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Vicario, S., Peacock, M., Buykx, P. et al. (2 more authors) (2021) Negotiating identities of 'responsible drinking': exploring accounts of alcohol consumption of working mothers in their early parenting period. Sociology of Health & Illness, 43 (6). pp. 1454-1470. ISSN 0141-9889

https://doi.org/10.1111/1467-9566.13318

Received: 29 October 2020 | Accepted: 17 May 2021

DOI: 10.1111/1467-9566.13318

SOCIOLOGY OF HEALTH & ILLNESS

ORIGINAL ARTICLE

Negotiating identities of 'responsible drinking': Exploring accounts of alcohol consumption of working mothers in their early parenting period

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Funding information
The authors received no additional funding for this work.

Abstract

Mothers' alcohol consumption has often been portrayed as problematic: firstly, because of the effects of alcohol on the foetus, and secondly, because of the association between motherhood and morality. Refracted through the disciplinary lens of public health, mothers' alcohol consumption has been the target of numerous messages and discourses designed to monitor and regulate women's bodies and reproductive health. This study explores how mothers negotiated this dilemmatic terrain, drawing on accounts of drinking practices of women in paid work in the early parenting period living in Northern England in 2017–2018. Almost all of the participants reported alcohol abstention during pregnancy and the postpartum period and referred to low-risk drinking practices. A feature of their accounts was appearing knowledgeable and familiar with public health messages, with participants often deploying 'othering', and linguistic expressions seen in public health advice. Here, we conceptualise these as Assumed Shared Alcohol Narratives (ASANs). ASANs, we argue, allowed participants to present themselves as morally legitimate parents and drinkers, with a strong awareness of risk discourses which protected the self from potential attacks of irresponsible behaviour. As such, these narratives can be

viewed as neoliberal narratives, contributing to the shaping of highly responsible and self-regulating subjectivities.

KEYWORDS

Assumed Shared Alcohol Narratives, maternal drinking, qualitative study

INTRODUCTION

In England, over the last 30 years, female alcohol consumption has become the subject of growing public health concerns (Smith & Foxcroft, 2009). In line with international data, women are still more often lifetime abstainers than men (23% *vs*. 18%), less likely to drink on 5 or more days (8% vs. 12%), or to 'binge' drink (consuming more than 6 or 8 alcohol units[1] in the heaviest drinking day for women and men, respectively, 26% vs. 29%; ONS, 2018). The gender gap in alcohol consumption and related harm, however, is narrowing, due to an overall increase in women's drinking in all adult age groups, particularly in young adults and women in midlife (ONS, 2018). This trend, largely attributed to the growing female presence in the social and economic arenas, has been accompanied by changes to traditional norms regulating female drinking practices, associated with control and moderation (e.g. Emslie et al., 2015).

Women's drinking still appears as a morally complex balancing act, raising dilemmas around issues of respectability especially with regard to mothers (e.g. Emslie et al., 2015; Killingsworth, 2006; Waterson, 2000). Bell et al., (2009), McErlain (2015) and others argue that this view stems from longstanding associations between femininity with motherhood and its moral aspects, and the proliferation of public health messages and discourses around alcohol and reproductive health. Indeed, the phenomenon known as 'wine-o'-clock' (i.e. regular home drinking performed by mothers with young children), represented as a shared and pleasurable experience, but nonetheless one requiring a degree of legitimation, has received considerable media attention, both pre- and post-'lockdown' (Flynn, 2019; Morrison, 2020).

This study proposes a sociological interpretation of how public health messages and discourses are narratively filtered by women and linguistically conveyed to negotiate and legitimise their identities as parents and alcohol consumers. The empirical data presented here illustrate key findings from a study conducted in North-Eastern England, using a narrative approach to explore the shifts in female drinking practices during the early parenting period (0–3 postpartum years) in working mothers from different socioeconomic backgrounds. While similarities and differences in drinking practices across the social spectrum will be discussed elsewhere, here we focus on some narrative strategies common across the social divide. In particular, we put forward the concept of Assumed Shared Alcohol Narratives (ASANs), a set of discursive resources through which participants could affirm, to themselves and others, their marked adherence to public health recommendations.

Although the health and moral consequences of maternal drinking in pregnancy have been extensively explored (e.g. Lowe & Lee, 2010; WHO, 2021), far less research has investigated women's drinking in the early parenting period. The few qualitative studies exploring meanings and circumstances of maternal drinking in that phase have highlighted the narrative force of social expectations of moderation and self-control surrounding alcohol consumption (Emslie et al., 2015). Since mothers are most frequently the primary carer for children, they tend to balance the risks and rewards drawn from their drinking, and regulate their state of intoxication around family commitments (Wolf & Chávez, 2015). Mothers' drinking has been seen as a 'time out' from work and domestic duties, a

means to reconnect multiple identity aspects (e.g. autonomous woman and caring parent), or as an element of care practices (Jackson et al., 2018; Killingsworth, 2006). Other studies have explored how socioeconomic and domestic environments influence maternal alcohol use, describing participants' alcohol consumption as a cause and consequence of stressful life events (Baker, 2017; Waterson, 2000). These studies highlight a basic tension between the regulation traditionally associated with maternal consumption and the portrayal of drinking as an enjoyable and restorative activity, performed between paid and unpaid work. What is lacking in the literature is a more developed understanding of how mothers articulate socially legitimated identities, by bringing together the pleasant aspects of drinking with expectations arising from their parental role and the relevant public health messages.

