

Chapter XII

Dynamic between Partners and Pregnant Women in Relation to Smoking Cessation

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Abstract

Fathers-to-be are important factors in women's continued smoking during pregnancy irrespective of whether they themselves smoke or not. The study explored this by using data from two sets of interviews. One set consisted of interviews with 17 pregnant women and the other with 24 midwives working in Swedish antenatal care. Four themes were generated in data from how the pregnant women saw the partner's importance: his smoking behaviour, lack of understanding, feelings of being blamed and impact of withdrawal symptoms on the relationship. Whether or not the man is a smoker, the smoking issue has negative implications for the relationship. Even though midwives were often aware the problem of smoking cessation was a dynamic in the relationship, they dealt with it in different ways, either as a medical expert who acquired information or as a facilitator of dialogue. One objective of health education during pregnancy should be to improve dialogue between the parents-to-be about the meaning of smoking, since the risk is that smoking cessation attempts are abandoned in favour of harmony in the relationship. The partner should be acknowledged at his own pace as 'being an expectant father', with his own experiences, needs and thoughts.

Keywords: *Smoking cessation; Pregnancy; Partners; Relationship; Health education; Motivational Interviewing.*

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Introduction

Most smoking cessation interventions during pregnancy are focus exclusively on the individual. However, a woman's ability to give up smoking is very much influenced by her social circumstances. Those social circumstances not only include various social and economic pressures but also the smoking habits of those in her immediately surroundings [1, 2].

Closest of all is her partner, often also a smoker, but his role needs to be seen in its complexity beyond the obvious negative influence of the smoking behaviour itself [3]. Since pregnancy is seen as a golden opportunity to stop smoking for women [4], it is often assumed that this also applies to fathers-to-be. The partner is seen as an important target for smoking cessation, as a way to support his woman to stop smoking [5]. However, addressing the partner's smoking behaviour has been shown to meet resistance [6]. Ziebland and Fuller [7] concluded that men's motivation more often increases later after delivery when the baby feels more real. They suggest that: "Quit attempts may be more successful if the couple recognise any mismatch in the timing and intensity of their motivations to quit, rather than following advice that may impair conjugal harmony" (p. 239).

Another way to see the partner's role in the woman's smoking behaviour is his emotional support or often rather non-support to the woman. This is independent of whether he smokes or not, since non-smoking partners could be counterproductive to pregnant women's attempts to stop smoking [8]. In an intervention by McBride et al. [8], partners' support to stop smoking during pregnancy was addressed. Counselling in phone calls was done separately with the man and the woman. The explanation for the sparse effects of the intervention was that men had greater difficulties than expected in thinking relationally. The authors concluded by suggesting the development of approaches with further refinement of couple-based support [8].

The partner's role in the context of pregnant women may therefore be seen in the light of mismatch in motivation and as social support for the woman. According to Donovan [9], pregnancy itself involves a transitional period in adulthood for the woman and also for the man. This change in life entails an emotional mismatch between the two that might be important for the couple's relationship.

Research on Swedish antenatal care could shed some light in this issue. Almost all pregnant women participate in a health screening and health education programme that also includes the smoking issue. Partners also are attending the encounters with midwives with increasing frequency during pregnancy, and at least at the first visit of a total 8-12 visits during the pregnancy. In a national project, "Smoke-free pregnancy", which has been in progress ongoing since 1992, Motivational Interviewing (MI) training is offered to interested midwives, although they focus on the individual. One of the aims in the project has been to encourage the midwives to emphasise smoking by establishing a dialogue [10]. The method sets out to actively engage the client by placing her in the role of expert on her situation, in which she has to verbalise her thoughts, feelings, and ambivalence to achieve changed behaviour [11]. The method is used increasingly frequently, primarily with women, but some midwives also have experience of using it when partners attend together with their women.

This paper explores experiences of the partners' role for women's smoking cessation attempts during pregnancy. Experiences of women smokers, and midwives working in Swedish antenatal care, are explored together and linked to how midwives talk about how they address the smoking issue in the relationship between the parents-to-be.

Method

Data for this paper are drawn from two sets of open-ended interviews undertaken as part of a set of studies on smoking cessation in pregnancy, one with pregnant and post-pregnant women and the other one with midwives [12, 13]. In both, the sampling of interviewees was purposive and designed to select "information-rich" cases. In order to uncover different experiences, respondents were drawn from a variety of different backgrounds [14].

