HETEROSEXUAL GENDER RELATIONS AND FATHERHOOD:
PERCEPTIONS OF NEW FATHERS WHO SMOKE

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Abstract

Despite many health promotion efforts to reduce or stop women’s smoking during pregnancy and postpartum, less attention has focused on fathers’ smoking behaviours. This qualitative study examined interviews conducted with 20 new fathers to describe the connections between gender relations and men’s smoking during their partners’ pregnancy and the postpartum period. In addressing the question of what fathers’ perceive as their partners’ strategies to assist them to reduce or quit smoking, three key themes were identified: Supporting autonomy in men’s smoking cessation, nagging to challenge men’s freedom to smoke, and contempt for men’s continued smoking. In addressing the question of how heterosexual gender relations influence fathers’ masculine ideals in the context of smoking, two themes were identified: Reconciling to maintain a smoke-free home and smoking to mediate relationships. Social constructionist gender frameworks were used to theorize the findings. The results reveal the importance of constructing tobacco reduction and smoking cessation as a fathering responsibility amid trading on masculine ideals by appealing to men’s autonomy, willpower and strength to be smoke-free.
Preface

This research study is based on data collected by a multi-phased research program called Families Controlling and Eliminating Tobacco (FACET) led by Drs. John Oliffe and Joan Bottorff. Permission to conduct secondary analysis was granted by the University of British Columbia ethics board (2006-022). The study was funded through the Investigating Tobacco and Gender (iTAG) research team grant from the Canadian Institutes of Health Research (Grant # 62R66082).
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Chapter 1: Introduction

Fathers’ smoking has adverse health consequences not only for their own health but also the health of their families (Bottorff, Oliffe, Kalaw, Carey, & Mroz, 2006). Smoking increases the risk of cardiovascular disease, respiratory disease, and cancers including lung, kidney, pancreas, stomach and cervix (Centers for Disease Control & Prevention, 2012). Reproductive health also can be negatively impacted by smoking. For example, smoking can reduce semen quality including sperm count, motility and morphology (Ravnborg et al., 2011). In addition, fathers’ smoking can negatively influence their partners’ attempts to reduce or quit smoking during and after pregnancy (Bottorff et al., 2006). Secondhand tobacco smoke from the father, regardless of mother’s smoking status, can also have repercussions for young children and has been linked to increased risk of sudden infant death syndrome, low birth weight and various respiratory illnesses including asthma (Blackburn et al., 2005). Despite negative consequences of smoking, many new fathers continue to smoke during and after their partners’ pregnancy (Bottorff et al., Oliffe, et al., 2010). Blackburn et al. (2005) found that of 286 UK-based fathers who smoked, less than 20% had tried to quit and only 4% had successfully quit. For many men, rather than quitting, not smoking in the home was more achievable with 60% of expectant fathers being successful (Blackburn et al., 2005). In contrast to expectant fathers, pregnancy for women has been a strong motivator for smoking cessation with higher rates of successful quitting than at other times in women’s lives (Graham & Der, 1999; Kerr, Capaldi, Owen, Wiesner, & Pears, 2011; Wakefield, Reid, Roberts, Mullins, & Gillies, 1998). Among expectant fathers, various tobacco cessation programs, media messages, and initiatives have been reported to be ineffective, resulting in few changes or only slight reduction in smoking (Bottorff et al., 2010; Johnson, Oliffe, Kelly, Bottorff, & LeBeau, 2009).
The World Health Organization global estimates suggest that men smoke up to five times as much as women (Hitchman & Fong, 2011). Statistics indicate that in most countries being born male is the greatest predictor for smoking cigarettes (WHO, 2003). Although the ratio of male-to-female smoking prevalence is not as high in some developed countries including the United States, Australia, and most countries of Western Europe, there is still a higher prevalence rate of men who smoke compared to women (Hitchman & Fong, 2011). Likewise, in Canada, a higher percentage of smoking in men have been reported compared to women (20% and 15% respectively) and up to 8.9% of children under the age of 12 are regularly exposed to secondhand smoke at home (Health Canada, 2011). One concerning issue is the higher male rates of smoking during their child-rearing years compared to women, and raise questions about whether men fully understand the consequences of secondhand smoke (Bottorff, Kelly, et al., 2010). Do expectant fathers recognize the health implications of their smoking on themselves, their partner and child? If they do, why do expectant fathers continue to smoke? Although some studies have shown that the transition to fatherhood can be a turning point for reduction in tobacco use (Kerr, Capaldi, Owen, Wiesner, & Pears, 2011), many men continued to smoke with only slight reductions in smoking during their partners’ pregnancies (Blackburn et al., 2005; Oliffe, Bottorff, Johnson, Kelly, & LeBeau, 2010).