Female drinking, risk messages and the self-surveillant mother

This study needs to be considered in light of a range of factors potentially influencing women's and mothers' alcohol consumption, such as the risk messages and discourses around maternal drinking, and the growing attention to maternal health practices in the context of contemporary motherhood. Mothers' alcohol consumption has been seen as a public health issue in Western countries since the early 1970s, in large part due to a growing awareness of foetal alcohol syndrome (Lowe & Lee, 2010).

While the detrimental consequences of heavy alcohol consumption have been well documented, there is still no consensus on the effects of low-to-moderate drinking on the foetus (WHO, 2021). Hence, the UK Chief Medical Officers' guidelines have shifted towards a precautionary principle, following the approach already adopted in other countries (e.g. the US, Lowe & Lee, 2010). In 2007, the guidelines advised that 'pregnant women or women trying to conceive' should avoid alcohol, but stated that if 'they do choose to drink… they should not drink more than one to two units of alcohol once or twice a week' (Department of Health, 2007). In 2017, they recommended that women in pregnancy or who 'think (they) could become pregnant' should not drink alcohol at all, to minimise the risks for the 'baby' (Department of Health, 2017). Discussing the guidelines, Lowe and Lee (2010) argue that uncertainty around the safety of drinking in pregnancy tends to expand the message of danger related to alcohol to all women of reproductive age. A primary factor underpinning this process is the imperative of children's protection, a central cultural value. More broadly, some have noted that maternal health practices potentially harmful to children (such as drinking, smoking and overeating) are central to morally loaded public health discourses and framed as deviant since they threaten infant health (Bell et al., 2009).

The critical attitude towards maternal health practices may be further emphasised by 'intensive mothering', the prevalent mothering ideology in Western culture (Hays, 1998), a second relevant factor related to female drinking. 'Motherhood' – Lupton explains – 'once taken for granted and relatively unreflective… become[s] imbued with the meanings of risk, danger, responsibility, and constant reflexivity upon how well one cares for one's children' (Lupton, 2011: 638). Based on this, some argue that maternal health practices may be seen, by women and others, as an expression of their being 'good' and responsible parents (e.g. Lupton, 2011; Murphy, 2000). Hence, health practices can generate anxieties about being judged, eliciting verbal defences to assert the acceptability of given behaviours and maternal identities.

Importantly, aspects of intensive mothering overlap with the dominant neoliberalist principles and discourses, the third factor we wish to highlight. Neoliberalism posits that 'human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterised by strong private property rights, free markets, and free trade' (Harvey, 2005: 2). Conceiving individuals as 'entrepreneurs of the self', neoliberalism constructs autonomous, responsible, self-directing human subjectivities. Individuals, considered largely responsible for their life

projects, are called to engage in continuous self-improvement, entailing constant self-monitoring and self-discipline. In the domain of health, neoliberalism promotes the idea that citizens should actively take care of their own health and wellbeing. Thus, alcohol drinking, especially in mothers, is seen as requiring personal responsibility, careful self-surveillance and respect of public health norms.

Narrative accounts of maternal health practices

Social and cultural views around alcohol impact on the negotiation of maternal drinking practices. This is a partially unconscious process, entailing the enactment and presentation of practices reflecting and constructing personal identities (Bourdieu, 1979). Other work has looked at the linguistic devices women use to account for maternal health practices regarding infant feeding and child nutrition (Bissell et al., 2018; Murphy, 1999, 2000). Murphy explored mothers' infant feeding decisions, finding that women tried to avoid social blame and present themselves as knowledgeable about their choices. Murphy drew on Mills' work on 'vocabularies of motives' (1940). For Mills, motives are at the root of subjective action and meaning-making, and may take the form of 'typical vocabularies having ascertainable functions in delimited societal situations' (1940: 904). From a sociological perspective, referring to a vocabulary of motives may be considered as a strategy of interaction, through which social actors relate their actions to codes of conduct legitimated within the group they belong to (Murphy, 2004). Hence, vocabularies of motives are not the product of an individual's mental state, but express what is acceptable in a collective setting (Murphy, 2004).

Mills' vocabularies of motives share similarities with Scott and Lyman's 'accounts' (1968). Accounts are statements used to explain practices that social actors consider 'untoward', that is, inappropriate, inconvenient. Scott and Lyman analysed the use of motive talk in empirical situations and categorised accounts as 'excuses' and 'justifications', with different subtypes. They highlighted the reparative function of accounts, as socially accepted statements that neutralise an act or its consequences when these are viewed as not fully legitimated. As such, accounts are 'a crucial element in the social order' (1968: 46). More recently, the framework of motive talk has been applied to analyse how mothers in disadvantaged conditions rationalise their non-conformity to the unrealistic demands of 'healthy eating' messages (Bissell et al., 2018). The study suggests that, in normalising 'untoward' nutrition practices, participants resisted health messages, while protecting themselves from the anxiety to be considered conscientious mothers and fit with community norms.