In total 17 pregnant and post-pregnant women were interviewed, all with partners. They had a variety of smoking cessation patterns, everything from complete stoppage to having made no change at all. For those who changed their pattern of smoking, the point of time for changing varied from early pregnancy to after the delivery. In the latter case the time after delivery varied from three weeks to six months. Interviewees were sampled in co-operation with midwives working in antenatal care. Midwives not involved in the study were consulted with regard to the sampling frame.

Interviews with 24 midwives were performed. Criteria in the selection of individuals were variation in interest in the development of ways to address the smoking issue and/or variation in how much they had participated in training in Motivational Interviewing. Sampling was conducted in areas where training in person-centred methods had been offered to the midwives.

Each interviewee was informed about the aim of the study, told that participation was voluntary and that it was possible to withdraw when ever they wished. They were also informed about how confidentiality would be maintained. Only the interviewer knew who had been selected for an interview. Tape-recordings, transcriptions and lists of names were kept in different locked places. In the reporting no details of the area or personal characteristics were given that could identify the individual interviewee. For those who gave their written consent to participate, an appointment was made for an interview.

Interview guides that covered different areas of the research question were used in both sets of interviews. Interviews were initiated with a broad question that aimed to elicit narrative answers. The response was followed up by open-ended questions. Summaries were used to arrive at a deeper common understanding between the researcher and the interviewee [15].

The interview guide that was used with the pregnant and post-pregnant women contained questions about experiences of smoking cessation focused on pregnancy, social implications of smoking and knowledge about risks [12]. The interview guide used with the midwives concerned experiences of addressing smoking cessation, objectives of the encounter, how midwives brought up smoking and their feelings about addressing the smoking issue [13].

In both interview sets, the interviewees mentioned the partner's importance in women's smoking cessation as important. Pregnant and post-pregnant women's statements were

followed up with questions about their experiences of partners' smoking and how important he was for their own attempts to cease smoking. Midwives statements about the partner's importance were followed up by additional questions about their experiences of counselling on smoking when partners attended and how they usually involved them in this.

This study used data from both sets of interviews that covered the partner's importance for pregnant women's attempts to stop smoking. In accordance to Taylor and Bogdan [16], a thematic analysis was undertaken by using the software package Atlas-ti. Data from the interviews with the pregnant and post-pregnant women were concentrated and patterns emerging were compiled into themes. Data from the interviews with midwives were concentrated and patterns emerging were listed. The same themes that were emerging from the analysis of interviews with pregnant and post-pregnant were the same as those emerging from the interviews with the midwives. These themes were subordinated into the two categories that could be formed based on their talk about how they approached parents-to-be.

Results

Pregnant Women's View of the Significance of Partners for their Smoking

In interviews with pregnant women four themes of experiences of the meaning of the partner for her smoking cessation were formed: *the partner's smoking behaviour*, *lack of understanding from partners*, *feelings of being blamed* and *impact of withdrawal symptoms on the relationship*.

The partner's smoking behaviour

The women's view of the significance of *the partner's smoking behaviour* was only to some extent focused on pregnancy as a golden opportunity for the partner to stop smoking. One of the women talked about how both she and her man succeeded in stopping smoking together.

We both struggled together and he was so sick. It was much worse for him than for me. I thought, if he can succeed in this, then I can too. Post-pregnant woman 13.

The quotation shows how the pregnant women sees the struggle with smoking cessation as a kind of common project, built on equal motivation and mutual support. However, more common in the interviews was women's disappointment with the partner's shortcomings in stopping smoking. In this example, the partner's failure is talked about as a reason to start smoking again.

It would have been much easier if we had both stopped, but he started again without telling me. He annoyed me a lot and I don't trust him any longer. Then I started smoking again and I even smoked more than before. It's not fair, why should I do this on my own? We are both parents-to-be, aren't we? Pregnant woman 15.

One of the pregnant women said that her partner did not see the point of stopping smoking at all.

When I wanted him to stop he said to me, but why, what's the point of me stopping smoking? He didn't think of the foetus at all. He kept on smoking everywhere and didn't even go outside to smoke. Post-pregnant woman 10.

Seemingly, these partners were not ready to stop smoking.

Lack of Understanding from Partners

A *lack of understanding from partners* was common, which resulted in complications in relation to the partner concerning smoking. The women's experiences were, for example, that the partner could annoy them and make it more difficult for them to stop smoking. The women became disappointed since they could not get along with the partner as well as they used to do before the pregnancy.

He kept on telling me to stop smoking and I got angry with him, although he just wanted me to do the best for the baby. It was not so easy for him, he didn't know what to do, he didn't understand. Pregnant woman 2.

