcerations of alcoholics (Sulkunen 2009). Since the 1960s and 1970s, however, such normative state control has lost its mandate and has been replaced by new methods. Sulkunen (2011) has called this development the victory of the principle of individual autonomy over the authoritarian and normative state: "the moral consensus about the good modern life, on which modern welfare states were constructed, has disappeared" (Sulkunen 2009, 139). Hence, the state no longer has the mandate to determine the good life for individuals. The increased freedom of choice over one's life-course in today's affluent societies has, however, posed a new problem for social coordination: how does a society that places a high value on freedom of choice deal with the consequences of unhealthy or otherwise risky lifestyle choices (Rose 1999, Sulkunen 2009)?

What the welfare state has left, according to Sulkunen (2009), is the mandate to protect people, especially innocent victims, from the adverse outcomes of other people's risky choices and lifestyles. A good example of this is the effort to reduce passive smoking in order to protect innocent bystanders: while health authorities cannot ban smoking, they can take steps to reduce the harm caused to others (ibid). Here Sulkunen draws on Garland (2001, 121-122), who has posited that the criminal justice system used to focus on the rehabilitation of offenders in the interest of the public and the offenders, whereas today the focus has shifted to serve the interests of

individual victims. Further, in criminal justice the emphasis on the victim's point of view is related to increasingly punitive policies (ibid.).

Within studies of government, the concept of risk is understood very differently from the socio-cultural tradition: the former understands risk as a specific way to manage dangers on the population level through calculative technologies (Dean 1999, 166). According to Robert Castel (1991, 289), modernity is obsessed with preventing risks through rationality and calculative reason building on "a grandiose technocratic rationalizing dream of absolute control of the accidental". The idea of risk involves multiple "responsibilisation" of individuals, families and communities for their own risks (ibid.). The primary focus, however, remains on the population (Dean 1999, 167). The responsibilisation of individuals gives a pronounced role to the professions as calculators and managers of risk (Rose 1999). The idea of risk as a way of governing populations through calculative technologies is useful for the purposes of the present study in that it helps to understand the logic of maternity care and the contemporary regulation of pregnancy more generally, which will be discussed briefly.

Professions increasingly approach "targeted populations" such as the unemployed or intravenous drug users with what Mitchell Dean (1999, 168) has called "technologies of agency", which engage these groups as active and free citizens who can be capable of managing their own risk. A good example of this phenomenon is the so-called harm reduction approach in the management of intravenous drug use where the aim of professional interventions is not to take a moral stand on drug use as such, but rather to help drug users minimise its harms (Tammi 2004, Perälä forthcoming). According to Dean (1999, 131-138), much of the literature on governmentality has stressed how the programmatic character of liberal government appeals to a notion of the subject as being active in its own government. Within liberal forms of government there is, however, a long history of people who are denied the status of juridical and political subject and subjected to all sorts of interventions. These groups, such as the feeble-minded and the minor, have been deemed as lacking the attributes of autonomy and responsibility required of citizens. Dean (1999, 131) coined the term "authoritarian government" to refer to non-liberal practices and rationalities of governing, that is, explicitly authoritarian types of rule that "seek to operate through obedient rather than free subjects". Such a government can make use of practices such as surveillance, coercion, confinement, strict disciplinary routines, forced labour and systems of punishment. Dean concludes that "liberalism always contains the possibility of non-liberal interventions into the lives of those" (1999, 137) who "are deemed not to possess or to display the attributes (e.g. autonomy, responsibility) required of the juridical and political subject of right" (1999, 134). Governing liberally thus does not necessarily entail governing through freedom or even in a manner that respects individual liberty.

3.4 GOVERNING PREGNANCY

It has been argued that women's sexuality and reproductive capacity have become particularly active sites of new risk technologies (Weir 1996, Ruhl 1999, Lupton 1999b, also O'Malley 2004, 8). Many studies have critically addressed the meaning of risk established through the proliferation of technologies of prenatal diagnosis (e.g. Rapp 1988, Rothman 1994, Helén 2002, Jallinoja 2002, Meskus 2009). Pregnancy has become a site of increasing risk talk; in fact, Ruhl (1999) notes how remarkable it is that pregnancy is currently defined in terms of potential risk even before it has started – and once the pregnancy has started, there seems to be no such thing as a “no-risk” pregnancy.

David Armstrong (1995) characterises twentieth-century medical practice as “surveillance medicine” in order to emphasise its nature as social control and to point out how it locates risks in populations and aims at regulating and monitoring the entire population through health promotion and extensive screening programmes. Armstrong's notion of surveillance medicine is an apt characterisation when it comes to maternity services: health promotion and wide-ranging screening programmes are at the very core of maternity services. Weir (1996) argues that recent changes in the government of pregnancy and human procreation more generally provide a rich site for governance studies. During the twentieth century pregnancy became densely regulated under the category of risk. Population-based risk techniques focused on the foetus in three principle forms: standardised risk assessment and routine prenatal screening tests for all pregnant women and prenatal diagnostic testing for some pregnant women based on indications of increased risk (*ibid.*).

Weir (1996) argues that the pregnancy risk technologies have similarities to risk technologies that estimate and manage risks over populations. However, Weir uses the term “clinical risk technique” to describe contemporary governance of pregnancy and argues that it is distinct from aggregate risk technologies because clinical risk attaches risk directly to individual bodies. Maternity services deal with individual women while the underlying idea that structures maternity services is based on epidemiological calculations of the incidence of certain risks in the pregnant population.

According to Lealle Ruhl (1999), the dominant, contemporary method of regulating reproduction relies on liberal governance and is thus far from being crude and punitive. Liberal governance of pregnancy, continues Ruhl, mobilises a discourse of risk prevention and reduction. The risk discourses are linked to an emphasis on responsible maternity, that is, a woman's responsibility for foetal health. Responsibility means behaving rationally, or in other words, calculating expected benefits and risks. Moreover, behaving responsibly is viewed as a moral act (*ibid.*). The quest for responsible motherhood feeds self-discipline, which in the Foucauldian approach is seen

as a form of regulation, that is, self-regulation (Ruhl 1999). Queniert (1992) argues that a sense of personal responsibility accompanied by self-blame has come to characterise the experience of pregnancy. Borrowing terminology from Pat O'Malley's (1992) work on crime control, Ruhl (1999) calls the contemporary method of pregnancy regulation the model of "individualised risk" as opposed to a "social insurance model of risk". The latter emphasises the need to average out risks across all classes of society, e.g. through unemployment or health insurance whilst the first emphasises individual responsibility and action.

According to Sirpa Wrede (1997), prenatal care provided at Finnish maternity centres initially, in the late 1930s, focused primarily on diminishing mortality among mothers and their children. The prevention of problems was tied to signs of pathology, and the focus was on medical complications in pregnancy or childbirth and the social problems that may affect the health of the mother (e.g. poverty or deviance). In the late 1960s the concept of risk emerged, which implied a shift of focus from the search for symptoms of individuals to the identification of risk groups (Wrede 1997). In the 1980s risk assessment became more commonplace and was discussed in terms of a dual strategy focused on social and medical risks. Concern for "families-at-risk" and their risky life conditions appeared, and the management of social risks was given a major role in the national maternity health policy. It was suggested that the maternity services should collaborate more closely with the other control agents in society. According to Wrede (1997), "by means of risk management the medicalisation of pregnancy extends to the future, and the medical gaze on all pregnant women – and their families – is legitimized in the name of health promotion" (ibid, 167). In other words, the increased emphasis on prevention in maternity services justifies the increased control of pregnant women's lives.

4 RESEARCH PROCESS, METHODS AND MATERIALS

In this chapter I will provide information about the method, research materials and analysis used in this study and describe how the research process evolved. Originally, the question of prenatal alcohol abuse and FASD prevention caught my attention through media reports; as a sociologist interested in gender, power and professional interventions into substance abuse, I found the whole phenomenon fascinating. In 2005 I was given the chance to join a large ethnographic research project on the cultural aspects of health care services, the everyday delivery of these services and the perspectives of those who used the services (Honkasalo 2003). I needed to choose a PhD topic in the area of health care services, and I decided to conduct an ethnographic case-study of the regulation of FASD in maternity care, specifically, at a specialised outpatient maternity clinic which provided prenatal services to women with alcohol and drug problems.

4.1 MULTI-SITED ETHNOGRAPHY

Methodologically the present study makes use of the principles of an anthropological approach called multi-sited ethnography (Marcus 1986, 1995, Hannerz 2003). "Multi-sitedness" was not, however, originally a part of the research design. I set out with the intention of conducting a single-site ethnographic study of the aforementioned maternity clinic. During the research process, however, I ended up gathering data outside the confines of the maternity clinic and gradually started to think of my approach in terms of multi-sited ethnography. I will begin this chapter by briefly sketching out the general principles of ethnographic inquiry and what a multi-sited approach adds.

According to medical anthropologist Marja-Liisa Honkasalo (2008), the ethnographic approach can be boiled down to the presence of four activities or intellectual tendencies: doing fieldwork, carefully contextualising the studied phenomenon in the local social world, focusing on the *meaning* of things to the participants and, finally, producing "thick descriptions" of the studied phenomenon. Doing fieldwork and focusing on meanings are at the core of ethnographic interest in the day-to-day, the desire to acquire an intimate knowledge of everyday actions and meanings through face-to-face encounters. "Thick description" is how the nuanced and detailed style of ethnographic analysis and writing has been classically characterised by Clifford Geertz (1973).

In classical anthropological studies the anthropologist travelled to a far-away place, immersed herself deeply in the daily life of a given community

for at least a year and afterwards produced a holistic account of the chosen primitive society, carefully contextualising the findings regarding meaning-making in everyday activities in the wider social and cultural structures. The anthropologist's engagement with his chosen field had an exclusive nature. By contrast in the classic ethnographic approach, a considerable amount of ethnography within anthropology today is conducted "at home" (e.g. Ådahl 2007, Honkasalo 2006, 2009) or at multiple sites.

What is now known as multi-sited ethnography first gained wider recognition in anthropology in the writings of George Marcus (1986, 1995). Marcus (1995) linked the emergence of multi-sited ethnography with ideas and concepts connected with postmodernism. More importantly, he saw it as a response to empirical changes in the world. According to Marcus (1995, 96), multi-sited ethnography "moves out of the single sites and local situations of conventional ethnographic research designs to examine the circulation of cultural meanings, objects, and identities in diffuse time-space" and takes "unexpected trajectories in tracing cultural formation across and within multiple sites of activity". Ulf Hannerz (2003, 207) has also characterised unexpectedness as a recurrent quality of multi-site studies: to an extent site selection is made "gradually and cumulatively, as new insights develop, as opportunities come into sight, and to some extent by chance." According to Marcus (1995), multi-sited ethnography focuses on the life worlds of situated subjects at the same time as it looks at aspects of the system itself through the associations and connections it suggested among sites.

"Being there", i.e. doing fieldwork, has been a key component of the ethnographic method and writing (Geertz (1988) and, in acknowledgement of this, Hannerz (2003) characterises multi-sited ethnography as "being there... and there...and there!" The key feature of multi-site studies, in Hannerz's (2003, 206) view, is "that they draw on some problem, some formulation of a topic, which is significantly translocal, not to be confined within some single place. The sites are connected with one another in such ways that the relationships between them are as important to this formulation as the relationships within them; the fields are not some mere collection of local units."

Ethnographic fieldwork is based on the idea that there is a time factor involved in how relationships evolve, which explains the ideal of long-term fieldwork. By contrast, in multi-site studies conducted in a modern setting, fieldwork usually takes place in shorter and more episodic sequences (Hannerz 2003). Multi-site studies acknowledge that contemporary lives are segmented and often transnational. For instance, if work is most central to the line of inquiry, then other aspects are less so: the ethnographer's ambition is less holistic than in the classical model and relationships with informants can be less personal (Hannerz 2003, Marcus 1995).

In comparison to anthropology the status of the classical anthropological model has not been as strong in sociology where less intensive and exclusive

ethnographic fieldwork conducted in the sociologist's own country has been an accepted mode of inquiry, for example, in the studies conducted by the well-known Chicago School of sociology. Because of this less rigid understanding of ethnography, multi-sited ethnography has not evoked similar "methodological anxieties" (Marcus 1995) within sociology as has been the case within anthropology.

After doing fieldwork at the maternity clinic, including interviews with staff and clients, and analysing the data, I decided to collect two other datasets. Instead of new geographical locations for ethnographic fieldwork, however, these new fields consisted of texts dealing with the regulation of prenatal alcohol intake, namely medical journals, political documents and health education materials for pregnant women. After collecting all the data that I was to use in the present study, I started to think that my approach resembled the logic of multi-sited research, even though I did not intentionally pursue a multi-sited project in the sense of conducting ethnographic fieldwork in different geographical locations. Instead, I think of the maternity clinic as well as the texts that I analysed as the multiple fields of the present study. I approached the maternity clinic by immersing myself in ethnographic fieldwork, while the other fields, that is, the different types of texts, were approached by diligent reading and re-reading in an effort to get to know the texts, understand them and, finally, to attempt to produce "thick descriptions" of them. Ethnographic studies regularly make use of textual materials in order to contextualise the studied phenomenon in time and place. In the present study, however, I think of the text materials as more than mere contextualisation: the texts are in the focus of my research in their own right. Further, the fact that two of the sub-studies are jointly written and comparative in nature adds to the "multi-sitedness" of my project. The analysis of a low-threshold outpatient service for injecting drug users and the analysis of Danish health education materials in the first sub-study add two new fields.

Why did I not stick to the single-site approach on which my original research design was based? When starting fieldwork at the maternity clinic, I assumed that the clinic's clients were predominantly pregnant women with alcohol problems, and my aim was to scrutinise the everyday practices and encounters around FASD prevention. The clients were, however, predominantly drug users – surprising, given that the public debate on prenatal substance abuse had focused on the urgency of FASD prevention and given that, in Finland, heavy drinking is much more commonplace than problematic drug use. It started to look like prenatal drug use was claiming a bigger role in the study than I had planned, and when the opportunity came, it seemed reasonable to acquire additional data specifically on pregnancy and alcohol use. Secondly, a coincidence that prodded me to generate data outside the clinic was that a public debate in the media on FASD prevention surfaced just as I started fieldwork at the clinic. I felt strongly that this debate on compulsory treatment was worth sociological scrutiny.