While previous studies have analysed the articulation of maternal identity in women's accounts of infant feeding and nutrition practices, this study focuses on alcohol narratives of mothers from different socioeconomic backgrounds. The key theme regards women's narrative negotiation of self in the transition to motherhood, and the place of relevant public health messages and discourses regarding alcohol. This study demonstrates mothers' attempts to adhere to, rather than resist, public health messages. This appeared the case for all the women and across the social spectrum, presenting themselves as morally legitimated parents and alcohol consumers.

METHODS

Sample and recruitment

This study was located in North-Eastern England and aimed to explore narratively women's drinking practices in the early maternity period, and their possible shifts after the return to work from maternity

leave. Ethical approval was obtained from The University of Sheffield (TUoS). A purposive sampling strategy was used to recruit 20 participants, to prioritise the quality of data collected. Women taking part in the study were (a) over 18; (b) preferably first-time mothers; (c) involved in paid labour, having been back at work for between a few months and up to 2 years post-maternity leave and (d) consumed at least one drink per month (to include very moderate drinkers but exclude abstainers).

We considered it important to involve participants from a variety of backgrounds, because alcohol consumption patterns and meanings vary along the socioeconomic gradient. For example, Lewer et al., (2016) found that people in disadvantaged groups were less likely to exceed low-risk limits for weekly consumption compared to those with higher status, but more likely to drink at more harmful levels. Furthermore, features of drinking occasions, such as type and place of consumption, may become symbolically marked and communicate social status (Bourdieu, 1979). These considerations intersected with the awareness that motherhood is etched by material inequalities and representations. Middle- and working-class parenting practices have been seen as diverging, with the former described as normative and socially desirable, and the latter as needful of support or change (Thomson, 2011). In light of this, participants' drinking might have been shaped by different material circumstances, and be perceived as more or less acceptable and legitimated. Thus, the recruitment aimed to reach women with different socioeconomic backgrounds, as defined through occupation. As 'labour market situation equates to… economic security and prospects of economic advancement' (ONS, 2021), following the National Statistics Socio-Economic Classification the sample was stratified into the following: non-professionals (corresponding to routine and manual occupations), professionals (higher managerial, administrative and professional occupations) and participants with intermediate job profiles (intermediate occupations). While issues related to participants' background will be addressed in a forthcoming paper, here we focus on some common narrative features.

Initially, the recruitment was conducted within the University, as it provided a large base for recruitment over a wide range of professional and non-professional occupations. Recruitment strategies included sending email invitations through TUoS mailing list, handing out flyers and placing posters in University venues. Due to the challenges in recruiting non-professionals, the recruitment strategies were expanded to include posters displayed in community settings, snowballing and advertising on Facebook parenting groups. Potential participants were contacted to verify eligibility. To identify the clusters, they were asked information regarding type of job and tasks, employment status and supervisory functions.

The final sample included 21 mothers aged 23–40, 13 recruited through the University and eight through other strategies. Eight women had non-professional occupations, ten had professional occupations, and three had intermediate job profiles (Table 1). The small sample size was necessary to allow for the collection and analysis of rich, narrative data but this necessarily means that the sample has limitations. There are fewer lower paid women and women with less education than would be found in the wider population.

Interview method and data collection

Data were collected using a biographical-narrative approach: the Free Association Narrative Interview method (FANI, in Hollway & Jefferson, 2013). This method is located in the broader field of psychosocial studies, aimed at 'researching beneath the surface and the purely discursive' (Hoggett & Clarke, 2009: 3). It understands the subjects as psychosocial, as 'simultaneously, the products of their own unique psychic world and a shared social world' (Hollway & Jefferson, 2013: XIII); and includes the role of non-discursive interactions in the research setting. In FANIs, interviewees and interviewers are posited as 'defended subjects', investing in particular positions to protect themselves against their

TABLE 1 Research participants

	Age	Child(ren)'s age(s) at next birthday	Time frame between interviews (days)	Occupational profile	Education[a]
Routine and manual occupations					
Wendy	20–25	2	7	Administrative	NVQ
Elizabeth	26–30	3	22	Administrative	NVQ
Christine	31–35	2	Single interview	Administrative	GCSE
Rosa	26–30	2	14	Housekeeper	A-Level
Tracy	26–30	3	7	Cashier	Bachelor's degree
Margaret	26–30	2	14	Waitress	BTEC
Valentina	26–30	1st child: 3 2nd child: 1	7	School supervisor, morning cleaner	NVQ
Lorna	26–30	1st child: 4 2nd child: 2	7	Saleswoman	NVQ
Higher managerial, administrative and professional occupations					
Anna	36–40	3	27	Project manager	Ph.D.
Kate	31–35	3	17	Accountant	CPA
Gemma	31–35	2	9	Researcher	Ph.D.
Jane	31–35	2	26	Administrative	Master's degree
Sophie	26–30	3	9	Researcher	Ph.D.
Ellie	36–40	2	17	Project manager	Master's degree
Julia	36–40	3	8	Researcher	Master's degree
Andrea	36–40	2	13	Researcher	Ph.D.
Louise	26–30	2	6	Researcher	Ph.D.
Laura	31–35	2	22	Researcher	Ph.D.
Intermediate occupations					
Sarah	20–25	2	20	Administrative	Master's degree
Lara	26–30	2	21	Laboratory technician	Master's degree
Stella	26–30	2	7	Administrative	GCSE

[a]NVQ (National Vocational Qualification) and BTEC (Business and Technology Education Council): vocational qualifications to age 16 or 18. CGSE (General Certificate of Secondary Education) and A-Level: academic qualifications to age 16 and 18. CPA (Certified Public Accountant): title of qualified accountant. Master's degree and Ph.D.: graduate and postgraduate qualifications.