I get so annoyed, and he take sit to heart. Then I can't stand all that silly things he says. It gets bigger and bigger. I mean we don't usually argue. Pregnant woman 6.

Feelings of Being Blamed

Even though she could see that these efforts were about getting her to stop smoking and not damage the baby's health she got *feelings of being blamed* from him, and therefore defence was natural. It could even be counterproductive, as she felt as if she wanted to smoke more.

I felt like he was accusing me when he told me to stop, and he made me feel even more stupid. I took another one because I felt awful. I don't think he was aware that he hurt my feelings, and I said nothing because I had nothing to say. All went wrong and we just continued this way. It would have helped if he had said something nice. Pregnant woman 9.

Negative Impact of Withdrawal Symptoms on the Relationship

Other experiences women talked about were *negative impact of withdrawal symptoms on the relationship*. They could have dramatic consequences for smoking cessation and their relationship.

Ok, I could stand the withdrawal symptoms, but I get so angry and silly. If I could get red of this it would be okay. It affects everybody around me. My partner says that I get so mad you can't do stopping smoking. It's better for you keeping on smoking. Why don't you start again? That makes me even more angry. Pregnant woman 6.

This influence of smoking cessation on their relationship made the pregnant woman and her partner come to the point where they had to decide whether smoking cessation was worth the cost.

Midwives' Views of the Partner's Significance for the Woman's Smoking Cessation

Midwives were often aware that the dynamic in the relationship between the parents-to-be was important to woman's smoking cessation, although they dealt with it in different ways. Two approaches previously described in Abrahamsson [13] were found useful to form the categories: medical expert and facilitator. These represent the two ways midwives talked about how they approached and explained the importance of partners for the woman's smoking cessation. In the medical approach it was addressed by giving information and in the facilitator approach by encouraging a dialogue about the difficulties.

The themes identified and described above, based on data from interviews with pregnant smokers will be described in this part from the perspective of midwives. The themes *the partner's smoking behaviour*, *lack of understanding from partners*, *feelings of being blamed* and *impact of withdrawal symptoms on the relationship* will be described in accordance with how midwives holding each approach talked about the smoking issue among parents-to-be.

Medical Expert Approach

Among midwives who talked about smoking as medical experts, the overall approach to addressing the smoking issue was by giving information. This was also believed to help the partner better to encourage his woman to stop smoking. The midwife took the role of being a spokesman for the baby and involved the partner in a fruitful way in the woman's attempts at smoking cessation.

The midwives approached *the partner's smoking behaviour* by giving him information about the risks of smoking. The midwife asked him whether he smoked or not, and how much. If he smoked, he was informed about the risks of passive smoking during pregnancy and for the newborn baby.

I ask him if he smokes and if he does 'I'll get on him as well'. I tell him about passive smoking, and he gets this little leaflet about risks to the child. Midwife 1.

But it's not just about pregnancy, it's also about being parents with a little baby, and allergy, asthma and so on. Midwife 2.

Among midwives who talked about approaching smoking in this manner, pregnancy was often assumed to be as much a golden opportunity for partners to stop smoking as for women. One midwife says:

... because I see the use of supporting each other in this. They've got a golden opportunity to do this together. He could support his woman by stopping smoking and it is easier for her if he helps her in this. Midwife 3.

As a consequence of this perspective, advice and support to stop smoking is offered individually to both as being equally important for the health of the foetus and the child.

Both receive an offer to get support in stopping smoking. I don't separate the woman and her partner, I see the couple as individuals who smoke. Midwife 33.

Ignorance was believed to be the reason for smoking during pregnancy. To stop smoking or avoid smoking in front of the woman was therefore seen in this approach as a rational decision based on responsibility for the baby's health and therefore he needed information.

Lack of understanding from partners and the woman's *feelings of being blamed* were also believed to be an issue caused by ignorance. This was thus met by the midwife telling the partner about her own experiences of pregnant women's reactions when they tried to cease smoking. He was informed that women in general reacted defensively when partners were nagging even though the partners did it in their efforts to support the women to stop smoking. A better alternative was to encourage her by giving compliments and to respect her own will.

The woman often gets very irritated when her partner tells me that I have to make sure that she will stop smoking. He has to understand how she reacts as a smoker. A smoker has to make up her mind on her own. No one can make up her mind for her. A better way for him to help her is to give compliments when she does something like cutting down. Midwife 17.