Marcus (1995) suggested six specific techniques for the design of a multi-sited ethnography based on *following* – in a pre-planned or more accidental manner – people, a thing, a metaphor, a story, a biography or a conflict. For instance, following a thing (e.g. a commodity, a gift, money or intellectual property) means tracing the circulation of a material object through different contexts. The present study started with the aspiration to focus on the day-to-day practices of FASD prevention at a specialised maternity clinic, but it turned into a more complex trajectory scrutinising the ways in which alcohol and drug related foetal harm and its minimisation are thought about and acted upon in various locations of contemporary Finnish society. In hindsight, using Marcus's terminology, I see my itinerary as following a conflict, namely, tracing some of the controversies and tensions that structure the regulation of prenatal substance use in contemporary Finland.

The present study focuses on daily life at a specialised maternity clinic, health education material targeting pregnant women, medical and political discourses on FASD prevention and, finally, the views and experiences of pregnant drug-using women. The data-sets consist of fieldnotes from the maternity clinic, including interviews with the staff and pregnant women, and different types of texts that deal with the prevention of alcohol-related foetal harm. In the following sections the generation and analysis of each dataset is described in more detail. The description follows chronologically the itinerary I followed and explains the logic behind the use of the different types of data. The story begins at a maternity clinic located in southern Finland.

4.2 PARTICIPANT OBSERVATION: DAILY LIFE AT THE CLINIC

Because the findings that were based on the data from the maternity clinic are reported in two concise articles (sub-studies III and IV) rather than in an extensive monograph, the reader obtains only a very narrow picture of daily life at the clinic. Before I describe my fieldwork there in more detail, I want to provide a glimpse of daily life at the clinic and what my fieldwork consisted of. The following description depicts how I, as an outsider, experienced the clinic in the very early stages of my fieldwork. The description is not, however, a direct quotation from my fieldnotes on one particular day; rather I have combined shorter episodes from notes written during the first few weeks at the clinic. This way I hope to give the reader a rich picture of the wide array of activities that took place during the fieldwork. I have edited episodes slightly and shortened them to make the text more readable and more concise. In ethnographic studies a monograph usually begins with an "arrival story" in which the ethnographer describes and analyses his or her arrival in the field. The arrival story serves to underline the authority of the ethnographer as someone who has actually

“been there” (Pratt 1986). The following description introduces the reader to the maternity clinic as well as to my role there and serves as my arrival story:

When I get to the clinic at 8 am in the morning, Riitta [a nurse] is speaking on the phone about a woman who has recently given birth. Riitta says that this woman should be kept on the ward because a urine sample is needed [for drug testing]; the sample should have been taken but it has not been done for some reason; if the woman has used drugs recently, the child protection social workers need evidence. Riitta is talking to a nurse from the hospital's maternity ward where the mother and newborn are at the moment. After the call Riitta explains to me that this mother is a particularly difficult case as she has used amphetamines throughout her pregnancy; usually, the treatment of amphetamine users is quite successful but not with this mother. “It will be pretty bad if she gets to go home with the baby”, Riitta says. She shows me some jokes she has been sent by e-mail, and she says; “These jokes help; the job can be pretty hard-going.”

Meeting with a client at 9 am. I ask Piia [born in 1971] if I could come along when she has her appointment with the nurse, and Piia says, “Of course”. The nurse has already told me that Piia became pregnant in the summer: at the time she was having a relapse after two years of opioid substitution treatment, and she was using amphetamines and benzodiazepines. It is a bit tense in the small room where the appointment takes place: during the appointment the nurse's phone rings twice, and later the other nurse walks in and asks something. Afterwards I say to Maria [the nurse] that Piia seemed to be very motivated, and Maria replies that Piia is motivated but she has a very long history of drug use and the timing of her relapse was really bad: it took place in the beginning of the pregnancy. First Piia chats about recent events in her life; she explains that she just got her driving license back, etc. Then Maria brings the chatting to an end by asking if there is something in particular that Piia would like to talk about today, and Piia says, “No, not really”. During the appointment Piia says more than once that she is worried about the baby's well-being: what if there is something wrong in the ultra sound examination next week? What if the newborn has withdrawal symptoms? Maria keeps very calm and sticks to the facts: it is likely that there will be withdrawal symptoms; the ultra sound examination very rarely reveals any abnormalities, but it is possible that the child will have some sort of learning difficulties later on. Although Maria is very friendly and easy-going, I'm wondering if Maria could be a bit more reassuring and supportive and try to help Piia with her feelings of guilt. Piia asks how Subutex affects the foetus; she has a friend who does not want to reveal her identity or seek treatment, but who needs some information. Maria says that the friend can phone the clinic anonymously and ask for advice, but she

can't get an appointment anonymously. Piia wants to talk about her dosage in the opioid substitution treatment programme; she says that a smaller dose might be enough for her, and Maria says that Piia should go to the physician who is in charge of her substitution treatment; some women manage to gradually lower the dose during pregnancy, but there is always the risk of a relapse.

I take a short break and go to the staff coffee room to write notes, as there were no clients or immediate appointments. I get back to the nurses' office at 11.30 and hear that I've missed Maija, who had an appointment at 12.30, but came early. I'm really annoyed that I've missed her. I say to Maria [the nurse] that they are very flexible with the timetables. Maria says that when they can afford it, they are flexible, usually when there are no obstetrician's appointments and the clinic is kind of quiet; when an obstetrician is around the schedule is tighter and there is less room for flexibility. Maria says that if these mothers attended the regular maternity clinic there would be total chaos, because they are often late etc.; the regular maternity clinic only allows only 20 minutes for each appointment. Riitta [the other nurse] adds,; "We also phone our mothers if they've missed an appointment."

Maria asks if I want to go along to a weekly "social work meeting", where physicians and nurses from the maternity hospital wards and the maternity clinics meet up with the hospital's social workers in order to discuss "social work cases". I don't know anybody apart from Maria. I find that the physicians are a bit arrogant when they talk about the patients which makes me feel a bit awkward. Afterwards I hear some of the physicians talking in a critical manner about the municipal child protection social workers, who, according to the physicians, seem to think that biological parents are always the best thing for a child: the parents have very strong rights, while the fetus has none.

Back in the nurses' office. There is a phone call from the hospital's obstetrician ward: the nurse from this ward explains to Maria that Netta, a client of the specialised clinic, has been in the ward for most of the weekend because she has contractions. She's in week 38 and is scheduled for a caesarian on the following week for medical reasons. Maria asks if I want to go along when she goes to see Netta on the ward. We walk down the long underground corridors, get to the ward, and Maria introduces me to Netta and I ask if it's okay if I'm there too. Netta is in the room alone, she is lying in a bed and has monitoring equipment on her big belly; she seems to be in pain. She looks very cute and young.

Maria asks how Netta is doing and pats her belly. Netta is uncomfortable because of the pain of the contractions and she finds it very frustrating to be stuck on the ward when she has a lot to do: she

needs to get her stuff from storage so that somebody could help her move it all into her new flat. Netta is very happy about the new apartment. Netta says that she would like to hold the baby for a while after it has been born but Maria explains that the baby will be taken straight away to the neonatal ward for special monitoring because it is easier for the mother that way, and the mother can go and see the baby as soon as she can get up. I recall reading somewhere that a Scottish obstetrician criticised the practice of automatically taking a newborn from a drug-using mother to a special monitoring ward to determine if something is wrong: the baby should be taken to the neonatal ward only if there are signs of something abnormal such as withdrawal symptoms, not as a precaution. Maria leaves the room in order to talk to the obstetrician about Netta.

I ask if Netta knows whether she's having a boy or a girl. Netta says it's a girl and tells me she has bought blue and green clothes for the baby because these are her favourite colours. I ask about the renovations in the new flat and Netta tells me about it. An obstetrician arrives with the nurse; Netta asks her about breast-feeding and the obstetrician says that if the virus count of Hepatitis C is very high, breast-feeding is not recommended. Later on the nurse mentions to me that in the US women with Hepatitis C are encouraged to breast-feed; the logic is that the Hepatitis C is not easily passed on via breast milk.

Back in the nurses' office. The phone rings. I gather that the caller has a daughter who is pregnant and opioid dependent. Riitta [the nurse] starts by saying: "You've phoned a specialised maternity clinic, we provide services to pregnant women with substance abuse problems." And: "I can't breach confidentiality, I can't talk about the clients or tell you if your daughter is our client." The phone call goes on for quite some time. Riitta explains on the phone that at the clinic they try to map out the mother's situation and they monitor the pregnancy. Riitta: "That's right, our physician does bring up abortion as one option if the pregnant woman's situation is particularly difficult, but our clients rarely want an abortion because drug users see the baby and the pregnancy as a good chance for something new." I'm thinking that pregnancy is an opportunity for something new for all of us, whether or not we have drug problems. Riitta says that if the daughter gets her Subutex from Tallin, then that is regarded as illicit use, even if she gets the drug from a clinic and with a prescription. Riitta explains to the caller that there aren't many studies on how Subutex affects the development of the child; they may suffer from withdrawal symptoms after birth but apart from that the babies she has encountered have seemed fine.

A client who had an appointment at 2 pm never turned up or cancelled the appointment. Maria [the nurse] says to me: "It's so frustrating when they don't turn up, and it happens a lot." Maria's

mobile rings again. Somebody from a local maternity centre needs to know something about a client, Johanna. I gather from the phone call that Johanna would like to try an outpatient Subutex detoxification at the specialised clinic and it seems that Johanna has missed her appointment at the maternity centre and the caller is worried.

A new client, 24 years old, comes for her first appointment. She is polite and pretty, but somewhat pale, and she wears nice, neat clothes. She explains that a really nice nurse at a low-threshold health counselling and needle exchange service told her to come to the specialised maternity clinic and got her referred there. Riitta asks questions and fills in a form; this interview takes over half an hour, and among other things Riitta tells the client that she should think about abstinence and would benefit from drug treatment.

Riitta's phone rings again. Somebody from a drug treatment institution wants to organise a meeting.

We go back to the ward to see Netta. Maria [the nurse] wants to talk to her about contraception. Maria asks if Netta is still happy with the idea of a contraceptive implant, but Netta hesitates and says that she is not sure. Netta says that she definitely does not want a coil because she is against abortions, and having a coil is the same thing as having an abortion because fertilisation has already taken place. Maria says that early miscarriages happen all the time, even before one knows about the pregnancy, so what happens with a coil is nothing unnatural as such. Maria adds that there are other options, for example, the implant. The conversation goes on, but no decisions are made. Afterwards we return to the nurses' office, and Maria goes on the computer and starts typing. I start to write down recent events in my notebook.

Riitta talks on the phone about a client. Riitta says,: "She has abstained from alcohol and I actually believe her. Her husband has been here too." The call goes on for 5 minutes or so. Riitta says to me afterwards,: "The nurses at the local maternity centres need quite a lot of support, and they want to share things with us. They are not necessarily familiar with substance misusers, and they will be responsible for monitoring the baby's health and well-being in the long run if the baby goes home with the mother."

Viivi and her partner arrive at 3 pm. Maria [the nurse] takes her blood pressure and asks about the results of her liver tests. Viivi and her partner, both Subutex users, talk about the results; they seem to know a lot about the topic and they are pleased that Viivi's results are good at the moment. Viivi is really sweet and very young. She is in inpatient drug treatment for the 5th week. This is a purely "medical" visit as the main subject is Viivi's blood pressure. The obstetrician

enters the nurses' office and says that Viivi needs medication for her blood pressure.

After Viivi has left, Maria mentions to us (me, Riitta and the obstetrician) that another client, Anna, had phoned yesterday and been very anxious because her partner, who suffers from severe depression, is doing very badly and his medication does not seem to help. Anna was asking where she could get help. Maria says to us that she couldn't help Anna much; all she could say was that they need to go to their local health centre, where they have to give the partner an appointment. Riitta recalls that Anna's partner used to visit a psychiatric nurse someplace else. Maria says that seeing a nurse is no use just now if his medication needs to be altered. I feel unbelievably tired; the nurses will leave soon and there are no more appointments left.

The maternity clinic where I conducted ethnographic fieldwork belonged to specialised care and was located in a large hospital in southern Finland. I entered the maternity clinic after time-consuming, but smooth negotiations with the gate-keepers. The gate-keepers agreed with me that permission from the hospital's ethical board was not needed, as my study made no interventions into patients' bodies and did not include the use of confidential patient records. This saved me a great deal of time. In addition the maternity clinic in question had a simple staff structure in that the two nurses, the obstetrician and part-time social workers formed their own unit. Once their boss had agreed to the study, there was no need to negotiate the entry with anyone else.

Following the Nordic model of public health and social services, Finnish maternity care is based on public funding and guided by the principle of equal and universal access. Local maternity care centres are run by municipalities and provide primary healthcare for pregnant women in the form of regular medical check-ups conducted by a public health nurse or a midwife and, less frequently, by a physician. Maternity care services are available free of charge to all pregnant women, and these services are used by virtually all pregnant women. Attendance is encouraged, for instance, by the fact that non-attendance can lead to missing out on maternity benefits, which are considerable. The care for those pregnancies that are potentially complicated by medical or social problems is defined as the domain of maternity clinics. Local maternity care centres can refer pregnant women to specialised care at obstetric and gynaecological maternity clinics located in public hospitals or university hospitals. These maternity clinics provide expert consultations and perform high-tech antenatal tests and diagnoses, while a number of maternity clinics provide prenatal services specifically for pregnant women with alcohol and drug issues.

On my first day of observing the mundane activities of the clinic I felt uneasy for three reasons. I wondered if the professionals were annoyed and

felt that I was in the way; I wondered whether the clients would consent to my presence; and, more abstractly, I felt overwhelmed with the task I had set for myself of trying to understand professional interventions in prenatal substance abuse. The day before I started at the clinic, the biggest Finnish daily newspaper published an article in which a prominent Finnish obstetrician and an FAS activist demanded compulsory treatment for pregnant women with alcohol problems in order to prevent FAS (Helsingin Sanomat, 30 October 2005). This article triggered comments by other experts in the media and lively discussions on the Internet. The sudden publicity around FAS prevention made me feel uncomfortable because I personally felt apprehensive about compulsory measures. My discomfort about this question and its topicality during the fieldwork affected the decision I made later on to study not only the maternity clinic, but also FASD prevention discourses, including medical and political discourses on compulsory treatment.