'anxiety', a concept used neither in a clinical, nor in a colloquial sense. Anxiety is both personal *and* social: it arises in the individual as a response to biographical experiences and affects, and is affected by discourses and representations.

The method aims at eliciting extended accounts, encouraging the emergence of thoughts and feelings, and the development of reflections around a particular topic over repeated interviews. This produces rich data relating to how participants make sense of their inner reality and social milieu. The interview format, minimally structured, renders FANIs particularly suitable to explore topics likely to generate defences or apprehension, such as maternal alcohol consumption.

At the first interview, informed consent was obtained. All women were interviewed twice, except for one participant who declined to participate in the second interview. Interviews lasted approximately 1 h each. The first one included the completion of a timeline of significant life events and a first exploration of the themes of the topic guide (e.g. daily routine, changes in alcohol consumption after becoming a parent). The second interview, scheduled roughly 3 weeks after the first, had a semi-structured format to clarify inconsistencies and cover questions not asked. Participants were not asked to precisely quantify their alcohol intake to avoid socially accepted answers. However, their accounts provided indirect information on frequency and amount of alcohol consumed (e.g. number/size of wine glasses, pints of beer/cider). An analytical distinction was drawn between 'low-risk' drinking (≤14 units/week) and 'single occasion drinking episodes' (5–7 units in a 3- to 6-h period, Department of Health, 2017). As we relied on self-reported consumption and lay accounts of drinking practices, the assessment of participants' drinking involved issues already observed in alcohol-related qualitative research (e.g. how to consider expressions such as 'a few sips', or the amount of alcohol in a home-made drink, Strunin, 2001). As in Strunin (2001), we examined narrative clues concerning feelings experienced or self-evaluations regarding consumption episodes. While we are aware that our interview data could not precisely quantify the amount of alcohol used, they allowed for characterising participants' drinking patterns and styles, without obscuring cultural norms and personal approaches to alcohol consumption. At the end of the interviews, participants were offered a £25 voucher.

Data analysis

All the interviews were audio-recorded, transcribed and anonymised. Data analysis was based on transcripts, audio recordings and the timelines. Initially, the audio-analysis of the recordings led to the elaboration of reflexive notes regarding participants' accounts. This entailed interrogating participants' personal investments, positions taken, possible interaction between daily life and broader cultural dynamics. A key part of the method is the development of a 'pen portrait' (a narrative analysis of a single case study) and 'pro-forma' (a structured synthesis of the interview content) for each participant. This process formed the basis for further thematic analysis conducted across the database. The multi-layered reading of data allowed identification of relevant themes and different perspectives concerning the relationship between motherhood and alcohol. Similarities and differences in participants' accounts were analysed. Interpretative hypotheses were formulated, triangulated with literature, discussed within the research team and iteratively tested against the transcripts.

FINDINGS

The interviews gathered extended narrative data regarding how women articulated their drinking practices in the transition to motherhood, including during pregnancy. Participants contextualised their

consumption alongside broader shifts in everyday routines, in changed economic circumstances and embodied identities. Even though all participants described low-risk consumption, their accounts reflected some of the tensions and dilemmatic aspects surrounding their drinking. We focus here on three areas: articulation of risk messages and discourses regarding drinking in pregnancy; breastfeeding and vocabularies of motives around alcohol consumption; maternal responsibilities with respect to responsible drinking. The findings presented to describe the forms ASANs took in participants' accounts, allowing us to understand their narrative work around drinking. They included the recourse to neutralisation strategies, verbalisation of 'othering' and expressions commonly used in public health advice.

Public health discourses and drinking in pregnancy

One of the most striking findings was that during the interviews all of the participants talked, usually spontaneously, about their decisions to significantly reduce or abstain entirely from alcohol consumption during pregnancy. Four participants, not sharing common characteristics (e.g. in terms of socioeconomic background, or health-related lifestyle), mentioned some occasional light drinking. However, for most of the women, abstaining from alcohol was articulated almost as an expectation. This was evident from the frequent reference participants from different socioeconomic backgrounds made to their 'obvious' alcohol avoidance during pregnancy, for example:

> When I was trying to get pregnant I stopped drinking, obviously.
>
> (Sarah)

> I obviously didn't drink when I was pregnant, I forgot to mention that –that's quite important.
>
> (Ellie)

> Obviously when I was pregnant I didn't drink at all.
>
> (Elizabeth)

Drinking in pregnancy is a highly stigmatised behaviour and, by referring to their abstention, women communicated to the listener (in this context, the interviewer) their adherence to the precautionary principle. Their statements suggest that not drinking in pregnancy may be considered a widely accepted social norm. Talking about their alcohol consumption in pregnancy, several women also made great play with respect to the need to 'avoid risks' and to 'protect the baby', echoing expressions commonly used in public health literature around female drinking and reproductive health (Department of Health, 2017; Lowe & Lee, 2010). Margaret, for example, was expecting her second child and explained her decision to not drink alcohol on the ground of uncertain scientific evidence, and of her willingness to avoid 'tempting' occasions.