In an effort to better contextualize fathers’ smoking behaviours, there has been an increasing interest in psychological and social changes during fatherhood with respect to family structure, gender roles, and social expectations (Bottorff, Kelly, et al., 2010). Recently, there have also been efforts to explain the differences in health-related gender behaviours of men and women (Courtenay, 2000a). Since biological explanations do not fully account for differences between, and diversity across, the health of men and women, gender, as socially-determined
norms has been used to explain tobacco use and other health-related behaviours (Courtenay, 2000a; Morrow & Barraclough, 2010; WHO, 2003). In chapter 2, gender theories are discussed to detail how social constructions of masculinity interconnect and sometimes collide with fatherhood in men who continue to smoke.

Given the aforementioned issues regarding men’s smoking, and particularly smoking among new fathers, the aim of this thesis was to provide much needed insights to the connections between masculinity and heterosexual gender relations to better understand smoking among new fathers. This thesis is unique in its approach and adds important empirical weight toward exploring smoking in the context of gender relations, masculinities and fatherhood by addressing the following:

1. What do fathers’ perceive as their partners’ strategies to assist them to reduce or quit smoking?

2. How do heterosexual gender relations influence fathers’ masculine ideals in the context of smoking?

By addressing the two research questions, the findings can be used to guide approaches to support fathers’ smoking reduction and cessation.
Chapter 2: Literature Review

Various theories have been proposed to explain men’s health behaviours including biological theories, socialization theory, and social constructionism. Both the notions of biological theories and socialization theory are contrasted amid the social constructionist framework, which serves as the framework for the current study. Following this, research evidence about the relationships between gender, masculinities, fathering and smoking are discussed, focusing on how authors conceptualize masculinities in the context of fathering and smoking.

2.1 Biological and socialization theory

Various frameworks, including biological theories, socialization theory and social constructionism, have been used to explain the relationship between sex, gender and health risk behaviours, including smoking. Proponents of biological theories argue that sex differences in genes and hormones result in gendered behaviours (Udry, 2000). For example, men are genetically and hormonally (e.g., the Y chromosome, testosterone and other hormonal influences) predisposed to risk taking behaviours because they are by nature more aggressive, dominant, and assertive than women (Fausto-Sterling, 1992). Socialization theorists, on the other hand, propose that gender roles are learned from significant others (Stockard, 1999). These theorists assert that men are socialized at a young age to be more dominant, aggressive and competitive, which predisposes them to poor health outcomes compared to women whose traits are characterized by being warm, gentle and nurturing (Flandorfer, Wegner & Buber, 2010; Hesselbart, 1981).

However, not all men conform to espoused genetic or gender role norms and when they cannot fulfill dominant masculine ideals (Robertson, 2007), socialization theorists refer to
behaviours arising from this as ‘male gender role strain’ (Pleck, 1981). Pleck (1981) further explains that the greater the gap between these gender ‘norms’ and men’s roles, the greater the role strain. In terms of fathers who smoke, ‘male gender role strain’ can occur when fathers continue to smoke even though society may expect a good father to be involved with childcare and remain healthy.

Although both biological theories and socialization theory provide insights to why new fathers continue to smoke after the birth of their child, these theories have limitations. For example, both biological and socialization theory essentialize masculinity and men’s risk behaviours; yet, not all men smoke or continue to smoke in the postpartum period (Courtenay, 2000b; Kimmel, 1986, p. 521). One of the major criticisms of both these theories is that they fail to account for diversity, implying that men and women have “two fixed, static and mutually exclusive role containers” (Kimmel, 1986, p. 521; Robertson, 2007). Connell (2005) explains that when gender relations are polarized with opposing characteristics, other important issues such as class and ethnicity are neglected; therefore, socialization theory fails to adequately explain new fathers’ smoking behaviours. To address the limitations of the two theories, social constructionism was used in the current study, an approach focusing on how gender relations are constituted and reproduced in a social realm (Möller-Leimkühler, 2003).
2.2 Theoretical framework