I did fieldwork at the clinic between 31 October 2005 and 26 May 2006, that is, for seven months. During this time I spent in average two to three days per week at the clinic, observing anything that was going on for about five to seven hours a day and conscientiously writing things down in my notebooks while events were taking place and afterwards when I was alone. I was most interested in what took place between the staff and the clients. I observed countless encounters between the nurses and the pregnant women and to a lesser extent encounters between a social worker or an obstetrician and the women. The nurses spent far more time with the women than did the social workers or the obstetrician and consequently knew the most about their lives.

In the present summary article I use the terms "pregnant women" or "women" and "client" to refer to those who had been referred to the specialised maternity clinic because of alcohol or drug issues. The clinic's staff referred to the women as "mothers" or "clients"; the latter term was used also at "regular" maternity clinics whose "clients" were not known to have alcohol or drug issues. The clinic's staff seemed to like the term "client" because it was neutral, that is, it did not put a negative label on the women despite their alcohol and drug issues and because it was different from the term "patient", which in this context was reserved for pregnant women who were hospitalized for one reason or another.

After starting at the clinic, I asked the two nurses with whom I spent most of my time whether they had been hesitant to allow me to observe their work. Their answer revealed the power relations at the hospital: the nurses were never asked whether they wanted me in their small office: the head of the clinic had simply told them that a researcher is coming to observe their work. Despite having landed in their midst without their approval, I got along well with the nurses from the very start. Some time after my arrival the nurses admitted that they had not been keen to have me there, but things were going surprisingly well and they did not feel that I was in the way. In the beginning

they felt the need to explain and justify their actions to me; for instance, they repeatedly made comments about their frequent jokes about the work and about the clients in the clients' absence. The nurses felt the need to emphasise that they meant no harm and that they took their work and their clients seriously despite the frequent black humour. I interpreted their joking as a way of coping with the stress of working with people whose lives were often sad and difficult and who were not easy to "treat". I found the nurses' humour funny, and I laughed along, even occasionally making similar jokes. Gradually, the nurses gradually stopped justifying this part of their everyday existence to me. I interpreted this as a sign that they had started to trust me. I assume that my genuine interest in their daily work facilitated the rapport between us: I kept asking them questions about the work and the women they worked with and in this way conveyed that I considered them to be the experts, not me. I was there to learn from them.

I tried to avoid the hierarchical position the nurses offered at start: I wished to be seen as one of them rather than above them, despite my status as a researcher with a university degree. The hierarchy amongst the clinic's staff was embodied for instance in how the nurses always made and served the coffee and sometimes brought in buns for the occasional shared coffee break. The clinic's obstetrician did not reciprocate, nor was it expected. The first time I offered to make the coffee and had brought some buns, the nurses were surprised but let me get on with it. Many ethnographers have observed that these kinds of small gestures can be vital in how the ethnographer's role at the field is constructed (for example, Lalander 2003).

The obstetrician's higher status compared to the nurses was reflected in his attitude. He did not object to my being around the nurses or taking part in joint meetings but at first he did object to my observation of his work. In the end, after repeated negotiations about how to ensure his anonymity, he allowed me to be in his office for two weeks. During this time he occasionally treated me as one of the nurses, asking me to do little services, such as change the paper sheets on his examination surface. My relationship with him remained more distant than with the nurses.

I was with the nurses when they performed various procedures such as taking the blood pressure, monitored the foetus's heart-beat and other routine tasks. I was also present when the nurses interviewed the clients on their first visit, as well as during later visits when the nurses talked about the pregnancy, the clients' physical and mental well-being, their substance use, and so on. Often the women's partners accompanied them to the clinic and took part in these conversations. I took part in internal meetings among the nurses, social workers and obstetrician in the specialised maternity clinic, when the clients were discussed. There were also larger multi-professional meetings involving staff from other hospital departments in which the purpose was to discuss cases in which social work involvement was deemed necessary because of the mother's or father's substance abuse or other social problems. I also took part in numerous meetings in which a client, often her

partner, the clinic's nurse and social worker and the child protection social workers from the municipality discussed the future and the need for child protection interventions. These meetings were organised whenever the clinic staff felt interventions were needed in the form of intensive support and surveillance or in placing the child outside the family home. I spent a lot of time in the nurses' office while they waited for clients to arrive, chatted about recent events at the clinic or did paperwork. Occasionally we took coffee breaks together. I also accompanied the staff to other treatment institutions where meetings were occasionally held.

Whenever I observed the obstetrician's work with the clients, I followed all of his activities, including his speaking with clients about their substance use and the effects of substances on the foetus. I was present when he performed ultrasound examinations and other medical procedures. I was also often present when social workers talked with clients about issues such as substance use, housing, relationships, family relations, the need of financial assistance or inpatient drug treatment and so on. With the nurses and the obstetrician there were chances to ask casual questions about their work and the clients' progress. In addition, I conducted informal taped interviews with all the members of the staff (six interviews) in which I asked more about their work on the basis of what I had seen at the clinic. I also conducted five interviews with staff at a similar clinic elsewhere in Finland. The interviews provided me with further information about how the professionals understood and experienced their work but I used the interviews only as background material for sub-studies III and IV.

During the seven months of my fieldwork a total of 93 women visited the clinic, and I personally encountered 42 of them. Many of them came with their partners. I encountered some of these women only once and other several times. During the fieldwork I was clearly closer to the staff than to the pregnant women: I spent most of my time with the nurses in one of the small rooms they used for meeting up with clients and doing computer or paper work. When the women entered the clinic they registered at an information desk, found a seat and waited to be called in for their appointment. If they came without an appointment, which sometimes happened, they skipped the registration and walked straight to the nurses' room and knocked on the door in the hope that they could be seen without an appointment. The set-up was such that there was no place such as a waiting room where I could have easily spent time with the women outside their appointments with the staff. The small specialised clinic for women with alcohol or drug issues was physically located inside a larger "regular" maternity clinic with the nurses' and obstetrician's rooms located along a long corridor. Only a few rooms belonged to the specialised clinic while the other rooms on the same corridor belonged to the "regular" maternity clinic. There was no specific waiting room or area designated for the specialised clinic: the chairs and benches scattered here and there along the long corridor and in small alcoves were for those coming either to the "regular" or the specialised clinic. A waiting area

for clients of the specialised clinic would have meant that the clients would have been able to identify one another as seeking the same specialised services, which might have encouraged the women to make contact with one another. A separate waiting room would also have provided me a place where to talk with the women and their partners.

I asked each woman for a written consent for my presence at the first meeting. I introduced myself as a researcher from the university who was following the work done at the clinic and I explained that participation was voluntary and anonymity was ensured for all participants. Sometimes I asked for the permission for my presence alone with the woman, but more often I was in the presence of a staff member. During the seven months only one client objected to my presence; on another occasion a member of the staff said that it would be better if I did not come to an appointment because the client was frightened of authorities and the situation was very sensitive. When I asked permission to conduct research at the clinic I was told that a written consent is needed from the clients; this was part of the hospital's research ethics protocol. Thus, acquiring written consent from the women benefited the hospital in that their research ethical requirements were fulfilled, but it did not necessarily mean that the women really felt that they were in a position to make a free choice to accept or refuse my presence. I got the impression that the women did not mind my presence and did not care if I was there or not. It is likely, however, that the women willingly consented to my presence at least in part because they felt the need to behave like "good" and "consenting" clients. They were, after all, in an asymmetrical power position in relation to the staff, whose members were seen by the women as extensions of the child protection authorities and thus wielded considerable power over the client's lives. Usually I encountered the women in one of the nurses' or the obstetrician's small rooms: I was already in the room with one or more staff members when the woman and sometimes her partner entered. This set-up probably gave the women the impression that I was "one of the staff" even though I introduced myself as "an outsider" who worked at the university, nor did I wear a white coat. During appointments between the women and staff, I took a back-seat: I did not talk and I usually wrote things down in my notebook. The rooms were small which meant that everyone was physically close to one another. Normally I sat at a table with the others in the nurse's office or stood on the other side of the bed on which a woman was lying while a nurse monitored the foetus's heart-beat from the other side of the bed. During ultrasound examinations, which involved removing undergarments, I placed myself in a corner behind the woman's head in order to avoid seeing her naked lower body. Occasionally I was left on my own with the woman when the staff member went to do other things but I felt that my efforts to have informal chats with the women in the staff's absence were not always successful; while the women were friendly they were not necessarily chatty. At the end of the day I had very little personal contact with

the clients. I knew something about their lives, however, as I was present when they talked about many personal things with the staff.

During my fieldwork I was clearly more closely connected with the staff than with the pregnant women. This made sense, as my initial interest was in social control, that is, how prenatal substance abuse is regulated or governed by the state and its expert systems. As a reflection of this interest, two of the sub-studies examined the encounters between the service providers and the users with a focus on the professionals' role and the construction of power relations between them and the women (sub-studies III and IV). The focus on the use of power in an institutional setting, however, means that, unlike many ethnographies on drug cultures and drug use conducted on streets (for example, Lalander 2003), in night-clubs (for example, Measham et al. 2001) or in other non-institutional scenes, the present study does not provide a vivid analysis of the everyday contexts, practices or meanings of drug use. Rather, it looks at encounters between drug users and health care professionals, and these encounters proved to be strongly shaped by the institutional agenda pursued by the professionals.

The first thing I learned when I started my fieldwork at the clinic was that, with few exceptions, the clinic's clients were "normal"-looking young women, and I would not have been able to identify them as problem drug users. The women did not fit my image of pregnant women with drug problems, which made me realise the power of the stereotypical and prejudiced view of drug users, especially pregnant users, as being somehow fundamentally and recognisably different from the rest of "us". We tend to imagine a pregnant drug user as looking untidy, visibly intoxicated, pale and thin. During my fieldwork I did encounter some clients who fit this stereotype, but these were a small minority amongst the clinic's clientele.

I transcribed more than two thirds of the hand-written fieldnotes I had taken during the period. This amounted up to 120 single-spaced pages. The rest of the fieldnotes I transcribed selectively, which meant that after identifying the theme I was interested in and wanted to pursue, I transcribed all the episodes that dealt with that particular subject. In analysing the field notes for the sub-studies III and IV, I used the Atlas.ti computer programme for coding the data to enable a systematic analysis.

Usually the encounters with the clients and staff were organised around an agenda set by the professionals, which left very little space for the clients' own agenda (sub-study IV). For example, in the encounters between staff and clients, more often the staff was telling the clients about the risks involved in prenatal drug use rather than listening to the mothers tell how they viewed the risks. At the clinic I had limited chances to talk to the women informally as there was usually some procedure or conversation going on between the staff and the mother. Although I did learn quite a lot about the women's lives and experiences by listening to their conversations with the staff and occasionally having informal chats with them, I was left with the feeling that I did not get to know nearly enough about these women. I

observed tensions between the women and the professionals (sub-study III), and I wanted to know, for example, how the clients experienced the services they used during pregnancy. It was obvious that I could only learn about the women's views and experiences on more neutral ground, and for that reason I decided to interview some of the women. It seemed vital to conduct the interviews outside the maternity clinic in order to distance myself from the clinic's staff and the social services and to emphasise that the interviews were strictly confidential.

4.3 INTERVIEWS WITH WOMEN FROM THE CLINIC

I conducted 14 interviews with clients who had used illicit drugs during pregnancy or before getting pregnant. The majority of the interviewees (10) were recruited during pregnancy from the maternity clinic. Two interviewees were recruited from the family ward of a large drug treatment institution and two were found by the "snowball method": asking interviewees if they had friends who could be interviewed. The inclusion criteria were that the woman was or had recently been pregnant, and that she had been referred to the specialised maternity clinic because of prenatal drug use (12) or a recent history of drug use before the pregnancy (2). The majority of the interviewees (12) were poly-substance users whose main illicit substance during pregnancy was Subutex. One interviewee had used illicit Subutex before pregnancy but stopped before she got pregnant. One interviewee was in a methadone programme before she got pregnant but had had a relapse and used illicit drugs at one point during the pregnancy. All but one of the women who used Subutex while pregnant injected the substance (11). The interviewees had given birth from four days to four months prior to the interview with the exception of one who was pregnant and one who had given birth almost two years earlier.

I refer to the interviews as "ethnographic interviews" because their planning and analysis were guided by my fieldwork experiences at the maternity clinic. Furthermore, I had met most of the interviewees prior to the interview, and my aim was to understand their experiences and have the women talk about their lives and experiences as informally as possible (Heyl 2007). The interviews were conducted in 2006 and took place in locations chosen by the interviewee: in their homes, in clinical settings, in cafés and at my office. Whenever possible, I suggested doing the interview outside a clinical setting to underline my position as an independent researcher and to create an informal atmosphere. In order to build trust with the interviewees, I stressed that I was not a part of the treatment/control system, but rather was affiliated with the university.

I conducted the interviews, which were semi-structured. I tried to establish an informal atmosphere in order to allow the interviewees to broach issues they found relevant, thus ensuring rich data. I told the

interviewees that I was interested in their experiences of being pregnant, in particular their use of health and social services. I also explained that I was not linked to the social services or the maternity clinic, but rather was an “outsider” who worked at the university and conducted independent research. I emphasized the confidentiality and anonymity of the interviews. The interviews lasted about an hour, and they were taped and transcribed. As I was leaving the interview, I gave the interviewees a gift-wrapped parcel containing baby clothes and/or a toy for the baby explaining that it was my little gift to the baby. I had not, however, promised anything in return when I asked for their permission to be interviewed, and thus the gift came as a surprise. The motivation behind gift-giving was to show my appreciation for the “gift” the women had given me, namely, the interview. In addition it seemed natural to give something to the baby, as giving gifts to newborns is a culturally recognised form of social bonding between friends, relatives, workmates and neighbours.

In interviewing the women, I avoided a typical “drug treatment institution” format, which starts with the client listing in detail her history of drug use. Instead I began by asking the women about their pregnancy in general terms: “How was your pregnancy? Did it go as you expected?” I started with this theme in order to relate to the interviewees as women and mothers, not primarily as drug-users. Many ethnographers have noted the importance of treating informants with full respect, and this is of particular importance when interviewing people with a stigmatised position in society. For instance, Lalander (2003, 175-176) writes that he never used terms such as “junkie” or “addict” with his informants and “saw them as fellow human beings who had experiences to convey.” This was my approach as well. At the time I had two very young children myself and could easily relate to the interviewees’ stories of pregnancy and use of maternity services. I also sometimes talked a bit about my own experiences of pregnancy and parenting if the subject came up naturally or if I was asked whether I had children. I had the feeling that the interviewees were quite happy to share their experiences with me.