> Why would you even take the risk when you don't know how much of an effect [alcohol] will have? So I don't drink anything at all… I think once you've had one glass you're just taunting yourself, you just want another one. I wouldn't want to have another one… if I just don't have any… psychologically for me, I feel like I'm better for it.
>
> (Margaret)

Margaret's words recalled Lupton (2011), according to whom risk discourses are associated with well-established expectations regarding the conduct of mothers-to-be. They should act rationally, following the relevant professional recommendations and controlling their bodily needs to protect the foetus. The account also suggests that the exercise of self-discipline in relation to drinking may be less troublesome than the psychological consequences of norm transgression, associated with feelings of self-blame.

Breastfeeding and vocabularies of motives around alcohol

Reporting on their drinking practices after giving birth, many of the women reported on the issue of alcohol consumption during breastfeeding. While participants expressed common views about abstention (or significant reduction) in consumption during pregnancy, their drinking in the breastfeeding period appeared rather more varied. In particular, those from professional backgrounds talked extensively about their knowledge of consumption guidelines and scientific evidence. They explained, for example, how they progressively increased their drinking in line with the changes occurring in infant metabolism. Consuming alcohol during breastfeeding was felt to be less concerning than drinking in pregnancy, but still appeared as morally problematic.

The following quotes illustrate participants' strategies to neutralise criticism or censure around those practices that might be deemed questionable, such as drinking during breastfeeding and the resumption of drinking while babies required intensive parental care. Interviewees articulated narratives around drinking occasions using a variety of explanations. These explanations are arguably examples of 'vocabularies of motives', employed to present behaviours as socially acceptable, in line with Scott and Lyman's categories of excuses and justifications. They defined excuses as 'socially approved vocabularies for mitigating or relieving responsibility when the conduct is questioned' and justifications as 'accounts in which one accepts responsibility for the act in question, but denies the pejorative quality associated with it' (1968: 47).

For example, Ellie defended the legitimacy of her alcohol consumption on the grounds of the inconsistent advice received. She excused her conduct by asserting that she was not fully informed about the risks of her actions. Her account suggests that she had to negotiate between different information and that clearer messages might have altered her practices in favour of more socially acceptable outcomes:

> I tried to not drink so much when I was breastfeeding but I did have the odd glass of wine when I was breastfeeding as well, I don't know if that's allowed or not… there were very mixed messages.
>
> (Ellie)

This statement, describing misinformation interfering with the deployment of free will, may be included in Scott and Lyman's subcategory of 'appeals to defeasibility'. Ellie, however, presented herself as knowledgeable of the need to limit consumption, since an assertion of ignorance about professional advice would be less likely to attract sanctions, but may expose mothers to unwelcome attempts to 're-education' (Murphy, 1999). Hence, the contextualisation of drinking within an evaluation process seemed to support Ellie's position as a 'competent' parent. The theme of public health advice also recurred in other narratives. Gemma, for instance, referred to competing dialogues between the self-regulating and surveillant self, and a more resistant self that sought to express autonomy:

> It's difficult because you're told that when you are breastfeeding you shouldn't have any alcohol, so you sort of want to abide by the rules… as well as think, 'Oh well, I can do what I want, it's my body and my baby, I'll have a drink if I want to', that's the rebelling part of your brain as well. So I think I will have had a drink or two… when I got home from hospital, and then I think we probably opened the wine within a month.
>
> (Gemma)

Such a statement may be included among the 'invocation of a biological driver', with the tension between the restriction of alcohol consumption and reappropriation of the pleasure of drinking also found in other accounts in which participants explained how they started to drink again after the birth of their children. Some described their first contact with alcohol as a rewarding act that, however, required justifications. For instance, Margaret prioritised the pleasures of consumption on the basis of the deserved gratification derived from drinking. In doing this, she used what Scott and Lyman (1968: 52) termed a 'peculiar modern type of justification', namely 'self-fulfilment':

> I had one glass about a week after because *I felt like I'd earned it* [emphasis added], I had one glass of Prosecco and it was lovely.
>
> (Margaret)

Finally, other interviewees referred to the pleasure derived from drinking, but pointed out the unintentional or occasional nature of their first drinking occasions. Their statements can be considered as excuses, grounded on 'appeal to accidents' (i.e. legitimating an activity because of its sporadic nature). For example, Valentina claimed that her resumption of consumption did not depend on herself. She attributed this to her being in a situation where a friend provided alcohol and invited her to drink. Valentina highlighted the moderation of her drinking, which occurred in a context necessarily requiring responsibility (breastfeeding), and during an evening meal.