According to the social constructionist theorists, the differences observed in men and women are not because of their genetic predisposition or their gender roles, but because of the perspectives and practices that they adopt from their culture about masculinities and femininities (Courtenay, 2000a). In this view, gender is defined as “a set of socially constructed relationships which are produced and reproduced through people’s actions” (Gerson & Peiss, 1985, p. 327). Men learn to adopt various behaviours from dominant norms of masculinity as culturally prescribed (Courtenay, 2000a). From a constructionist perspective, however, this does not mean that men are passive recipients of socially prescribed roles, nor are they conditioned by their cultures (Courtenay, 2000a). Instead, they actively construct and reconstruct masculine ideals in their lives (Courtenay, 2000a); therefore, gender is an “act” embodied by contextually bound actions (Butler, 2006, p. 360). Courtenay (2000a) remarks that a way to enact masculinity is through health-related beliefs and behaviours. Most important, Courtenay (2000a) also emphasizes that gender does not reside in any individual, but rather in dynamic social practices defined as gendered.

In terms of fatherhood and men’s smoking, if certain social practices and activities are idealized, could risky behaviours, such as being a father who smokes, be explained through gender relations? Courtenay (2000a) claims the risky behaviours men display are used to enact gender. Similarly, Messerschmidt (1993) argues that risky behaviours are practices “through which masculinities (and men and women) are differentiated from one another” (p. 85). Saltonstall (1993) supports this view, stating that the “doing of health is a form of doing gender” (p. 12). Therefore, healthy activities, or lack thereof, are seen as forms of “practice which constructs the subject in the same way that other social and cultural activities do” (Saltonstall,
1993, p.12). From this perspective, smoking for fathers can be understood as a “tool” to demonstrate masculinity and differentiate themselves from women and other men (Courtenay, 2000a).

The broader context of men’s adoption of risky behaviours is the relationship of power (Courtenay, 2000a). As mentioned previously, men display certain practices and behaviours to demonstrate dominant, hegemonic masculine ideals (Courtenay, 2000a). Hegemonic masculinity is not only the dominant, idealized form of masculinity, it also reflects power and authority over femininities and other forms of masculinity (Connell, 2005; Courtenay, 2000a). According to Connell (2005), hegemonic masculinity is not a fixed character type but a construct in a pattern of gender relations that is always contestable at any given time and place. In Western cultures, hegemonic masculinity is embodied most typically by heterosexual, white, middle-class men who embody dominance, assertiveness, physical strength, and emotional control (Evans, Frank, Oliffe, & Gregory, 2011); however, few men meet these hyper-masculine standards and even fewer rigorously act according to the ideals of hegemonic masculinity (Connell, 2005; Howson, 2005). Rather, the majority of men demonstrate complicit masculinity by sustaining the “hegemonic project” and by acknowledging the existence of an idealized benchmark (Connell, 2005; Howson, 2005). Although the practice of complicit masculinity is not always definitive, men, particularly fathers, find themselves compromising on numerous activities, such as childcare, housework, leisure and work routines (Howson, 2005). Subordinate masculinity, on the other hand, emerges in relation to differences in sexual orientation among men (Howson, 2005). Linked to homosexuality, subordinate masculinity is antithetical to hegemonic ideals and associated with characteristics such as domesticity, weakness and lack of authority (Howson, 2005). In addition, race, class and ethnicity also de-privilege men’s position within the
“masculinities schema” (Howson, 2005). For example, marginalized masculinity is often “relative to the authorization of the hegemonic masculinity of the dominant group” (Connell, 2005, p. 80-81). Connell (2005) gives an example of how individual Black athletes may exemplify hegemonic masculinity but this alone does not yield social authority for Black men in general. Although the health risk associated with various forms of masculinity may differ, the desire to exhibit hegemonic masculinity can be problematic (Courtenay, 2000a). For example, men often adopt unhealthy beliefs and behaviours in striving to demonstrate masculine ideals which lead them to harm and self-injury (Courtenay, 2000a). Men are also more likely to attract greater scrutiny compared to women if they show un-masculine behaviours or do not conform to masculine ideals (Evans et al., 2011). In the context of the current thesis, men are constructing gender when they continue to smoke even though they know the risks associated with tobacco use (Oliffe et al., 2010). By aligning hegemonic masculinity with smoking behaviours, men perpetuate cultural beliefs that men are more powerful than women, that caring for one’s health is feminine, and that the most powerful men are those who view their health and safety as trivial (Courtenay, 2000b). In addition, rejection of feminine ideals not only contributes to how masculinities are constructed but also the systemic oppression of women and other men who do not endorse or embody hegemonic ideals (Courtenay, 2000b). Courtenay (2000b) specifies that when a man engages in perceived feminine behaviours, he risks being undermined to a subordinate status and being called a “wimp” or a “sissy,” emphasizing the notion that health care is “girl stuff” (p. 1389). As a result, the dominant social constructions of gender and masculinity are, for the most part cast in opposition to positive health behaviours and beliefs.