While the analysis for sub-study V was inspired by a theoretical interest in risk perception, the analysis was at the same time inductive and sensitive to the data (Charmaz 2006). The transcribed interview data were coded manually, and I started by first identifying all the episodes in which the interviewees expressed any worries, fears, threats and dangers they had experienced or encountered during the pregnancy in connection with drug use. These episodes were further coded as one of the following four main risk themes: 1) risks to the pregnancy, foetus, newborn or child; 2) risky encounters with health care and social welfare professionals; 3) risks related to abstaining from drug use.

4.4 MEDICAL AND POLITICAL DISCOURSES

Why did I divert from my original plan and decide to analyse medical, political and health education discourses as well everyday life at the clinic? The reason was motivated in part by a rational decision as explained above, namely, that in this way I could say more about prenatal alcohol use, not only drugs. Another part of the motivation, however, was triggered by strong curiosity and coincidences. First of all, the public dispute about the compulsory treatment of pregnant women with substance abuse problems had started to haunt me. By a coincidence the public debate on the matter gained new life around at the time I started my fieldwork, and I was repeatedly asked for my take on the subject. I was also asked to speak at various seminars about the Finnish debate on compulsory treatment, and I wrote some short popular texts on the subject. The controversy or anxiety I had felt on the first day doing fieldwork at the clinic did not go away: a prominent medical authority on prenatal substance abuse had advocated coercive measures in a newspaper article in the biggest daily newspaper of Finland, but somehow instinctively I felt apprehensive about the idea. Why did she think the idea was good? Why did I not like the idea? The set-up was exactly the same as in the public debate: medical experts advocated compulsory measures, while social scientists or those with a social work background objected to it (e.g. Lehto 1998, Helsingin Sanomat 30 October 2005). Neither group, however, campaigned for their views as large group of professionals, but rather as individual representatives of their particular field of expertise. What was this all about? This question made me so curious, almost obsessed, that I started to gather data about the genealogy of the Finnish debate on the compulsory treatment of pregnant women with substance abuse problems. Sidetracked from the original research plan, I ended up with a substantial amount of new data and a new question: how did the idea of the compulsory treatment originate and develop in the first place?

The first dataset for sub-study II consists of early coverage on FAS (research articles, letters to the editor, editorials and so on) in the two largest Finnish medical journals between 1979 and 1999, *Duodecim* and the *Finnish Medical Journal*. These journals were chosen because the Finnish public debate on FAS started here. During these two decades the two medical journals contained a total of 26 articles on the risks of prenatal alcohol intake and FAS. The journals' analysis showed that FAS prevention became a topic of political debate in connection with the Child Welfare Act of 1990. The second dataset consists of the Child Welfare Act and the government documents pertaining to its preparation and retrospective evaluation. These are the documents in which the political debate on FAS prevention began, and for that reason I analysed them. I found no reference to FAS prevention in any earlier legal documents; for instance, the Alcohol Misuse Act of 1987 does not mention FAS or pregnant women. The analysis made use of discourse analysis, which focuses on language and its rhetorical organisation

and the organisation of knowledge and meaning (Potter 1996, 1997). Armstrong's (2003) concept of maternal-foetal conflict was used as a central tool in analysing the arguments and the rhetoric by focusing on how the mother and the foetus are portrayed in the data. Maternal-foetal conflict refers to a discursive formation in which the pregnant woman and the foetus are seen as separate entities with opposing interests.

4.5 HEALTH EDUCATION MATERIAL

In 2009 when a Danish colleague at an international alcohol research conference suggested that we could compare recommendations to pregnant women about alcohol intake in the Nordic countries, I found myself agreeing, even though I did not need more data or research questions to complete my PhD. I became curious about the subject. I thought it would be useful to look into the regulation of alcohol intake during pregnancy. Moreover, I saw that I could widen the scope of my study by addressing the question of how the "mainstream" pregnant population is approached by the authorities.

In sub-study I, written jointly by myself and Dorte Hecksher, we examine the policy for alcohol intake in pregnancy by analysing health education material produced for pregnant women by the government health authorities in Finland and Denmark. The material is distributed to nearly all pregnant women in Finland and Denmark early on in their pregnancy. Second, we scrutinise the rationale behind these recommendations in order to understand the arguments justifying the the policy. These official documents serve both as a source of public information and as guidelines for professionals. I was in charge of the generating and analysing the Finnish data, which included reprints of the government health education booklet for pregnant women distributed from 1971 to 2009. These booklets provided information about pregnancy and childbirth and gave advice about such things as nutrition, smoking and alcohol use. Additionally, all government documents (reports, guidelines for professionals) that might shed light on the rationale behind the recommendations were analysed. These documents were published by Ministry of Health and Social Affairs and the central agency subordinated to the ministry between 1999 and 2009. In addition a search was made to locate expert debates on this issue, but such debate was virtually non-existent in Finland.

The data were analysed using qualitative content analysis, in which we systematically sought the meaning of 1) the recommendations given to pregnant women regarding alcohol consumption during pregnancy and 2) the rationale behind the recommendations; in other words, whether the recommendations were justified by scientific evidence. By using data covering several decades, we were able to examine the changes in recommendations that had taken place. Next, I will present the main findings of the five sub-studies.

5 RESULTS

In this chapter, results from the five individual sub-studies are presented in three parts. The first part focuses on alcohol and presents the results of the sub-studies I and II, which were based on documentary material. The second part focuses on institutional face-to-face interaction and presents the results from sub-studies III and IV. The third part presents the results of sub-study V, which examined how women who used illicit drugs during pregnancy view the risks involved. The results of the five sub-studies are discussed at the end of each of the three parts in a way that goes beyond the scope of the published sub-studies.

5.1 THE IMPERATIVE OF FOETAL HEALTH

Sub-study I, "The Rise of the Total Abstinence Model. Recommendations regarding Alcohol Intake during Pregnancy in Finland and Denmark", analysed official recommendations for alcohol intake during pregnancy. Written in collaboration with Dorte Hecksher, the study compared Finnish and Danish guidelines distributed to pregnant women in health education material since the 1970s and sought to identify the rationale on which the recommendations were based on.

If official recommendations on alcohol intake during pregnancy were strictly based on scientific evidence, then the recommendations would be identical in different countries. The inspiration for this sub-study came from two international comparative studies, which examined recommendations on alcohol intake during pregnancy internationally and found variations between countries and also within countries (O'Leary et al. 2007, Drabble et al. 2009). Nordic countries were not included in these comparisons. The variations in the policies were explained by noting that authorities may interpret scientific evidence differently and that scientific evidence of the effect of low-to-moderate alcohol intake during pregnancy is uncertain and does leave room for interpretation.

In Finland the message about alcohol intake in pregnancy became gradually less tolerant of any alcohol intake, and in 2006 an unequivocal total abstinence message was launched. By contrast, in 1999 Denmark shifted from its message of total abstinence, upheld from 1984 to 1998 to tolerating a low intake of alcohol, yet in 2007, the Danes returned to a total abstinence message. In the Danish material the uncertainty of the scientific evidence regarding a low alcohol intake was clearly communicated to pregnant women, but in Finland any mention of this uncertainty was omitted from the educational material in 2006. We consider this a problematic feature of the Finnish recommendations.

The Danish policy for recommendations on alcohol intake in pregnancy was transparent: the shifts between the total abstinence message and the small-amounts-are-safe message were explained in the government reports and guidelines. The Danish small-amounts-are-safe message (1999-2006) was based on a review of the scientific literature conducted by the health authorities. The review showed no evidence of any harm from low alcohol intake in pregnancy. The “principle of caution”, which guided Denmark’s shift back to a total abstinence message in 2007, was explicitly discussed in the policy documents, and it was critically debated by Danish experts. By contrast, Finnish policy was characterised by lack of transparency and debate: the government reports and the guidelines for professionals vaguely referred to “scientific evidence” and to a consensus amongst Finnish experts as the basis for the recommendations, but no references were given and the grounds of the consensus were not explained.

The adoption of the total abstinence message in Finland and Denmark in 2006 and 2007 respectively was not linked to scientific evidence for the harmfulness of low-to-moderate alcohol intake during pregnancy: no such evidence exists. Sub-study I thus argues that the rise of the “principle of precaution” behind the total abstinence model is linked to a change in the socio-cultural climate with regard to FASD. In both countries a growing urge to protect the foetus from alcohol has been manifested, most strikingly in the recent discussions on the compulsory treatment of pregnant women with alcohol and drug problems. Sub-study I suggests that the rise of the total abstinence model is a wider international trend, a diffusion process whereby ideas and policies are copied and adopted from country to country.

Substudy II “The Emergence of the Foetus: Discourses on Fetal Alcohol Syndrome Prevention and Compulsory Treatment in Finland”, analysed discourses on the compulsory treatment of pregnant substance-abusing women from the late 1970s to the 1990s. The idea of compulsory care for pregnant women as a means of preventing FAS is a distinctly Nordic phenomenon: Norway and Sweden have implemented such measures, and their use has been and is currently debated in Finland and Denmark.

Finnish medical journals dealt with FAS for the first time in 1979 in a review article on the novel issue, and in 1985 a new problem category of “alcoholic mothers who do not know or care about the pregnancy” was created. This category justified the demand for more direct state interventions in alcoholic drinking during pregnancy. The compulsory treatment of pregnant women with alcohol problems came up in the medical journals in 1988 when a prominent FAS activist criticised the renewal of the child welfare legislation for not proposing compulsory treatment and thereby “putting too much emphasis on individual freedom and autonomy” at the expense of the “unborn child” (Halmesmäki 1988). These arguments build on the maternal-fetal conflict (Armstrong 2003), in which sees the mother is viewed as an enemy of the foetus.

The activist medical experts' arguments for compulsory measures were picked up by politicians at the end of the 1980s and carried into the 1990s. This was the first time the issue made its way into parliamentary documents. Some of the political documents called for "the special protection of pregnant women" with alcohol problems, with reliance on the provision of voluntary public services as the means of this protection – a stance that focuses on the mother and her rights as a citizen of the welfare state. In contrast, other documents proposed compulsory measures and called for the "protection of children and fetuses". The arguments in the documents advocating coercion echoed the views expressed in the medical journals. The discourse that focused on the foetus was linked to negative imagery of the alcoholic pregnant woman as an uncaring and uncooperative mother. What actually took place in these parliamentary documents was the emergence of a new subject, the foetus.

Despite the prominence of compulsory treatment in the political debate, the political decision made in the latter half of the 1990s promoted the expansion and development of voluntary services aimed at helping pregnant women with substance abuse problems. Recently, however, there has been a new wave of political advocacy for involuntary measures in Finland.

Sub-study II suggests that the high status of the medical profession and the contemporary cultural capital of the foetus lent persuasive power to the demands for coercive measures. It is also observed, however, that the Finnish tradition of collective alcohol control, which has been based primarily on policies that target the whole population (such as taxation and availability control) and secondarily on the public provision of voluntary treatment services, has made demands for compulsory treatment controversial and, thus far, politically impossible.

The main finding sub-studies I and II was the identification of a phenomenon that could be called "the rise of the foetus at risk": in FASD prevention discourses the foetus was increasingly seen as vulnerable and in need of protection. The increased concern for the foetus was not strictly based on scientific evidence of alcohol-related foetal harm, although the scope of the problem expanded when concern for FAS was replaced by concern for FASD in the early 2000s. The new term FASD included less serious harm than FAS and was linked to less heavy alcohol consumption. These two sub-studies demonstrated an increasing discursive tendency to see alcohol-related risks that potentially threaten the foetus as unacceptable and preventable.

Sub-study I on health education material for pregnant women attributed the international diffusion of the total abstinence model to a change in the risk rationale behind the official recommendations. The study suggested that health authorities are less and less willing to take any risks with regards to foetal health and thus have promoted the message of total abstinence. This development is linked to the rise of a new logic, the "principle of caution". A notion originally deriving from environmental policy, the principle of caution

is based on the idea that “lack of full scientific certainty shall not be used as a reason for postponing cost-effective measures to prevent environmental degradation” when there is a threat of serious or irreversible damage (Rio Declaration on Environment and Development 1992). The spread of this new logic caught the critical attention of social scientists. For example, Françoise Ewald (2002) has argued that contemporary culture has become increasingly “riskphobic” and the principle of caution has become its new regulatory principle. In a similar fashion Frank Furedi coined the terms “culture of fear” (1988) and “paranoid parenting” (2002) to refer to the increased contemporary concern about safety. Furthermore, Armstrong’s (2003) suggestion, namely, that the growing anxiety about FASD is in fact linked to increased anxiety and moral concern about women’s changing role in society sheds light on this growing “culture of fear” around FASD.

Lealle Ruhl (1999) has noted that health education materials for pregnant women have hardly been studied at all; instead research has focused more on “draconian illiberal” modes of governance. According to Ruhl (1999), health education materials assume a cooperative and risk-averse reader, “the ideal liberal subject”, who willingly modifies her diet and gives up pleasures, such as smoking cigarettes and drinking alcohol. Efforts to educate mothers-to-be are embedded in a risk discourse that is inherently individualised and moral: the concept of risk itself implies that risk-aversion is morally good, while taking risks is a sign of irresponsible mothering. Health education materials provide a measure of what the “ideal of responsible behaviour” might be for a pregnant woman (Ruhl 1999, 103). The distribution of official health education booklets is a benign governing technology for targeting the entire pregnant population. It is a non-personal, non-invasive risk management technology with the objective of urging pregnant women to be self-governing.