> Obviously, I need to be aware, I need to be responsible to be able to feed him. To be honest, the only reason I had my first drink after having him is because my friend brought a couple of beers round, she said, 'Oh do you want one?' I was like, 'Yeah, I can do…' and it was a month after having him… but it was, 'Ooh, this is nice, I've not had this for a while'.
>
> (Valentina)

The accounts above illustrate that all the participants used narrative strategies to describe drinking practices acceptable to themselves and which they could anticipate as being acceptable to the listener (coming from a university public health school) and thus deflecting possible criticism. In Murphy's research on breastfeeding (1999), the 'appeal to self-fulfilment' was rare because it was not perceived as a reason to position children's needs as secondary to that of their mothers. Differently, in the context of alcohol consumption, the hedonistic aspect is more socially accepted (Emslie et al., 2015). Thus, referring to the entitlement of pleasure as a neutralisation strategy did not endanger the integrity of participants' parental identity, as long as their drinking was presented as contained, context-appropriate and, above all, responsible. The motive talk about alcohol consumption incorporated references to the sense of responsibility participants felt towards their children, which could generate concern and apprehension. These feelings became explicit when interviewees talked about their approach to alcohol consumption more extensively.

Maternal responsibility and responsible drinking

After the first few months following childbirth, all participants reported that they had started to adopt more regular drinking habits. For many mothers, concern and apprehension associated with alcohol consumption appeared connected to their sense of responsibility for their children's safety, mainly expressed in two ways. For some participants, responsibility and its relation to alcohol consumption were at the centre of recurring accounts, where drinking evoked worrisome scenarios. As Sarah's quote illustrates, mothers expressed their sense of the need to be responsible parents at all times, *constantly aware* of the need to stay in *control* (emphasis added to highlight recurring expressions). Their accounts suggested the sense of guilt and shame they would have felt if, as a consequence of drinking, they could not deal with their care duties. Hence, they tended to avoid even the thought, or possibility, that this could happen:

> I think to myself, 'Well, have a drink', but then I'm always like constantly aware that I don't overdo it, because I think to myself: 'What if I do need to do something with him?' Like if there was an emergency or something, I'm always, kind of, in the back of my mind thinking about that, so I might say, 'Oh I'll have a beer', but that's it, literally.
>
> (Sarah)

Several participants presented themselves as responsible parents and drinkers by distancing themselves from 'other' styles of consumption that they deemed inappropriate. Previous research had proposed that, through 'othering', people develop their identities by difference, drawing a negative comparison with another's behaviour. Othering practices define personal values, represent positions of dominance or inferiority, and protect the self, moving away from undesirable identities (Peacock et al., 2014; Skeggs, 1997). 'Othering' may be included among the strategies used to ward off the blame for untoward behaviours. For example, while reflecting on her change of drinking habits, Rosa expressed her disapproval and 'othering' of her friends who spent considerable amounts of money on alcohol, as opposed to her careful budgeting, allowing her to 'spoil' her daughter. Similarly, Laura noted the inevitability of the social comparison among mothers and underlined her responsible approach to alcohol, thus distancing her conduct from that of other mothers she met during a hen-do:

> I was home at three o'clock, they were all at home at five, 'cause I had to get a flight the next morning, but I had three beers over the course of the whole night, and I really paced myself, and it was an unusual night, 'cause I'm never out on a night, so I was like 'Oh'. So I had three beers but my other peers, who also have children, they were one, one, one, one, one and they continued until five in the morning… I knew that I had a flight to get the next morning as well and I just thought to myself, 'I don't wanna be absolutely wrecked'.
>
> (Laura)

These narratives suggest that interviewees shared a similar vocabulary of responsibility and background expectations concerning parental drinking. These expectations, focussed on control and moderation, represented the criteria through which they evaluated both their conduct, and that of their peers.

DISCUSSION

This study focuses on the narrative strategies through which working mothers in their early parenting period articulate and negotiate their identities as parents and alcohol consumers. The findings

demonstrate how public health messages and discourses around alcohol are taken up and integrated into the presentation of self through ASANs. We conceptualised ASANs as a set of narrative resources employed by participants to express, overtly or covertly, their adherence to public health recommendations and neutralise aspects of drinking perceived as 'untoward'. As such, we propose that ASANs contribute to the construction of a subjectivity that is highly health conscious, self-surveillant and oriented to orthodox public health messages, while also replicating neoliberal discourses around responsibility for personal health and the health of others (Lupton, 1999). This subjectivity was mirrored in the discipline participants exerted over their bodies through the control, monitoring or denial of drinking.

ASANs, we suggest, are likely to be employed in numerous settings where people need to account for their drinking practices. However, they are more clearly identifiable in contexts that elicit anxiety, where the self is potentially exposed to critical external judgments. These might include the research encounter, where the description of daily drinking practices could be felt as under the magnifying glass of an 'other' representing an organisation (a university) contributing to the institutionalisation and dissemination of public health messages. In such contexts, we would argue that ASANS, and the public health messages they support, represented an important source participants drew from to construct and obtain legitimacy around their drinking practices, at different levels. We make some additional points about the significance of ASANs below.

Firstly, ASANs in this study represent specifically gendered narratives, through which participants re-affirmed notions of respectability characterising their drinking and its moral legitimacy. Respectability is a symbolic capital associated with moral authority and worth, displayed via conducts and bodily practices considered 'right' and appropriate, and has been considered to be central to the construction of female legitimacy (Skeggs, 1997). Through their accounts, participants aligned their drinking to the core values of respectability: (embodied) moderation, control, care of self and others. Thus, they placed themselves within the boundaries of normative, and thus morally acceptable, female drinking patterns.