However, recent literature suggests that characteristics of hegemonic masculinity can work for men and their health as well. In a qualitative study, although men framed direct interest
in health as being construed as feminine, they justified their health practices in terms of appearance concerns, being autonomous, and sporting performances (Sloan, Gough, & Conner, 2010). More specifically, participants gave up smoking to excel in sports, positioning their bodies as an instrument for sport-oriented activities, rather than an entity to be cared for (Sloan et al., 2010). In addition, men can be convinced to do health for others when they believed it to be necessary (Robertson, 2007), and these practices have been observed to often trade on protector or provider masculine ideals (Bottorff et al., 2006). Similarly, in the context of smoking, will power and self-reliance can be pitched to men as qualities needed to be smoke free (Bottorff, Radsma, Kelly, & Oliffe, 2009). New, expectant fathers may also find that their masculine identities redefined as their roles change (Gordon et al., 2013), and they tend to reduce smoking as they get more involved with children and childcare (Bottorff et al., 2006). Therefore, assumptions that all men adopt ‘unhealthy’ masculine positions without considering how masculinity is constructed in context is naïve and inaccurate (Sloan et al., 2010).

Nevertheless, social constructionist theory is not without its limitations. Biological theorists argue that men’s smoking behaviours reflect physical dependency to a highly addictive substance. To counter this criticism, Laurier, McKie & Goodwin (2000) assert that smoking cannot be treated as an isolated addiction, and that contextual factors have enormous influence on smoking behaviours. Other studies have found that although men admitted to being physiologically addicted to nicotine, they also acknowledged being influenced by masculine ideals of risk taking (Bottorff et al., 2006). The multi-faceted nature of masculinity and the way in which it interacts with men’s smoking in various social contexts, including fatherhood are highlighted in the following sections.
2.3 Research evidence

2.3.1 Gender, masculinities and smoking

Although one can argue that a variety of factors are associated with healthy behaviours including socio-economic status, ethnicity and culture; these factors alone do not explain gender differences in health-risk behaviours (Courtenay, 2000a). For example, national studies conducted in the United States demonstrate that, compared to women, men are more likely to engage in over 30 risky behaviours (Courtenay, 2000b). Numerous studies have shown that being male impacts almost every risk-taking behaviour (e.g., alcohol and tobacco use, sexual risk, and not seeking medical care) beyond that accounted for by other variables, including education and income (Bowleg et al., 2011; Mahalik, Burns, & Syzdek, 2007). Indeed, gender has consistently been argued to be one of the most critical sociocultural factors influencing health-related behaviours (Courtenay, 2000b; Messerschmidt, 1993; Evans, Frank, Oliffe, & Gregory, 2011).

Historically, smoking has been associated with masculinity (Pachankis, Westmaas, & Dougherty, 2011); a prime example is how the “Marlboro Man,” is represented as a rugged, confident, and fearless cowboy (Starr, 1984). Although the tobacco industry exploited gender norms and promoted smoking to women as they strove for social equality, the representation of smoking as a male activity remains central to tobacco advertisements and popular culture (Hunt, Hannah, & West, 2004); as a result, smoking has provided a venue to confirm, reassure, and/or bolster an image of masculinity for young men, gay as well as heterosexual (Pachankis et al., 2011).