At the core of this project of self-government that health education materials encourage pregnant women to embrace is what I would like to call new “imperative of foetal health”, to paraphrase the expression “imperative of health”, which Deborah Lupton (1995) borrowed from Foucault (1984) to highlight how health has become a key value in contemporary western societies. The rise of the imperative of foetal health also has a key role in the controversial question of compulsory treatment of substance-abusing pregnant women. Those medical and political discourses of the 1980s and 1990s advocating compulsory measures constructed the foetus as a new subject. In comparison to health education about alcohol intake during pregnancy, compulsory care of substance-abusing pregnant women represents what Ruhl (1999) called a “draconian” or “illiberal” mode of governing. Not surprisingly, the targets of these two technologies of government are different: health education messages are intended for the “ideal liberal subject” while coercive measures would be used on those women who are seen as unfit in the area of self-governance.

Where do the increasingly foetus-centred discourses place the pregnant substance-using woman? On the discursive level there is a shift towards more

precaution and tighter regulation of the pregnant women. The demands for tighter control could be linked to the recent transformation of Finnish alcohol policy. Since Finland joined the EU in 1995, the collective aspects of Finnish alcohol policy such as taxation and availability control have become increasingly problematic (Tigerstedt 2001, see also Sulkunen and Warsell 2011). Consequently, alcohol taxes, for example, have been cut (Tigerstedt 2001). It has been argued that the new ethos of Finnish alcohol policy is based on a division between increased freedom given to the general population via liberalisation of alcohol policy, and increased control exercised on those who are deemed "problem citizens" (Kaukonen 2000). The recent influential advocacy for the compulsory treatment of pregnant women supports Kaukonen's (2000) conclusion about this division.

In advocating tighter controls on substance-abusing pregnant woman it makes sense to highlight the vulnerability of the foetus because an argument based on the need to protect an innocent victim tends to be persuasive. Sulkunen's (2009) discussion on the rise of the victim's point of view in the media and in political decision making examines the rise of the victim in the context of how the use of power is has changed in the Nordic welfare states. Mirka Smolej (2011) posits that what she calls "the emergence of the victim" is a key trend in recent Finnish crime media.

All societal efforts to manage dangers or risks are based on an understanding of the nature of the dangerous phenomenon, person or group. Is the pregnant woman an active agent capable of self-discipline and risk aversion, as the health education discourse examined in sub-study I assumed? Or is the woman a hopeless problem, who needs to be approached as the target of authoritative interventions, as the advocacy for compulsory measures suggests? The latest Finnish recommendations on alcohol intake for pregnant women are in fact ambivalent: while the woman was addressed as a person capable of risk aversion, she was not given the relevant information about the uncertainty of the knowledge base on which the abstinence recommendation was based. She was thereby patronised, treated as someone incapable of drawing reasonable conclusions from the available knowledge. In the foetus-centred discourse examined in sub-study II and used in the advocacy for compulsory measures, the pregnant woman was given the role of the uncooperative and dangerous "other". If the woman with alcohol or drug issues is not positioned as the "other" and made an object, then a dialogue is needed with her and her autonomy needs to be taken into account when efforts are made to "conduct her conduct". The next section explores these themes and moves from the world of discourse to the level of clinical practice.

5.2 HYBRID ENCOUNTERS

Sub-study III, "Interfering in Prenatal Drug Use at a Specialised Maternity Clinic", analysed the logic of the encounters in which maternity care professionals tried to help their pregnant clients stop or reduce the use of illicit drugs. Such interventions in health care and social work settings are a problematic mode of face-to-face interaction, as they question the client's conduct and her moral worth (Goffman 1967). The majority of the pregnant women whose encounters with professionals were analysed in this sub-study were opioid-dependent poly-substance users. The professionals encouraged the opioid users either to abstain or to enrol in an opioid substitution treatment program. Amphetamine users were encouraged to abstain.

In the professionals' view it was important for the well-being of the foetus that the pregnant women reduce her use of illicit drugs or preferably, stop using drugs altogether. However, according to the professionals, the women may feel threatened or irritated if professional interventions were too direct or forceful and the women were hurt if they were approached with a negative and moralising attitude. The challenge of the interventions was thus to meddle in the clients' lives, but not too much and in a respectful manner. I call this meddling "interfering" in an attempt to create a concept that captures the intrusive and therefore problematic qualities of the professionals' daily work.

The organising principle of interfering was to start gently with the client and, as the weeks went by, gradually exert more pressure if necessary; I call this "the continuum of interfering". Interfering started when the woman first visited the clinic and was asked about her drug use, her personal life and other matters. During the very first interview the professionals determined if the woman had plans to stop drug use and what the planned method was. From the very beginning the professionals encouraged opioid-dependent women to enrol in an inpatient detoxification unit, which they saw as the best option for anyone desiring to break a long-term habit of opioid use. If the woman's illicit drug use continued, then the professionals gradually employed more authoritative and intrusive style of interfering. The maternity clinic got in touch with the child welfare social services if the client gave her consent, and most often she did because it was obvious that refusing would not be looked upon favourably. In this way the threat of child protection interventions conducted by the municipal social workers was used by the clinic's staff as a tool for intervention. The clinic's nurses carefully tried to time the interference so that the right amount of pressure was exerted at the right time so as not to jeopardise the collaboration, meanwhile being careful to protect the foetus. The professionals also took into the equation the situation of the pregnant woman's partner; for example they sometimes refrained from talking forcefully about child protection social work if they assumed that such talk might upset the partner.

The encounters between the clinic's staff and the clients were often riddled with tension, especially if drug use continued. The power relationship was very asymmetrical, and a great deal was at stake for the women: the Finnish social services can exercise enormous power in the women's lives after a child is born, for example, by deciding if the newborn can go home with the parents. There was also a great deal at stake for the professionals: they were concerned about their client's health, but also they were concerned about the foetus, possibly most of all. The paradox of interference was as follows: the professionals engaged in specific methods to make their clients feel morally worthy and autonomous while at the same time they questioned the clients' lifestyle and encouraged them to comply with the institutional agenda.

Sub-study III concludes by addressing Rose's (1999) notion of "governing through freedom" and the way in which Dean (1999, 2007), for example, has emphasised that, despite the prominence of liberal governance, illiberal modes of governance also exist and need to be taken into account. The study highlighted the mundane and practical ways in which the professionals tried to enact the clients' autonomy and moral worth. At the same time, however, the professionals made use of the possibility and threat of domination by hinting at the possibility intervention by the social workers.

Sub-study IV "User Involvement in Finland: the Hybrid of Control and Emancipation" was written with Riikka Perälä. The starting point was that "the provision of public services is nowadays increasingly characterised by the discourse of consumerism and user involvement that claims to offer a new, empowered role for service users underlining choice, flexibility and the users' needs and agency" (Sub-study IV, 359). The study investigated how this new "agenda of choice" is translated into practice. Do the ideals or discourses of user involvement and consumerism lead to practices that actually empower service users and erode the power of the professionals? Theoretically, the study drew on the notion of governmental rationalities, "styles of thinking" (Miller and Rose 2008). In our case this rationality provided the formula for how the relations between welfare professionals and service users need to be organised. The study also made use of Miller and Rose's notion of governmental technologies, which refers to human technologies, namely, "all those devices, tools, techniques, personnel, materials and apparatuses that enabled authorities to imagine and act upon the conduct of persons individually and collectively." (ibid., 16). Our goal was to explore how the consumerist governmental rationality, which underlined the service-users' choice and agency, was translated into practical strategies to enable the professionals to influence the conduct of the service users.

The empirical analysis was based on a comparison of two ethnographic case-studies, namely, a health counselling service (hereafter HCS) for injecting drug users and a specialised maternity clinic (hereafter SMC) for pregnant women with alcohol and drug problems. Perälä was in charge of the former case study and I was in charge of the latter case study. Both

institutions had a serious public health issue on their agenda, both dealt with a particularly challenging group of clients and both claimed to represent a “soft” rather than a punitive or moralising approach with their clients. In both institutions the professionals used the term “client-centred” to describe their approach. The former service was run by a non-governmental organisation with a strong human rights ethos, while the maternity clinic was part of a large, public maternity hospital with a biomedical approach.

In both institutions active face-work (Goffman 1967) was a central professional tool for taking into account the service users’ needs. Friendly greetings and a pleasant, humorous manner in face-to-face interactions were there to generate respect and create a positive atmosphere geared to reducing stigma. At the SMC, however, the professionals very much set the agenda for service use by deciding who was to become a client, when appointments were needed, what the goal of the treatment was and so on. The approach was normative and hierarchical. By contrast, at HCS the relationship between the service providers and users was more symmetrical in terms of power: professional paternalism was replaced by a dialogical relationship in which the service user largely set the agenda and goals for the service use. The goal of visiting the needle exchange service could simply be to have a rest or to hang around (see also Perälä, forthcoming).

The study emphasised the highly contextual nature of realising ideals such as user involvement, agency or choice. We found a strong link between the ideological and professional roots of an institution and the realisation of the “agenda of choice”: at the HCS client-centeredness was a core value that drove all practices. This was linked to the HCS being part of an organisation with a long tradition of promoting the social rights of people with substance abuse problems. In addition the staff members consisted mainly of social workers, whose training and professional ethos involves egalitarian values. At the SMC making space for the service user’s autonomy was an instrument, a useful tool for avoiding too much paternalism and cultivating good relations with the clients. Furthermore, the fact that the users of the SMC were pregnant very much shaped the relationship between the service providers and the users: the clients (men and women) of the HCS had far more autonomy in their dealings with the professionals than did the pregnant clients of the SMC. Finally, in both institutions the promotion of new rationalities challenged traditional professional practices and created a “new professionalism”. It was no longer sufficient for professionals to have only technical expertise; they also needed to have the skills to tune into the service users’ expectations.

We argued that a new form of “professional capital” had emerged at the HCS: the staff had become experts in how to involve service users and meet their needs. At the SMC the development was a more ambivalent combination of traditional and hierarchical patterns with new dialogical elements. We concluded that the authority of professions is currently being questioned by policymakers and the public alike, and the promotion of new

kinds of governmental rationalities has generated demand for a “new professionalism” based on a more equal relationship with service users. Increasingly, the professional capacity to govern people builds on the ability to listen to service users and make space for their agency. This development, however, is highly contextual and can be ambivalent in that it combines practices of “governing through freedom” with more authoritarian approaches.

Sub-studies III and IV analysed how professionals can use power in everyday encounters with their clients and they provide an account of hybrid encounters at the maternity clinic: the professionals addressed the women’s autonomy and freedom *and* tried to get them to comply with the institutional agenda. The findings are valuable in providing a nuanced account of institutional practices and face-to-face encounters in the context of prenatal drug use.

Dean (1999) uses the expression “technology of agency” to refer to use of power that underlines the freedom and agency of those who are governed. However, he argues that the focus on the rationalities and technologies of governing through freedom has sidelined the study of the more illiberal forms of government in contemporary societies. Sub-studies III and IV contribute to the understanding of the concrete ways in which technologies of agency and domination are intertwined in the context of everyday institutional encounters. Further, these studies demonstrate that the technologies of agency at the maternity clinic were embedded in a tight web of surveillance and domination. In the context of the clinic the much-used formulation – that contemporary use of power relies primarily on “at distance” mechanisms – is thus not very fitting. Despite the strong presence of technologies of agency, professional power in the drug-using pregnant women’s lives was used “at close quarters” rather than at a distance.

Sub-studies III and IV move the focus of this inquiry from discourse to the level of everyday practice. In the health education discourse scrutinised in sub-study I, the pregnant woman was addressed primarily as a responsible, risk-averse person capable of self-government, while the discourse that advocated compulsory measures analysed in sub-study II constructed the pregnant woman as someone who has failed in self-governance and whose conduct needs to be strongly influenced. On the level of everyday, face-to-face institutional practices these contrasting constructions of the pregnant substance-using woman become intimately intertwined, or hybridised, and the picture becomes more ambivalent, messy, or “fuzzy”, which is how Pierre Bourdieu characterised the “logic of practice”, which can be revealed by using the ethnographic method (Bourdieu and Wacquant 1992, 19-26) . It is precisely this ability to look closely at the everyday “messiness” of people’s actions and aspirations that gives the ethnographic method its particular strength.

An interesting finding that was not explicitly discussed in sub-studies III and IV was that the maternity clinic dealt mainly with pregnant women who

struggled with drug problems. According to the clinic's own data in 2004, the "main substance" of their clients was alcohol in ten per cent, cannabis in five per cent, misuse of prescribed medicines in two per cent (benzodiazepines), opioids in 26 per cent, amphetamines in 26 per cent. Thirty per cent of the women were classified as "poly-substance users", meaning that their "main substance" was impossible to define because of poly-substance use. Most of the women who were classified as having opioids or amphetamines as their "main substance" were, however, also poly-substance users. Typically, poly-substance use involved some or all of the following: opioids, amphetamines, cannabis and benzodiazepines and, to some extent, alcohol. Several times during my fieldwork I wondered why drug use was so clearly overrepresented among the clinic's clientele. When I asked the professionals about this, they replied that they assumed it was because alcohol use was easy to conceal from health professionals and that furthermore alcohol users did not necessarily think they needed help or would gain anything from disclosing their excessive drinking. By contrast, drug addicts were often already known by the authorities in which case it would have been difficult or impossible to conceal the problem during maternity care. Further, opioid-dependent pregnant women in particular often felt that they needed professional help: if they were interested in opioid substitution treatment, then they had to disclose their problems.

What is striking here is the large number of drug users in comparison to women whose main problem was alcohol. Most people who follow the Finnish media debate on FASD prevention and compulsory treatment would assume that the professionals at maternity centres and maternity clinics deal with a large number of alcoholic pregnant women and experience great difficulties in motivating these women to abstain from alcohol. However, this was not the case. During the seven months I spent at the clinic there were no clients known to be alcoholics who were also known to continue drinking excessively during the pregnancy, and not one pregnant woman visited the clinic drunk. The women who were referred to the clinic from local maternity centres for excessive alcohol use had admitted to heavy consumption before the pregnancy and in some cases low consumption during the pregnancy. There was not much the professionals could do about these women's possible alcohol use during pregnancy because the women did not disclose the problem if they had one. The professionals put much more effort into interference with the drug using clients. The fact remains, however, that, according to the current understanding, alcohol is much more dangerous to the development of the foetus than drug use. Professionals and authorities in fact have very few chances to influence and help pregnant women with alcohol problems as so few of these women are known to the control and care system. By contrast, professionals have ample opportunity to meddle in the lives of pregnant drug users, as sub-studies III and IV demonstrated. This meddling was facilitated by the fact that the women had disclosed their drug problem and attended the clinic. Interfering in the lives of drug users was

facilitated further by the technology of drug testing: the professionals carried out regular urine drug tests on the pregnant drug users (with their consent), and these tests detected drug use fairly reliably. Similar tests were not available for detecting alcohol use, even though blood tests can give some indication of excessive alcohol intake.