Secondly, ASANs facilitated the recognition of the participants as knowledgeable drinkers, aware of public health guidelines and actively engaged in the promotion of health for themselves and their children (Lupton, 2011). Through responsible drinking, participants adopted a code of conduct that, following current cultural orientations, defined them as competent and adequate members of society. This kind of social recognition, we argue, may be connected with a third crucial element regarding legitimacy, concerning participants' parental role.

The search for acknowledgement as a responsible mother is both a private and public matter (Murphy, 2000). Parents, and mothers in particular, have been assigned the practical and moral duty to care for their children's development and guardianship (Lupton, 1999). As Lupton notes, 'women have been constructed as active citizens… predominantly through their responsibilities in caring for the health and wellbeing of others, particularly as wives and mothers. Their efforts in fulfilling these responsibilities are aligned with those of the state through risk and public health discourses' (1999: 62). Over the last century, mothers have been seen as increasingly responsible for their children's development for many reasons, including the privatisation of care work and the decrease in family size, contributing to the perception of children as a precious resource, mirroring parental skills and achievements (Lupton, 1999). As participants' narratives show, maternal responsibility needed to be constantly narratively re-confirmed in interactional settings and was felt as a moral imperative. Responsibility can be described as 'the integration of feelings, cognitions, and behaviours and may be more accurately represented as an ongoing perceptual state' (Leslie et al., 1991: 199). Such a condition was mirrored in participants' monitoring of their alcohol consumption and, consequently, in the permanent task of self-surveillance and regulation of their corporeal selves. If in the contemporary

concept of health, bodily regulation is seen as an outward sign of a moral standard (Crawford, 2006), our findings suggest that the ethical dimension of bodily control is even more salient in relation to motherhood, as it was intertwined with the concern of preserving children's health. Thus, our results contrast with the stereotype of 'wine-o'-clock' proposed by the media, and more in line with recent evidence on the improvement in parenting practices related to drinking (Oldham et al., 2018).

ASANs, due to their function in terms of constructing positive, legitimate social identities in relation to an external gaze, can also be considered to be protective narratives, partly comparable to others identified in the literature. Rhetorically, ASANs share common characteristics with the speech patterns identified by Bissell et al., (2018), who analysed how mothers neutralised their untoward conducts in the context of healthy eating messages. These authors noted that participants introduced in their accounts excuses, justifications and rationalisations, formulated with different degrees of awareness. Where participants articulated untoward behaviours, they expressed justifications or rationalisations for these in an assertive or common-sense style, strongly inviting the interviewer to express approval, rather than ask for clarification or raise doubts. Through their narratives, mothers sought to legitimise themselves by normalising untoward behaviours around food. As such, their accounts expressed resistance to healthy eating messages, by exposing the failure to conform to unrealistic standards. In this study, participants used ASANs to support the fluidity of the conversation and to protect the self. However, their function is markedly different from Bissell et al., as participants negotiated and obtained legitimacy by demonstrating a firm adherence to public health messages. As an example of how ASANS function, many participants referred, unprompted to their 'obvious' abstention during pregnancy, a topic in which the concept of risk has a central place. Lowe and Lee (2010) observed that, by recommending abstention from alcohol without clear evidence, guidelines link the concepts of 'risk' and 'danger', with moral and ethical implications for women. In this study, participants anticipated possible external judgments by introducing the information regarding their abstention in a common-sense style, with a standardised reply. Hence, by aligning to the relevant guidelines, they could place themselves on the 'safe' ground of responsibility and be recognised as conscientious mothers.

ASANs encompassed strategies of rationalisation and accounts as seen with Scott and Lyman's conceptualisation of motive talk, articulated especially in the accounts of drinking during breastfeeding. Through these, participants affirmed acceptable identities by neutralising possible 'untoward' drinking practices. Even though the 'untoward' aspects of their alcohol consumption may appear limited, we would argue that the pervasiveness of risk discourses and expectations around alcohol and motherhood may lead women to consider even small amounts of alcohol as questionable, or dangerous. Consequently, through ASANs, participants could present their drinking while remaining consistent with an adherence to public health messages and adequate mothering practices. Participants' narrative work also shed light on the tension between two contemporary, opposite representations of health (and drinking practices): health as a denial of pleasure and discipline, or as a release and enjoyment (Crawford, 2006). Crawford argues that in the contemporary construction of health, people oscillate between these oppositions, trying to find a balance between them. In doing so, they engage in a cyclic process, because disciplined health practices intensify desire and self-indulgence, which is subsequently compensated by a need for greater control. In this study, ASANs represented a discursive attempt to reconcile the dualism of denial and pleasure, finding a 'good enough' balance. The pleasure of drinking was something participants felt entitled to, 'earned', after tight self-regulation and physical restraint. However, such pleasure could be experienced only in a much rationalised manner, as it was compressed by caring duties and the imperative of maternal responsibility.