Impact of withdrawal symptoms on the relationship could not be identified in data that formed this approach.

Facilitator Approach

In the facilitator approach, the midwives were talking about an approach that proceeds from the men's desire to support their women. They, as well as the pregnant women, wanted to give the child a smoke-free start. However, they needed to listen to the woman's view on the problem of stopping smoking, which could improve his success in supporting her to stop smoking. The approach of enabling the woman and her partner to give voice to their thoughts, intentions and feelings was believed to improve both parties' chances of smoking cessation.

When he's nagging at her I start to ask her about her feelings when he's telling her off. I try to get her to bring to the fore her own thoughts and anxiety about her smoking without defending it. There will often be some arguments here, but after a while she comes up with her worries, and he often has had no idea about this. It's important to her that she says this herself and that a great deal of attention is paid to her worries. Otherwise, there is a risk that their relation gets poisoned by this since they live with it all the time. By this time I often leave it here for them to think it over. Maybe I ask them if they want to talk more about it, or if they want to carry on with it next time we meet. Midwife 20.

The partner's smoking behaviour as an important factor for the woman's smoking was tackled by initiating dialogue either about his own smoking or as something negative for the woman. The following quotations illustrate this.

I ask him if he smokes and if he does, I'll ask him about his thoughts and if he has considered stopping smoking. Midwife 3.

Some midwives using this approach had noticed that pregnancy could not be taken for granted as a golden opportunity for the partner to stop smoking. Therefore they spoke about how they could acknowledge him as a father-to-be as a way to improve his motivation. The partner's feelings of involvement and importance for pregnancy outcome were believed to increase by inviting him into a dialogue about his role.

I try as much as I can to get the father to come, because I want him to feel that he is as important for the baby's well-being. If he feels he is important, he will try harder. Midwife 1.

The midwife holding this approach proceeds from each partner's view of the difficulties of smoking cessation. Questions were asked to each parent in order to address *lack of understanding from partners*. Insights that might come up are believed to be useful for countering their arguments about the difficulty of stopping smoking and breaking a negative development in favour of support for smoking cessation. An overall objective was to increase his ability to encourage her to try even harder.

Often they are so angry with their women. It is too easy to make a deal with him against her, but I don't want this to happen. Instead I ask him about his opinion of her attempts to cut down. Then he often says he wants her to stop smoking completely. I say, but she has cut down, isn't that a good thing? What about trying to work from here? Then I ask the woman about her ambitions from now on, now when you have been successful in cutting down so far. Often the woman says she wants to stop completely. Then I try to make a deal with the partner about how to encourage her ambitions. Midwife 9.

This quotation also illustrates how the woman's *feeling of being blamed* by her partner was addressed by changing the focus from the woman's failures to stop smoking to her small steps towards smoking cessation. The midwife asked the woman to tell her partner about her intentions, thoughts or measures to stop or to cut down. These were focused on together with her motivation for doing this.

Midwives spoke about the *impact of withdrawal symptoms on the relationship* as a common reason for relapses into smoking. It was believed that it could help to bring this dilemma to the fore.

When the woman gets really pissed off by stopping smoking, he would rather prefer her to give up since he can't stand it. After a while he feels he has to accept that she will not stop smoking, although this puts a lot of guilt on her shoulders. Midwife 8.

Midwives who talked about their role as facilitators for parents-to-be believed that the midwife's presence could improve the couple's ability to deal with the problem of smoking

cessation on their own. An alliance between midwife and partner in encouraging woman in her attempts could thereby be created, whereas the pitfall of an alliance blaming the woman could be avoided.

Discussion

This study has offered some insights into the part played by the relationship between parents-to-be in smoking cessation during pregnancy. It confirms the findings of other studies that arguments about giving up smoking can have a negative effect on such relationships at a time when they are already undergoing redefinition [17, 18]. Thus, health education about smoking cessation would gain from seeing smoking as a socially constructed activity within the relationship rather than as an undesirable individual behaviour that has to be changed [19]. The social implications of smoking have a different meaning for the relationship than merely as support by the man's smoking cessation.

As Donovan [9] has shown, arguments are parts of a more general mismatch in relationships during pregnancy. The man is more focused on his own role of becoming a father and wants to receive support from the woman in this, whereas the woman is more focused on the baby in her than on the man and her process of change in becoming a mother. Men undergo an adjustment to the notion of becoming a father, and this adjustment takes place at a different pace from that of their partners [9]. Partner-assisted interventions to address smoking cessation during pregnancy may therefore be improved by the development of the relationship in general during pregnancy. This is irrespective of whether the man is a smoker or not. Thus father-to-be smokers need to be respected as individuals with their own experiences and with their own need to stop smoking, rather than just viewed as passive participants who exacerbate the smoking cessation challenges faced by their pregnant women. One way of doing this is to acknowledge those needs as a prelude to engaging in dialogue about supporting their partners.