Sub-studies III and IV dealt with the clinic's most "difficult" clients – those whose drug habit was so strong that the drug use continued during the pregnancy. The lives of these women tended to be burdened by many hardships, such as mental health problems, a partner's drug use and sometimes violence, housing issues, and financial difficulties. These women were not atypical clients, but the clinic's clientele also included women with a much more mainstream way of life and fewer problems with substance use. I decided to examine the work done with this particular group of "difficult clients" because through this "extreme", it was possible to learn something essential about power relations at the clinic and to determine where the use of professional power placed the pregnant woman in this specific context.

5.3 BETWEEN BIOMEDICAL AND OTHERS RISKS: SUBJUGATED KNOWLEDGE

The dominant biomedical discourse stresses the physiological risks posed by prenatal use of illicit drugs to the development of the foetus or to the normal course of pregnancy. The maternity clinic in the present study had as its goal to stop pregnant from using illicit drugs (sub-studies III, IV). Previous research on drug users' risk perceptions has demonstrated that lay understanding of risks often departs from the biomedical view, for example, in the question of the risks of drug use (e.g. Peretti-Watel 2003, Miller 2005).

Sub-study V, "Subutex is Safe: Women's Perceptions of Risk in Using Illicit Drugs during Pregnancy", explored how women themselves understood the risks: did they accept or reject the dangers pointed out by the medical experts? Theoretically the study drew on the socio-cultural theory of how people understand risks.

In interviews women who had used illicit drugs during pregnancy expressed a wide range of fears and worries linked to prenatal drug use. However, the question of safety and risk was a much more complex issue for them than the simple biomedical notion that abstaining from drugs equals safety. The women were not primarily concerned about biomedical risks to the foetus, such as problems in the course of the pregnancy or permanent damage done to the foetus's development. Instead, they feared losing their child to the social services, withdrawal symptoms in the newborn and encountering negative and hurtful attitudes when seeking professional help. In addition abstinence was linked to the fear of physical and emotional pain and disruption to their significant social bonds with their partners and

friends. From this perspective, the interviewees did not view abstaining from drugs as a safe, risk-free option. On the contrary, the prospect of abstaining from drugs was filled with fears linked to pain and suffering. The women were, however, aware of the biomedical understanding of risks, and instead of rejecting them, they negotiated their way between the biomedical risks and other dangers. A common denominator in the negative experiences and fears was the feeling of being treated by professionals as an object of interventions and moral judgements, that is, a person who is not competent with regards to knowledge, behaviour or morals.

Public health discourses and health education materials underline the pregnant woman's personal responsibility in risk-aversion (Weir 1996, Ruhl 1999, sub-study I). The interviewees' accounts of their use of illicit drugs during pregnancy, however, showed that their actions were embedded in a context that strongly shaped those actions. Knowledge about the safety and the dangers of drugs was strongly influenced by the peer group. The continuity of social bonds was a key value, which made abstinence a real challenge. Further, the women described their actions as being at times beyond their rational control, such as when bodily cravings for drugs were powerful.

In the accounts given by the women in the interviews, for instance, the descriptions of the physical pain and suffering linked to withdrawal and abstinence should be understood not only as realistic descriptions of their experiences, but also as a way in which the interviewees could explain to themselves as well as to the interviewer why they had continued drug use during pregnancy. By appealing to addiction and thereby denying agency, they cleared themselves of personal responsibility and blame.

While sub-studies I— IV investigated dominant knowledge (biomedical and expert knowledge, knowledge used in political decision-making) and practices (maternity care practices based on a biomedical model) around prenatal substance use, sub-study V examined prenatal substance abuse from the perspective of the pregnant women. The four other sub-studies explored the societal constructions of and responses to the risks of prenatal substance use, while the fifth study asked how the targets of these responses viewed the risks involved.

Foucault's notion of subjugated knowledge is useful in characterising the kind of knowledge explored in sub-study V. By subjugated knowledge, Foucault referred to knowledge that is hidden behind more dominant knowledge and has been disqualified as "insufficiently elaborated knowledges: naive knowledges, hierarchically inferior knowledges, knowledges that are below the required level of erudition or scientificity" (Foucault 2003, 7). Pregnant women with substance abuse problems have not had a prominent role when prenatal substance abuse has been discussed in public. In discourses that underline the protection of the foetus, the pregnant woman can be easily be sidelined or at least her status is negotiated in relation to the foetus. The women's perspectives were, at least to some

extent, absent in the practices of the maternity clinic as well: as mentioned before, I ended up interviewing the clients in order to get closer to their experiences because I did not get to know enough about them in our encounters at the clinic. Further, I wanted to do the interviews outside the clinic and in places chosen by the women themselves because at the clinic their voices seemed to be strongly shaped by the clinic's expectations and institutional agenda.

What did I learn through these interviews? Above all, I learned that the women prioritised risks differently from the priorities established by the dominant biomedical discourse. I learned that the women did not want to be treated as if they were morally unworthy or as mere targets of other people's decisions and interventions. They wanted to be treated with respect, as sensible and competent agents, despite their struggles with drugs, and they wanted to feel that they had a say in their lives. Their negative experiences with professionals were largely from care and control agencies other than the specialised maternity clinic examined in the present study. These findings support the results of previous Finnish studies which have demonstrated that health care and social work professionals may have negative attitudes towards drug users (Kuussaari 2006, Weckroth 2006, Virokannas 2011). As Riikka Perälä (2007) puts it, for people with heavy drug use and related problems, every encounter with the care and control system can be "a test" in which they are given feedback about their value as human beings and their status in the society.

6 DISCUSSION

Fetal alcohol syndrome (FAS) was identified in the 1970s. Since that time, alcohol and drug use by pregnant women has gained the status of a serious problem in the developed western countries and has become a target of political and professional concern, moralising reactions, and a variety of health education, punishment and treatment responses. The regulation of alcohol and drug use during pregnancy poses a genuine dilemma for contemporary liberal societies. What can and should be done about the risks posed by prenatal substance use? How can individual freedom be squared with the public good – and with the wellbeing of the foetus? The present study explored the regulation of risks linked to prenatal use of alcohol and illicit drugs in Finland. The theoretical framework for approaching these questions was drawn, on the one hand, from socio-cultural approaches to risk on the one hand (Douglas and Wildavsky 1982, Boholm and Corvellec 2010) and, on the other hand, from notions of power that underline the freedom of subjects who are being governed in contemporary liberal societies (Miller and Rose 1990). The main research questions were the following : What is the pregnant woman's place vis-à-vis the foetus in discourses on prenatal substance use? How is the pregnant woman with drug problems approached in institutional face-to-face practices in maternity care in terms of power? What do women who have used illicit drugs during pregnancy make of the risks? Is their risk perception in line with the dominant biomedical perspective?

The study is ethnographic and followed the methodological principles of multi-sited ethnography (Hannerz 2003, Marcus 1995). I began generating the research material at a maternity clinic, which provided services for pregnant women with alcohol and drug problems. I conducted ethnographic fieldwork by observing daily life at this clinic for seven months. In addition I interviewed the clinic's staff and clients. Gradually, from this single institution and clearly-defined geographical location, I began drawing data from other kind of sources, including health education materials, medical journals and political documents. As a result, the study examines the regulation of prenatal substance use as reflected in discourses, institutional face-to-face practices and women's interview accounts.

In the discussion of the results in chapter five I have established associations between the different types of data I used and reflected on the interplay between them. The many-sided picture of the regulation of prenatal substance use in contemporary Finland presented in this study was facilitated by the employing the principles of multi-sited ethnography, which allows juxtaposition of different perspectives. In other words, using this methodology made it possible to explore how "risk objects" and "objects at

risk", to use Boholm's and Corvellec's (2010) terminology, are constructed differently by different actors in different contexts.

The main research findings were the following: Firstly, the discursive logic of the regulation of prenatal alcohol use in Finland is characterised by "the rise of the foetus", a process in which the foetus has gradually gained a more prominent role in discourses on prenatal alcohol use. This is exemplified in the debate on compulsory treatment during the 1980s and the 1990s and in the health education recommendations during the last thirty years. Both discourses are characterised by increasing unwillingness to accept any kinds of risks when foetal health is at stake. Secondly, the study demonstrates that face-to-face encounters between maternity care professionals and pregnant women with drug problems are characterised by the use of technologies of domination and agency and tension between these two orientations. Moreover, the study suggests that the service system does not perform well in reaching pregnant women with alcohol problems. Thirdly, the study reveals that women's risk perceptions regarding prenatal use of illicit drugs were partly in line with the biomedical understanding, but their understanding of risks and dangers covered a much wider range of topics. Moreover, the women prioritised risks differently. Many of the issues the women classified as risks were linked to an experience of not being treated by professionals as morally worthy and competent agents.

Sub-studies I and II make a significant contribution to the existing literature by providing a Nordic perspective on the study of discourses on FAS/D, an area of inquiry which previously has been studied mainly in English-speaking countries, especially in the United States. Many North-American studies have identified a growing conflict between the pregnant woman and the foetus in discourses on prenatal alcohol and drug use, a sidelining of the pregnant woman and an increase in punitive discourses and practices (e.g. Young 1994, Campbell 2000, Armstrong 2003, Greaves and Pool 2006). Sub-studies I and II identify a similar development in the Finnish context with regards to the "rise of foetus" but demonstrate that in the Finnish context prenatal substance abuse has been framed as a health issue and the demands for increased control of the pregnant woman are channeled through the treatment system, not the criminal justice system.

The exploration of institutional face-to-face practices in the maternity clinic in sub-studies III and IV provides a nuanced and "microscopic" account of professional practices and power relations between professionals and their clients, a topic that has not been previously studied in the context of prenatal drug problems. Focusing on the everyday enactment of power relations through ethnographic data revealed that theoretical concepts such as "governing at a distance" or "technology of agency" do not aptly describe the mundane encounters that take place in real life between professionals and service-users: in these encounters governing took place "at close quarters" rather than at a distance and the technologies of agency were

closely entwined with or embedded in technologies of dominance and authoritarian power.

The main contribution of sub-study V is that it adds to the scarce knowledge about how women with substance abuse problems view the risks or dangers involved in prenatal drug use. Previous research on the subject has been conducted in the US, and sub-study V demonstrated that risk perceptions regarding prenatal drug use are tied to specific historical times and societies in that they are shaped by culture, that is, values and meanings attached to a given substance as well as by the wider social context of drug use. Sub-study V gives pregnant women with drug problems a voice and highlights their subjugated understanding of risk. What is of particular importance is that in the interviewees the women described professionals' negative attitudes as a major risk to their sense of autonomy and moral worth.

Drug use and uncontrolled use of alcohol trigger fear and moralising attitudes. When the person with the alcohol or drug problem has a marginalised position or a low social status, the risks seem greater and the moralising reactions become stronger. Pregnant women with substance abuse problems are assigned a particularly low status because of women's key role in social reproduction: women are expected to give birth to and nurture future generations. Shortcomings in this area are highly problematic and heavily stigmatised; because of their valued social role in child-bearing and mothering, women are targets of intense education, care and control mechanisms. When a pregnant woman uses alcohol or illicit drugs, highly valued objects or cultural formations are at stake, namely, the institution of motherhood and social reproduction. The quest to protect the foetus is currently so intense that the "principle of precaution", which is typically applied in cases of the risk of large-scale and catastrophic environmental disasters, is seen as a sensible foundation for the regulation of prenatal alcohol intake. The societal quest to protect the foetus from maternal use of illicit drugs and alcohol is a particularly illuminating example of how the regulation of existing risks is entwined with symbolic guarding of purity – the foetus on the one hand and the institution of motherhood on the other hand – from pollution (alcohol and illicit drugs), to use terminology proposed by Mary Douglas and her followers. In the case of prenatal alcohol or drug use certain risks exist without a doubt but knowledge about the level of danger they pose and their mechanisms is uncertain.

Consumption of alcohol and drugs can be regulated either at an aggregate level or on an individual level. In recent decades Finnish alcohol policy has been based on both of these approaches, but more recently Finland's membership in the European Union and a change in the ethos of alcohol policy have made aggregate-level policies, such as availability and price control, increasingly difficult. In line with these developments the solutions that have been proposed for the regulation of pregnant women's alcohol and drug use have focused predominantly on measures that target the individual

rather than the population (Raskaana olevien päihdeongelmaisten... 2009). When authorities seek to intervene in people's lifestyles, technologies which rely on self-governance may seem insufficient in institutional contexts where the aim is to make service users change their lives quickly, as is the case with prenatal substance abuse. The use of authoritarian power, however, has proved to be difficult in a society that puts a high value on individual autonomy, exemplified in the controversy triggered by the idea of placing pregnant women with severe substance abuse problems in treatment institutions against their will. Further, the use or the threat of authoritarian power is socially challenging in the context of face-to-face interactions between service providers and users, as has been demonstrated in the present study. The value of the present study to the analysis of power in contemporary society lies in the way in which power has been approached from the "micro" level in real-life face-to-face situations, enabling a nuanced account of the ways in which authoritarian power and power that relies on the freedom and agency of those upon whom it is used are entwined in face-to-face institutional interaction resulting in a hybrid of governing through freedom and domination.

For the pregnant women with drug problems interviewed for this study, the "object at risk", that is, the valued object at stake was, apart from the foetus and the child, the women's sense of autonomy, competence and moral worth. Even if the Finnish debate around the use of compulsory treatment for pregnant women with substance abuse problems results in the implementation of such measures in the future, coercion would only be applied to a small minority of all pregnant women with substance abuse issues. Subsequently, approaches that are not based on the use of force will continue to have a central role in managing prenatal substance use. Hence, the question of how to promote discourses and practices that foster women's sense of autonomy, competence and moral worth will be of crucial importance.

Pregnant women with alcohol problems are very much "a hidden population", and Finland's care and control system, including local maternity centres, specialised maternity clinics and the alcohol and drug treatment services, performs very poorly in reaching pregnant women who drink too much. It would be highly valuable to study women who in way or another struggle with alcohol issues during pregnancy in order to find out who they are, how they define risks in a context of scientific uncertainty about the effect of low-to-moderate alcohol intake and what risks they identify in the prospect of discussing alcohol-related issues with professionals. More generally, future studies on the subjugated knowledges of pregnant women with substance abuse problems would be very valuable.

