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The experiences of women who quit smoking during pregnancy and how they dealt with their spouses' continued smoking

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ABSTRACT

Objective: to explore how pregnant women in Taiwan dealt with their spouses who continued to smoke and with passive smoking during their own process of quitting and abstaining.
Design: a qualitative study using an oral history approach. Data were collected via tape-recorded open-ended interviews. All interviews were transcribed verbatim. Data were analysed using narrative analysis.
Setting: the homes of the participant women living in the district of a regional hospital of eastern Taiwan.
Participants: a purposive sample of 10 Taiwanese women who had quit smoking while pregnant was recruited at 1–3 months following the birth of their infants.
Findings: five major themes emerged: (1) the women coping with tobacco addiction on their own, (2) creating a non-smoking section or environment at home, (3) dealing with passive smoking, (4) conflict over the wife's sensitivity to her spouse's residual tobacco smell, and (5) allowing the husband to continue smoking to avoid conflicts.
Key conclusions: the pregnant women were expected by their spouses to quit smoking, yet the husbands continued to smoke. Women had to struggle to quit smoking on their own. The findings from this study support the need to listen to pregnant women's stories, as this is paramount to understanding their experiences of tobacco-use reduction and cessation, and for developing gender appropriate interventions to support their efforts.
Implications for practice: health care providers should encourage and help pregnant women who are willing to quit smoking. This help could be more family-centred instead of focusing on the pregnant women alone, and therefore involve educating the spouse to support his wife.

Introduction

Smoking during pregnancy may readily lead to premature birth and the slow growth of the fetus *in uterus*; the more a pregnant woman smokes, the greater the influence will be (Hammoud et al., 2005; Vardavas et al., 2010). Various studies have shown that half of pregnant women who smoked intended to quit smoking during pregnancy, especially in the first trimester, and that as soon as they found themselves pregnant, they intended to do so. This is because they wanted the fetus to be healthy and not affected by smoking (Thompson et al., 2004; Näsman and Ortendahl, 2007).

In Taiwan, about 4–5% of pregnant women smoke cigarettes, about 60% of the pregnant women's spouses also smoke, and almost all of smoking women's spouses smoke. Even though the women may actively quit smoking during pregnancy, they will still encounter secondary smoke (passive smoking) at home (Shih et al., 2008). If the pregnant woman does not smoke cigarettes herself but is exposed to the surroundings of such secondary smoke, the fetus will be influenced, being smaller than the normal gestation age (SGA) and easily become a low birth weight infant (Hammoud et al., 2005; Aagaard-Tillery et al., 2008). The difficulties confronted by pregnant women intending to quit smoking have been shown to be associated with having spouses who smoke (Ma et al., 2005; Schneider et al., 2010). Also, the strongest

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predictable factor for a pregnant woman who has quit smoking to resume the practice of smoking after birth is that of her spouse smoking (Moffatt and Whip, 2004).

For pregnant woman who quits smoking, the symptoms of withdrawal such as unstable emotions, insomnia and thirst will decrease the longer she abstains from smoking. These withdrawal symptoms may be ignored because of the strong nausea and vomiting during the early stage of pregnancy (Thompson et al., 2004). However, when the woman sees her spouse smoking or the cigarettes at home, this could undermine her determination to quit smoking (Tod, 2003; Moffatt and Whip, 2004). On the other hand, the pregnant woman able to quit smoking during pregnancy may encounter her spouse's encouragement and supporting acts and therefore feel she is not alone in facing the challenge of quitting (Koshy et al., 2010). Therefore, when health care providers help a pregnant woman quit smoking, they are advised to invite and teach her spouse to support her. This will lead to a more significant rate of smoking cessation than simply helping only the pregnant woman quit smoking (McBride et al., 2004).

Once a pregnant woman quits, she may like to change those situations that might entice her to resume the practice, and she may also expect her spouse to reduce or quit smoking, or at least not to smoke in her presence. However, although the spouse who smokes may expect the pregnant woman to quit smoking, he does not always provide her with real support, or himself quit (Thompson et al., 2004), possibly giving only a verbal promise that remains unfulfilled (Bottorff et al., 2010). Although the husbands may know the expectation of their wives and accept some pressure, they may also think the fetus is protected in the womb and therefore passive smoking should not affect the fetus (Wakefield et al., 1998). When the secondary smoke of the spouse becomes the focus of conflict for the couple, threatening their relationship, the pregnant woman more often than not is faced with great psychological pressure (Bottorff et al., 2006). Accordingly, after the pregnant woman quits smoking, her attitude towards her spouse's smoking may change; she not only has to face her spouse's secondary smoke, but also face a change in the relationship with her husband.