Even if a woman is able to give up smoking during pregnancy on her own, passive smoking remains a risk to the foetus if the partner continues [3]. Surprisingly some of the partners of the women interviewed appeared not to be aware of the risks of passive smoking to the foetus. However this data should be treated cautiously since the question was not asked directly. In an Australian study, however, men saw the foetus as being protected against the influence of passive smoking in the womb of the woman [18]. One way of addressing this misconception is through a public information campaign, or it could be addressed more at antenatal care in a way that does not confront the man. Rather than being given information, the male partner could be asked what he knows about passive smoking and the foetus. This may prevent a common situation where he immediately feels accused because of his smoking behaviour and becomes defensive about his smoking.

The breadth of experiences was explored by data triangulation between pregnant smokers' and midwives' views of the partner's importance for smoking cessation during pregnancy. Even though the sampling of interview data was not originally focused on this particular research question, it provided some insights into the importance of the dynamic in the relationship and why it could be beneficial to address it more in antenatal care. This

limitation in the data sampling may however have implied more superficial data than if it had initially been focused on the partner's importance for smoking cessation during pregnancy.

The positive aspect of this way of using data from the original studies made it possible to link these findings to the two different approaches previously identified, the medical expert and the facilitator [13]. One crucial difference between the two approaches was the extent to which they were generalised or adapted to the individual encounter to deal with partners' and women's relationship as a determinant for smoking continuation. In the medical expert approach, midwives acquire generalised information based on their view of the problem, whereas in the facilitator approach midwives proceed from the woman's and the man's lived experience. An approach that does not meet needs is more likely to be disregarded since the man and woman are not motivated to accept it [20]. Asking questions to improve reflections instead of offering facts and advice on how to achieve change is one way to meet individuals' needs. This may possibly get both the woman and the man to feel acknowledged and more open to change.

Another crucial difference between the two approaches was how they revealed the tradition in health care of valuing expert knowledge more highly than lay perceptions [21]. This notion of asking questions rather than just giving information reflects a different approach to health education than traditionally used in a health care setting. Midwives who are traditionally oriented found the medical expert approach more natural, whereas some midwives found this approach too limited based on their experiences of counselling parents-to-be. They had used experiences to develop progressive ways of health education that are more like the spirit of MI [22] but they focused on the relationship instead of the individual's smoking behaviour. However, to succeed in assuming the role required by the facilitator approach, midwives have to distance themselves from their traditional role of being the medical expert so they become able to consciously choose between the roles. Reflections on the implications of traditions in health care may help this change [13].

This change of role could be useful knowledge in this field to adapt to other settings. In the future, formative work for couple-focused approaches may be successful if midwives are educated in taking on this role of facilitating for men and women to give voice to their thoughts, intentions and feelings on a more equal basis. The couples should get an opportunity to reflect upon and discover the meaning of those aspects for themselves. It would also appear essential to enhance self-efficacy in order to take control over smoking, whilst at the same time avoiding defence of the smoking behaviour [12]. Altogether, midwives thereby may find a more gainful way to handle smoking around pregnancy that improves the health of all in family.

Conclusion

The smoking issue has negative consequences for the relationship between woman and man during pregnancy whether or not the man is a smoker. The mismatch between the parents-to-be that is linked to smoking cessation should be seen as one part of a more general mismatch in the pace of awareness of 'becoming' pregnant. This may result in smoking cessation attempts being abandoned in favour of harmony in the relationship.

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The objective of health education during pregnancy should be to improve dialogue between the parents-to-be, and smoking cessation is one part of that picture of challenges to their relationship that contributes to ill health. Reflections upon smoking in order to discover the meaning of their relationship are essential. To both the woman and the man, as individuals and as a couple, it would also appear essential to enhance self-efficacy in order to take control over smoking, whilst at the same time avoiding defence of the smoking behaviour.

Education for midwives to facilitate a dialogue should acknowledge how difficult it is to change the way to approach the smoking issue. Reflections on the implications of traditions in health care may help in this change, as midwives in this study demonstrate there is a need for them to detach themselves from the tradition of being a medical expert who has to acquire information on solutions for smoking cessation.

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