The present study has several policy implications. Firstly, experts, authorities and policymakers should be better equipped to consider both the foetus and the pregnant woman and not sideline the the woman with foetus-centred discourses. Too much emphasis on the protection of the foetus can

lead to discourses that demonise the pregnant woman, ignore her or overstate the dangers of prenatal substance use. Secondly, the particular challenges that the task of “interfering” poses to health professionals who work with substance-using pregnant women need to be better acknowledged within the service system, and sufficient resources and recognition need to be granted to institutions where such work is conducted. In health and social services particular attention needs to be paid to the ways in which pregnant women with substance abuse problems are encountered: a respectful, non-moralising and encouraging attitude facilitates service use by fostering a sense of autonomy and moral worth. The development of such services requires a profound change in the attitudes of many professionals, and effective training programmes should be designated for this purpose. Easily accessible low-threshold services, such as internet-based and anonymous groups might be useful in reaching pregnant women with alcohol problems. Pregnant women’s own understanding of risks should be taken seriously in service provision, which could provide a starting point for increased dialogue between service providers and users and thereby make space for the service-users’ agency.

REFERENCES

- Abel E. L. (2009) Fetal Alcohol Syndrome: Same Old, Same Old. Commentary on Gray et al. *Addiction*, 104, 8, 1274-1280.
- Armstrong D. (1995) The Rise of Surveillance Medicine. *Sociology of Health and Illness*, 17, 3, 393-404.
- Armstrong E. and Abel E. (2000) Fetal Alcohol Syndrome: the Origins of a Moral Panic. *Alcohol and alcoholism*, 35, 3, 276-282.
- Armstrong E. (2003) *Conceiving Risk, Bearing Responsibility. Fetal Alcohol Syndrome and the Diagnosis of a Moral Disorder*. Baltimore: The John Hopkins University Press.
- Autti-Rämö I. and Ritvanen A. (2005) Miten selvitämme lisääntyvätkö alkoholin aiheuttamat sikiövauriot? *Suomen lääkirilehti*, 60, 12-13, 1388-1389 [How to Find out if Alcohol-related Foetal Damage Is on the Rise? editorial].
- Bancroft A. (2009) *Drugs, Intoxication and Society*. Cambridge: Polity Press.
- Bogren A. (2008) Women's Intoxication as 'Dual Licentiousness': An Exploration of Gendered Images of Drinking and Intoxication in Sweden. *Addiction Research and Theory*, 16, 1, 95-106.
- Boholm Å. (1996) Risk Perception and Social Anthropology: Critique of cultural theory. *Ethnos*, 61, 1-2, 64-84.
- Boholm Å. (2003) The Cultural Nature of Risk: Can there be an Anthropology of Uncertainty? *Ethnos*, 68, 2, 159-178.
- Boholm Å. and Corvellec Herve (2010) A Relational Theory of Risk. *Journal of Risk Research*, 1, 1-16.
- Bourdieu P. and Wacquant L. (1992) *An Invitation to Reflexive Sociology*. Cambridge, Polity Press.
- Campbell N. (2000) *Using Women. Gender, Drug Policy, and Social Justice*. New York, Routledge.
- Caplan P. (2000) Introduction: Risk Revisited. In P. Caplan (ed.) *Risk Revisited*, 1-28. London, Pluto Press.
- Castel R. (1991) From Dangerousness to Risk. In G. Burchell, C. Gordon and P. Miller *The Foucault Effect: Studies in governmentality*. Chicago, The University of Chicago Press.
- Charmaz K. (2006) *Constructing Grounded Theory. A practical Guide Through Qualitative Analysis*. London, Sage.
- Cohen, S. (1972) *Folk Devils and Moral Panics*. London, Routledge.
- Day K., Gough B. and McFadden M. (2004) "Warning! Alcohol Can Seriously Damage Your Feminine Health". *Feminist Media Studies*, 4, 2, 165-183.
- Dean M. (1999) *Governmentality. Power and rule in modern society*. London, Sage.
- Dean M. (2007) *Governing Societies. Political perspectives on domestic and international rule*. Maidenhead: Open University Press.
- Demant J. (2007) Youthful Drinking with a Purpose: Intersections of age and sex in teenage identity work. *Nordic Studies on Alcohol and Drugs* 24, 149-176.

- Douglas M. and Wildavsky A. (1982) *Risk and Culture: An Essay on the selection of environmental and technological dangers*. Berkeley: University of California Press.
- Douglas M. (1992) *Risk and Blame: essays in cultural theory*. London and New York, Routledge.
- Drabble, L. & Poole, N. & Magri, R. & Tumwesigye, N.M. & Li, Q. (2009) Conceiving risk, divergent responses: perspectives on the construction of risk of FASD in five countries [unpublished paper]. 35th Annual Alcohol Epidemiology Symposium of the Kettil Bruun Society, Copenhagen.
- Ewald F. (2002) The Return of Descartes's Malicious Demon: An outline of a philosophy of precaution. In T. Baker and J. Simon (ed.) *Embracing Risk: The Changing Culture of Risk and Responsibility*, 273-302. Chicago, The University of Chicago Press.
- Ettorre E. (1997) *Women and Alcohol. A Private pleasure or public problem?* London, The Women's Press.
- Foucault, M. (2003) *Society Must Be Defended: Lectures at the College de France, 1975-76*. New York, Picador.
- Foucault M. (1984) The politics of health in the eighteen century. In P. Rabinow (ed.) *The Foucault Reader*, 146-165. New York, Pantheon Books.
- Friedman J. and Alicea M. (2001) *Surviving heroin. Interviews with women in methadone clinics*. Gainesville, The University of Florida Press.
- Furedi F. (1988) *Culture of fear. Risk-taking and the morality of low expectation*. London, Cassell.
- Furedi F. (2002) *Paranoid parenting. Why ignoring the experts may be the best for your child*. Chicago, Chicago Review Press.
- Garland D. (2001) *The Culture of Control. Crime and social order in contemporary society*. Chicago, Chicago University Press.
- Garland D. (2003) The Rise of Risk. In R. Ericson and A. Doyle (Eds) *Risk and Morality*, 48-86. Toronto, University of Toronto Press.
- Geertz, C. (1973) Thick Description: Toward an Interpretive Theory of Culture. In C. Geertz *The Interpretation of Cultures: Selected Essays*, 3-30. New York, Basic Books.
- Geertz C. (1988) *Works and Lives. The anthropologist as author*. Stanford, CA, Stanford University Press.
- Goffman E. (1967) *Interaction Ritual: Essays on face-to-face behavior*. New York, Doubleday Anchor.
- Golden J. (2005) *Message in the Bottle. The making of fetal alcohol syndrome*. Cambridge and London: Harvard University Press.
- Gomez L. (1997) *Misconceiving Mothers: Legislators, Prosecutors and the Politics of Prenatal Drug Exposure*. Philadelphia, Temple University Press.
- Gray, R., Mukherjee, R. A. S. & Rutter, M. (2009) Alcohol consumption during pregnancy and its effects on neurodevelopment: what is known and what remains uncertain (for debate). *Addiction*, 104, 8, 1270–1273.
- Greaves L. and Poole N. (2006) Victimized or validated? Responses to substance-using pregnant women. *Canadian woman studies*, 24, 1, 87-92.
- Hacking I. (2003) Risk and dirt. In R. Ericson and A. Doyle (Eds) *Risk and morality*, 22-47. Toronto, University of Toronto Press.

- Hakkarainen P. and Tigerstedt C. (2005) Korvaushoidon läpimurto Suomessa. *Yhteiskuntapolitiikka*, 70, 2, 143-154. [The Breakthrough of Opioid Substitution Treatment in Finland]
- Halmesmäki, E., 1988. Pitäisikö alkoholistiäidin sikiötä suojella lailla? *Duodecim*, 104, 1482-3. [Does the foetus need legal protection from maternal alcoholism?] Letters to the editor).
- Hannerz U. (2003) Being There.. and There.. and There! Reflections on Multi-Site Ethnography. *Ethnography* 4, 201-216.
- Hecksher, D. (2009) Gravide med rusmiddelproblemer i Danmark. Omfang, risikovurdering og aktuel praksis. *Nordisk alkohol- & narkotikartidskrift*, 26, 3, 295–303. [Substance abuse among pregnant women in Denmark: Incidence, risk-assessment and current practice]
- Helén, I. (2000) Welfare and its Vicissitudes. *Acta Sociologica*, 43, 1, 157-164.
- Helén I. (2002) Risk and Anxiety: Polyvalence of ethics in high-tech antenatal care. *Critical Public Health*, 12, 2, 119-137.
- Helsingin Sanomat*, Päihdeäitien lapset tarvitsevat suojelua, 30.10.2005. [Children born to mothers with substance abuse problems need protection, newspaper article]
- Henderson, J., Gray, R. and Brocklehurst, P. (2007) Systematic Review of Effects of Low-to-Moderate Prenatal Alcohol Exposure on Pregnancy Outcome. *International Journal of Obstetrics and Gynaecology*, 114, 3, 243–52.
- Heyl B. S. (2007) Ethnographic Interviewing. In P. Atkinson. A. Coffey. S. Delamont, J. Lofland and L. Lofland (eds.) *Handbook of ethnography*, pp. 369-383. London, Sage.
- Holmila M. (1992) *Kulkurin valssi on miesten tanssi. Naiset alkoholin suurkuluttajina*. VAPK kustannus, Alkoholipoliittinen tutkimuslaitos, Helsinki 1992. [Women and Excessive Alcohol Consumption]
- Honkasalo M.-L. (2003) Changes in the population, changes in distress - challenges for Finnish health care. Research proposal for the Academy of Finland Health Services Research Programme, 15.9.2003
- Honkasalo M-L. (2006) Fragilities in Life and Death: Engaging in uncertainty in modern society. *Health, Risk and Society*, 8, 1, 27-41.
- Honkasalo M.-L. (2008) Etnografia terveyden, sairauden ja terveydenhuollon tutkimuksessa. *Sosiaalilääketieteellinen aikakauslehti*, 45, 1, 4-17. [Ethnography in the study of health, illness and health care services]
- Honkasalo M-L (2009) Grips and Ties: Agency, uncertainty and the problem of suffering in North Karelia. *Medical Anthropology Quarterly*, 23, 1, 51-69.
- Horlick-Jones T. and Prades A. (2009) On interpretative risk perception research: Some reflections on its origins, its nature and its possible applications in risk communication practice. *Health, Risk & Society*, 11, 409-430.
- Humphries D. (1999) *Crack mothers: Pregnancy, drugs and the media*. Columbus, Ohio State University Press.
- Hutton F. (2004) 'Up for it, Mad for it? Women, drug use and participation in club scenes. *Health, Risk and Society*, 6, 3, 223-237.
- Jallinoja P. (2002) *Genetics, Negotiated Ethics and the Ambiguities of Moral Choices*. Helsinki, Kansanterveyslaitos.

- Jessup M. A., Humphreys J. C., Brindis C. D., Lee K. A. (2003) Extrinsic Barriers to Substance Abuse Treatment among Pregnant Drug Dependent Women. *Journal of Drug Issues*, 2, 285-304
- Järvinen M. and Rosenqvist P. (1991) *Kön, rus och discipline – en nordisk antologi*. Helsinki, NAD-publikation no 20.
- Järvinen M. (1991) Kontrollerade kontrollörer. Kvinnor, män och alkohol. *Nordisk Alkoholtidskrift Tidsskrift*, 3, 143-152.
- Kaskutas L. A. (1995) Interpretations of Risk: The Use of scientific information in the development of the alcohol warning label policy, *The International Journal of the Addictions*, 30, 12, 1519-1548.
- Kaukonen, O., 2000. *Päihdepalvelut jakautuneessa hyvinvointivaltiossa* [Specialised Substance Abuse Services in the Divided Welfare State]. Helsinki, Stakes.
- Kelly Y., Sacker A. Gray R., Kelly J., Wolke D. and Quigley M.A. (2009) Light Drinking in Pregnancy, a Risk for Behavioural Problems and Cognitive Deficits at 3 Years of Age? *International Journal of Epidemiology*, 38, 129–140.
- Kuusssari K. (2006) *Näkemyksen kirjo, sirpaloitunut tieto. Terveysthuollon, sosiaalitoimen ja nuorisotoimen työntekijöiden käsityksiä huumeiden käyttäjien hoitopalvelujärjestelmästä*. Tutkimuksia, 155. Helsinki, Stakes. [Diverse Understandings, Fragmented Knowledge. Health, Social Welfare and Youth Professionals' Views on Drug Treatment Services]
- Lalander P. (2003) *Hooked on Heroin. Drugs and Drifters in a Globalized World*. (Translated by Alsling O'Neill). New York, Berg Publishers.
- Lehto J. (1998) Pakkohoitoa sikiövaurioiden ehkäisemiseksi? *Tiimi*, 3-4. [Is Compulsory Treatment Justified in FAS Prevention?]
- Leppo A. (2008) Pidä kiinni -projektin yhteiskunnalliset ulottuvuudet. In M. Andersson, R. Hyytinen and M. Kuorelahti (Eds) *Vauvan parhaaksi. Kuntoutuminenpäihteistä odotus- ja vauva-aikana*. Helsinki, Ensi- ja turvakotien liitto ry. [The Social Context of the "Hold On"-project. In: For the Baby's Sake. Treatment of Substance Abuse during Pregnancy and Early Motherhood]
- Leppo, A. (2009) Illusionen om enkla lösningar [The Illusion of magic bullet solutions]. *Nordisk alkohol & narkotikatidskrift* 26 (3): 314–317
- Lovell A.M. (2006) Addiction Markets. The Case of high-dose buprenorphine in France. In A. Petryna, A.Lakoff, A.Kleinman (Eds) *Global Pharmaceuticals. Ethics, Markets, Practices*.Duke University Press.
- Lovell A. M. (forthcoming) Elusive Travellers : Narcology, toxicomanias and ecological experiments of drug management. In : E. Raikhel, W.Garriott (eds), *New Anthropologies of Addiction*. Submitted to Duke University Press.
- Lundeberg I.R., Mjåland K., Nilssen E. Ravneberg B. (2010) *Tvang overfor rusmiddelavhengige. Evaluering av Lov om sosiale tjenester §§ 6-2, 6-2a og 6-3*. Stein Rokkan senter for flerfaglige samfunnsstudier, University Research Bergen, Rapport 2.
- Lupton D. (1995) *The Imperative of Health. Public health and the regulated body*. London, Sage.
- Lupton Deborah (1999a) *Risk*. London and New York, Routledge.
- Lupton D (1999b) Risk and the Ontology of Pregnant Embodiment. In D. Lupton (ed.) *Risk and Socio-cultural Theory*. New Directions and perspectives. Cambridge, Cambridge University Press.