In Taiwan, the population of smoking females has gradually increased. Women's smoking rate was 2.3–3.8% between 1986 and1996, which increased to 4.1–5.3% between 1999 and 2007 (Bureau of Health Promotion, 2008); thus, quitting smoking by pregnant women has become an important issue. However, in Taiwanese culture males seldom change their lifestyle or habits for their wives, and this includes few Taiwanese males quitting smoking during their wives' pregnancy (Chen et al., 2002). Given that nearly all spouses of smoking females smoke, it is not surprising that 80% of women continue to smoke during their pregnancy. Those who do quit have a relapse rate of 69.2% after the birth of the first child and 91.7% after the second child within one year after the birth of their child (Shih et al., 2008).

In 2004 the Taiwan government began promoting ‘smoke-free families’. According to an evaluation report for this program, the cessation rate for participants one year after joining the program was 21–22%, (Bureau of Health Promotion, 2006). However, there has been no further follow-up evaluation for this program.

Although health care providers advise smoking pregnant women to quit, they encounter not only this significant percentage of women who continue to smoke during pregnancy but also neglect the passive smoking that pregnant women have to face after quitting. Those who successfully quit may face their spouses' secondary smoke, and have to avoid or otherwise deal with passive smoking. When their spouses do not accept their advice or requests to quit smoking, they may feel disappointed. Research related to these aspects of quitting is limited. By knowing the pressures and difficulties confronted by pregnant woman in having to deal with passive smoking, and helping the pregnant woman herself to quit smoking, we can better know how to reduce those pressures. We can learn how to offer the pregnant woman adequate support and help, and how to develop communication with the spouse to encourage him also to quit or, in the least, to reduce the number of cigarettes smoked. Therefore, the aim of this qualitative research was to explore how pregnant women dealt with their spouses who continued to smoke and with passive smoking during their own process of quitting and abstaining.

Methodology

Study design

This study used an oral history method to capture personal stories and construct new evidence and avenues for future research. It explored the individual and, thematically, the collective experience of pregnant women who encountered their spouse's secondary smoke, thereby generating evidence where little other documentation exists (Thompson, 2000). We considered oral history as more attuned to compiling short narratives about people and particular events, as in this case (Feldstein, 2004). As a research methodology, it allows the individuals to be central to the empirical data, giving voice to those who have arguably been ignored, marginalised or silenced within particular contexts. As our study was focused on a particular event in the women's lives, with practical implications, rather than a more philosophical understanding of what this meant for them, we opted for oral history rather than a phenomenological approach. Our interview style encouraged the participants to recall and convey their spouses' secondary smoke issues and what it meant to be pregnant and a mother, or how the situation strained relationships, or how it was done and how the participants felt about doing it, etc. Using the oral history approach vis-à-vis two to three times deep interviews provided an opportunity for participants to articulate their own situations and feelings, memories were understood in new ways, and the self story is both confirmed and recreated. This oral history method has been considered appropriate in the verbalisation of different beliefs and particular experiences, allowing for the exploration and elaboration of lives, or aspects of life, in particular (Thompson, 2000; Banks-Wallace, 2002).

Ethical considerations

This study was approved by the ethics committee of the hospital. Written informed consent was obtained from each participant before the interviews. Confidentiality and the right of refusal at anytime were stressed. The data disclosed in the interviews were confidential. To preserve the participants' anonymity, pseudonyms for all persons were used throughout the research.

Participants

Inclusion criteria for participation in this research were (1) the female and her spouse were older than 20; (2) each spouse was a current smoker (defined as one who had smoked at least 100 cigarettes in their entire life and was currently smoking every day or some days) (Centre for Disease Control and Prevention USA, 2011); (3) the pregnant woman was in her third trimester, had quit smoking in the first trimester of pregnancy, and had not smoked until after she gave birth; (4) both the pregnant woman and the fetus had no major obstetrical or medical complications according to the antenatal check chart, and had a singleton pregnancy.