ASANs, we would also suggest, allude to 'othering'. Participants' narratives recall those of previous studies, observing that attributing unwanted behaviours to real or imagined 'others' is a powerful

discursive tool to construct legitimation around drinking. Othering may be directed from middle-class drinkers to those in lower social positions or from older to younger drinkers (e.g. Emslie et al., 2012; Rúdólfsdóttir & Morgan, 2009). In this research, the 'others' were constructed as those who breached the integrity of parental conduct and, because of this, emphasised participants' higher moral position. 'Othering', we would suggest, may be here understood as a neoliberal narrative, focussed around the presentation of a self-regulating, responsible and autonomous self (Peacock et al., 2014). As such, othering could be accompanied by concurrent processes, including constant self and social scrutiny, and the self-surveillance of the quantity of alcohol consumed. Thus, 'othering' drinking practices deemed inappropriate was intended both to avoid forms of 'mother blaming', and to position participants as consumers able to discipline their drinking.

Finally, ASANs incorporated commonly accepted expressions, recalling the ideas and language of public health discourses (i.e. risk avoidance, awareness, responsibility regarding drinking), corroborating at the verbal level participants' positions within the sphere of legitimated practices. Such expressions, found in many accounts, are here visible in Margaret's consideration of the importance of not taking risks during pregnancy, or Valentina's statement about the need to be 'aware' and 'responsible' in relation to her drinking, to be able to take care of her child.

ASANs, as we see them here, were linguistic strategies employed by all the interviewees, independent of their socioeconomic background. Following Crawford (2006), this may be due to the 'supervalue' status of health, as it encompasses the key qualities of good citizenship. Hence, demonstrating 'health consciousness has become increasingly unavoidable' (2006: 415), regardless of an individual's socioeconomic position. Participants' conformity may be explained through the percolation of public health and risk discourses around alcohol along the social spectrum. Lee et al., (2016) describe this process in terms of the 'democratisation of risks' regarding maternal drinking. This expression 'draw(s) attention to the expansion of the definition of the problem of drinking in pregnancy to include any drinking and all women', regardless of their social conditions (Lee et al., 2016: 247). Hence, women may be exposed to messages and discourses that, while leading to a wide recognition of the problematic aspects of drinking, also amplify their apprehension in relation to *any* alcohol consumption. Our findings corroborate this conclusion and propose that the use of ASANs in participants from different backgrounds is suggestive of a high awareness of risk messages around alcohol, especially those concerning their reproductive health. These appeared to have successfully tapped into women's feelings of parental love and their efforts to be responsible mothers.

A potential limitation of the study is the inclusion of a small number of participants from markedly disadvantaged social groups. Even though we did not achieve the desired balance between professionals and non-professionals, there was a socioeconomic gradient in the sample, indicating the potential generalisability of our findings. In addition, while obtaining rich narratives, the study relied on a limited group of participants, composed of heterosexual, British mothers. A greater sample differentiation might have better highlighted similarities and differences in participants' approaches to alcohol. Hence, future research might explore the use of ASANs in samples more varied (e.g. in relation to ethnicity or gender).

CONCLUSION

This study proposes the concept of ASANs, a set of narrative strategies through which participants filtered, conveyed and re-affirmed, at the micro-level, public health messages around alcohol consumption. In doing so, they protected the self, while reproducing ideas and practices regarding drinking, emphasising self-surveillance and control. ASANs, we propose, should be understood as neoliberal

narratives, contributing to shape highly responsible and self-regulating subjectivities. As such, they appeared as a crucial resource for participants to negotiate and obtain social legitimacy, affirming their moral value as mothers and alcohol consumers. The shared articulation of ASANs is suggestive of the percolation of public health and risk discourses around alcohol and reproductive health across the social spectrum. The concept of ASANs illuminates one of the pathways through which public health messages 'get under the skin', constructing women's inner, social and embodied identities and offers an original insight into how they interact with peoples' normative, emotional and ethical spheres.

ACKNOWLEDGEMENTS

We are very grateful to all the participants for talking freely about their drinking, and to the School of Health and Related Research for founding participants' incentives.

AUTHOR CONTRIBUTIONS

Serena Vicario: Conceptualization (equal); formal analysis (lead); investigation (lead); writing–original draft (lead). **Marian Peacock:** Conceptualization (equal); supervision (supporting); writing–review and editing (lead). **Penelope Buykx:** Conceptualization (equal); formal analysis (supporting); supervision (equal); writing–review and editing (equal). **Petra Meier:** Conceptualization (equal); formal analysis (supporting); supervision (lead); writing–review and editing (equal). **Paul Bissell:** Conceptualization (lead); formal analysis (supporting); methodology (lead); supervision (equal); writing–review and editing (lead).

DATA AVAILABILITY STATEMENT

Data availability statement: The data supporting the findings of this study are available from the corresponding author [SV]. The data are not publicly available due to privacy or ethical restrictions.

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ENDNOTE

[1] In the UK, one unit of alcohol equals 10 ml/8 g of pure alcohol.

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How to cite this article: Vicario, S., Peacock M., Buykx P., Meier P. S., & Bissell P. Negotiating identities of 'responsible drinking': Exploring accounts of alcohol consumption of working mothers in their early parenting period. *Sociology of Health & Illness*. 2021;00:1–17. https://doi.org/10.1111/1467-9566.13318