- Marcus G. E. (1986) Contemporary Problems of Ethnography in the Modern World System. In J. Clifford and G. E. Marcus (eds) *Writing Culture. The Poetics and Politics of Ethnography*, 169-93. Berkeley, University of California Press.
- Marcus G. E. (1995) Ethnography in/of the World System: The Emergence of Multi-Sited Ethnography. *Annual Review of Anthropology* 24:95-117.
- Marcus G. E. (1998) The Uses of Complicity in the Changing Mis-en-Scene of Anthropological Fieldwork. In G.E. Marcus (1998) *Ethnography through Thick and Thin*, 105-131. Princeton, Princeton University Press.
- Mattila M. (1999) Kansamme parhaaksi: rotuhygienia Suomessa vuoden 1935 sterilointilakiin asti. Jyväskylä, Biblioteca Historica, Suomen Historiallinen Seura. [Improving our Nation: Eugenics in Finland until the Sterilisation Law of 1935]
- Measham F., Aldridge J. and Parker H. (2001) *Dancing on Drugs: Risk, health and hedonism in the British club scene*. London, Free Association Books.
- Measham F. (2002) "Doing gender" – "doing drugs": conceptualizing the gendering of drugs cultures. *Contemporary Drug Problems* 29, 2, 335-373.
- Measham F. , Williams L. and Aldridge J. (2011) Marriage, Mortgage, Motherhood: What longitudinal studies can tell us about gender, drug 'careers' and the normalization of adult 'recreational' drug use. *International Journal of Drug Policy*, 22, 420-427.
- Meskus M. (2009) *Elämän tiede. Tutkimus lääketieteellisestä teknologiasta, vanhemmuudesta ja perimän hallinnasta*. Tampere, Vastapaino. [Science of Life. Study on medical technology, parenthood and the governing of heredity]
- Metso L., Mustonen H., Mäkelä P., Tuovinen E-L. (2002) *Suomalaisten juomatavat vuonna 2000. Taulukkoraportti vuoden 2000 tutkimuksen perustuloksista ja vertailuja aiempiin juomatapatutkimuksiin*. Stakes, Aiheita 3, Helsinki 2002. [Alcohol consumption in Finland in 2000: Results and comparisons to previous years]
- Miller P. and Rose N. (1990) Governing Economic Life. *Economy and Society*, 19,1,1-31.
- Miller P. and Rose N. (2008) Introduction: Governing economic and social life. In P. Miller and N. Rose (eds) *Governing the Present*. Polity Press, Cambridge.
- Miller P. G. (2005) Scapegoating, Self-confidence and Risk Comparison: the Functionality of risk neutralization and lay epidemiology by injecting drug users. *International Journal of Drug Policy*, 16, 4, 246-253.
- Murphy S. and Rosenbaum M. (1999) *Pregnant Women on Drugs. Combating stereotypes and stigma*. New Brunswick: Rutgers University Press.
- Mäkelä K. (2009) Vård och kontroll av missbrukarmödrarna. [Care and control of mothers with substance abuse problems] *Nordisk alkohol och narkotikatidskrift* 26, 3, 318–328.
- Nätkin R (2006a) Kulttuurisista merkityksistä hoidon tutkimukseen. In R. Nätkin (ed.) *Pullo, pillerit ja perhe. Vanhemmuus ja päihdeongelmat*, 5-22. Jyväskylä, PS-kustannus. [Cultural meanings and treatment services. In: The Bottle, the Pill and the Family: Parenthood and substance abuse]
- Nätkin Ritva (2006b) Äitiys ja päihteet – kertomus ja politiikka In R. Nätkin (ed.) *Pullo, pillerit ja perhe. Vanhemmuus ja päihdeongelmat*, 23-54. Jyväskylä, PS-kustannus. [Motherhood and Substance Use – Narratives]

- and Politics. In: *The Bottle, the Pill and the Family: Parenthood and substance abuse*]
- Nuorvala Y, Huhtanen P, Ahtola R & Metso L (2008) Huono-osaisuus mutkistuu - kuudes päihdetapauskenttä 2007. *Yhteiskuntapolitiikka*, 6, 659-670. [Growing Marginalisation – Study on alcohol related visits to primary health care in 2007]
- O'Leary, C. M. , Heuzenroeder, L., Elliott E. and Bower C. (2007) A Review of Policies on Alcohol Use during Pregnancy in Australia and other English-speaking Countries, 2006. *MJA*, 186, 9, 466–471.
- O'Malley P. (1992) Risk, Power and Crime Prevention. *Economy and Society* 21, 3, 252-275.
- O'Malley P. (2004) *Risk, Uncertainty and Government*. London: Glasshouse Press
- Pajulo M. (2001) *Early motherhood at risk: Mothers with substance dependency*. Turku, Turun yliopisto.
- Partanen J. and Metso L. (1999) Suomen toinen huumeaalto. *Yhteiskuntapolitiikka* 64, 2. [The second drug wave in Finland]
- Partanen J. (2002) Huumeet maailmalla ja Suomessa. In O. Kaukonen and P. Hakkarainen (eds.) *Huumeidenkäyttäjä hyvinvointivaltiossa*. Helsinki, Gaudeamus. [Drug Use: Global and Finnish Perspectives. In: Drug User and the Welfare State]
- Peretti-Watel P. (2003) Neutralization Theory and the Denial of Risk: Some evidence from cannabis use among French adolescents. *British Journal of Sociology*, 54,1, 21-42.
- Perälä R. (2007) Huumeidenkäyttäjien tulkintoja ongelmistaan ja niihin kohdistuvista sosiaali- ja terveystoimen palveluista. *Yhteiskuntapolitiikka*, 72, 3, 256-271. [Drug users' perspectives on their problems and health and social services]
- Perälä R. (forthcoming). Haittoja vähentämässä: Etnografinen tutkimus suomensisäisten hummeidenkäyttäjien terveysneuvonnasta ja sen ympärille muotoutuvista valtasuhteista 2000-luvun Suomessa. (PhD Dissertation) [Reducing harms. Ethnographic study of health counselling for IDUs and power relations]
- Plant M. (1997) *Women and Alcohol. Contemporary and historical perspectives*. New York, Free Association Books.
- Potter, J., (1996) *Representing Reality: Discourse, Rhetoric and Social Construction*. London: Sage Publications.
- Potter, J., (1997) Discourse Analysis as a Way of Analysing Naturally Occurring Talk. In: D. Silverman, ed. *Qualitative Research: Theory, Method and Practice*. London: Sage Publications.
- Porter D. and Porter R. (1988) The Enforcement of Health: the British Debate. In E. Fee and D.M. Fox (eds.) *AIDS: The Burdens of history*. Berkeley: University of California Press, 97-120.
- Pratt M. L. (1986) Fieldwork in Common Places. In J. Clifford and G. E. Marcus (eds.) *Writing Culture. The Poetics and Politics of Ethnography*, 27-50. Berkeley, University of California Press.
- Queniert A. (1992) Risky Business: Medical definitions of pregnancy. In D. Currie and V. Raoul (eds) *The Anatomy of Gender. Women's struggle for the body*. Ottawa, Carleton University Press.
- Raskaana olevien päihdeongelmaisten naisten hoidon varmistaminen. Työryhmän raportti (2009) Sosiaali- ja terveysministeriön selvityksiä 2009:4. [Report of the Working Group to ensure the care and treatment

- of pregnant women with substance abuse problems, Ministry of social welfare and health]
- Rapp R. (1988) Chromosomes and Communication: the Discourse of Genetic Counseling, *Medical Anthropology Quarterly*, 2, 143-157.
- Rio Declaration on Environment and development 1992. United Nations Environment Program. Accessed 15.5.2010
<http://www.unep.org/Documents.multilingual/Default.asp?DocumentID=78&ArticleID=1163>
- Roberts S. and Nuru-Jeter A. (2010) Women's Perspectives on Screening for Alcohol and Drug Use in Prenatal Care. *Women's Health Issues*, 20, 3, 193-200.
- Rose N. (1999) *Powers of freedom. Reframing Political Thought*. Cambridge, Cambridge University Press.
- Rothman B. K. (1994) *The Tentative Pregnancy. Amniocentesis and the sexual politics of motherhood*. London, Pandora.
- Ruhl L. (1999) Liberal Governance and Prenatal Care: Risk and regulation in pregnancy. *Economy and Society*, 28, 1, 95 -117.
- Runquist, W., (2009) Sverige – om konsten at sila mygg och svälja kameler, *Nordisk alkohol och narkotika tidskrift*, 26, 3, 304-313.
- Rönkä S. and Salonen P. (eds.), Lillsunde P., Salasuo M. *Huumetilanne Suomessa 2006. Kansallinen huumevuosiraportti EMCDDA:lle*. Sosiaali- ja terveystieteiden tutkimus- ja kehittämiskeskus (STAKES), <http://www.stakes.fi/FI/tilastot/aiheittain/Paihteet/reitox.htm> (Accessed 16.5.2011). [Drugs in Finland, 2006. The national annual report to EMCDDA]
- Smolej M (2011) *News media, crime and fear of violence*. Phd dissertation. Helsinki, National Reserach Institute of Legal Policy, Research report 257.
- Sokol R., Delaney-Black V. and Nordstrom B. (2003) Fetal Alcohol Spectrum Disorder. *JAMA*, 290, 2996–2999.
- Stenius, K. (2009) Ogenomtänkta förslag om tvångsvård av gravida misbrukare. [Incomplete Proposals on the Compulsory Treatment of Pregnant Women with Substance Abuse Problems, editorial] *Nordisk alkohol & narkotikatidskrift*, 26, 3, 241–242.
- Sulkunen P. Alasuutari P., Nätkin R. and Kinnunen M. (1997) *The Urban Pub*. Helsinki: Stakes. (Originally in Finnish, 1985)
- Sulkunen P (2009) *The Saturated Society: Regulating Lifestyles in Consumer Capitalism*. London, Sage.
- Sulkunen P (2011) Autonomy against Intimacy. On the Problem of Governing Lifestyle Related Risks. *Telos*, 156, 99-112.
- Sulkunen P. and Warsell L. (2011) Universalism against particularism. Kettil Bruun and the ideological background of the Total consumption model. Paper presented at the 37th Annual Alcohol Epidemiology Symposium of the Kettil Bruun Society, 11-16.4.2011, Melbourne, Australia.
- Søvig K.H. (2007) *Tvang overfor rusmiddelavhengige – sosialtjenesteloven §§ 6-2 til 6-3*. Oslo, Fagbokforlaget.
- Tigerstedt C. (2001) *The Dissolution of the Alcohol Policy Field. Studies on the Nordic countries*. Helsinki: Department of Social Policy, University of Helsinki.
- Tigerstedt C. (2006) *Alkoholiolot EU-Suomessa. Kulutus, haitat ja politiikan kehys 1990-2005*. Sosiaali- ja terveystieteiden ministeriö, Selvityksiä 19, Helsinki

2006. [Alcohol in Finland and the EU. Consumption, harm and development of policy 1990-2005]
- Tulloch P. and Lupton D. (2003) *Risk and Everyday Life*. London, Sage.
- Törrönen J. and Maunu A. (2007) Whilst it's red wine with beef, it's booze with a cruise! Genres and gendered regulation of drinking situations in diaries. *Nordisk alkohol & narkotikatidskrift*, 24, 177-199.
- Virokannas E. (Forthcoming) Identity categorisation of motherhood in the context of drug abuse and child welfare services. Forthcoming in *Qualitative Social Work: Research and Practice*
- Väyrynen S. (2007) Usvametsän neidot. Tutkimus nuorten naisten elämästä huume kuvioissa. *Acta Universitatis Lapponiensis*, 118. [Enchanted girls in a Magical Forest. A study on young women's lives in the drug scene]
- Warner J. (1997) The Sanctuary of sobriety: the emergence of temperance as a feminine virtue in Tudor and Stuart England. *Addiction* 92, 1, 97-111.
- Weckroth A. (2006) *Valta ja merkitysten tuottaminen korvaushoidossa. Etnografinen tutkimus huumehoitolaitoksesta*. Alkoholitutkimussäätiön julkaisuja 47. Helsinki, Stakes. [Constructing power relations and meaning in opiate substitution treatment. Ethnographic study of a drug treatment institution]
- Weir L. (1996) Recent Developments in the Government of Pregnancy, *Economy and Society*, 25, 3, 372-392.
- Wilkinson I. (2001) Social Theories of Risk Perception: At once indispensable and insufficient. *Current Sociology*, 49, 1, 1-22.
- Wrede S. (1997) The Notion of Risk in Finnish Prenatal Care: Managing risk mothers and risk pregnancies. In E. Riska (ed.) *Images of Women's Health. The Social Construction of Gendered Health*. Publications of the Institute of Women's Studies at Åbo Akademi University, Åbo 1997, p. 133-180.
- Young I. M. 1994 Punishment, Treatment, Empowerment: Three Approaches to policy for pregnant addicts. *Feminist Studies*, 20, 1, 33-58.
- Zinn J.O. 2008. A Comparison of Sociological Theorizing on Risk and Uncertainty. In J.O. Zinn (ed.) *Social Theories on Risk and Uncertainty*. Oxford Malden (MA): Blackwell, 168-210.
- Zinn J.O. and Taylor-Gooby P. (2006). The current significance of risk. In J. Zinn and P. Taylor-Gooby (Eds), *Risk in Social Science*, 1-20. Oxford, Oxford University Press.
- Åhdahl S. (2007) *Good lives, hidden miseries. An ethnography of uncertainty in a Finnish village*. Research reports no. 250. Helsinki, Department of Sociology, University of Helsinki.