The depiction of smoking as being synonymous with masculinity was highlighted in a study by Bottorff et al. (2006), which captured themes related to men’s constructions of their
smoking. The study’s findings revealed how men linked their tobacco use to autonomy, self-control, and physical resilience to a harmful substance (Bottorff et al., 2006). In fact, participants proudly stressed that smoking did not impede their ability to work or play sports (Bottorff et al., 2006). Accounts from other participants who continued to smoke also drew on masculine discourses of self-reliance through rationalizations that they could control their smoking and manage their own health (Bottorff et al., 2006). Moreover, Bottorff et al. (2006) observed that participants who admitted that smoking was their “flaw” or “addiction” defended their smoking behaviours on the basis of their right to be independent and to experience pleasure or rewards. Studies analyzing masculinity and femininity scores on gender differences show that high masculinity scores among men and women are associated with higher tobacco use, whereas femininity scores are not tied to smoking behaviour (Emslie, Hunt, & Macintyre, 2002).

In Bottorff et al.’s (2006) study of young men, continuing to smoke into old age was positioned as unsavory, if not somewhat repulsive, suggesting a changing influence of masculinity over the lifecycle. Complex relationships between smoking and masculinity were demonstrated by Hunt, Hannah, and West (2004) when they collected male and female data from three generations in Scotland. Although the authors did not find any significant association between masculinity and femininity scores and smoking among men, they did find that smoking was associated with femininity scores among women (Hunt et al., 2004). Despite inconsistent results, the authors noted that the practices of masculinity and femininity could change in response to locale, the media, and aging across generations (Hunt et al., 2004). These findings demonstrate that individuals are not only socialized by their changing socio-cultural environment to enact gendered health behaviours, but that they also participate and actively construct gender norms through their smoking practices (Alexander, Frohlich, Poland, Haines, & Maule, 2010).
2.3.2 Smoking, masculinity, and fatherhood

The last several decades have greatly changed the social patterns and expectations of gender and fatherhood (Bottorff, Kelly, et al., 2010). In the past, fathers usually played the breadwinner role in the family, while mothers were responsible for maintaining the household and rearing children (Cabrera, Tamis-LeMonda, Bradley, Hofferth, & Lamb, 2000). In the 21st century, however, this trend has shifted, and fathers are expected to become more involved with childcare, while mothers are expected to contribute more to household income (Bottorff, Kelly, et al., 2010; Cabrera et al., 2000); as a result, fathering, for many men, poses a direct challenge to hegemonic masculine ideals owing to these competing societal demands: to be involved as a parent as well as to continue to fulfill a breadwinner role (Bottorff et al., 2010; Williams, 2009).

In addition to this shift in societal trends, the transition to fatherhood may leave men feeling vulnerable and unsure of their purpose in the world (Williams, 2009). Bottorff et al. (2010) claim that fathers continue to smoke not only to offset the tensions of competing societal demands but also as a way to enact gender by displaying strength and emotional control, and to manage feelings of vulnerability (Bottorff et al., 2010). Although fathers who align with masculine ideals were more likely to continue to smoke even after the arrival of their child, many fathers talked about tensions in their relationships or of feeling uncomfortable smoking inside the home (Bottorff, Greaves, Kelly, Oliffe, & Ponic, 2010). Therefore, some fathers physically separated their smoking from their children and child-care activities by smoking outside the home or by concealing their smoking (Oliffe et al., 2010).

For some men, fatherhood can be a transformative experience (Kerr et al., 2011). A recent longitudinal study showed that crime trajectories (e.g., number of arrests) as well as
tobacco and alcohol use among young, at-risk fathers markedly decreased (Kerr et al., 2011). These contradictory findings support Connell’s (2005) contention that diverse masculinities are continuously contested within and across men’s lives and history; likewise, men can take up ideals of fathering in varied ways (Bottorff, Greaves, et al., 2010).

A few studies that attempt to explain why fathers continue to smoke during their partners’ pregnancy and postpartum periods report multi-factorial reasons. For example, some authors argue that stress, tobacco addiction, and lack of motivation and knowledge are contributing factors (Blackburn et al., 2005). In a focus group study of eight men, expectant fathers reported that they were unaware of how their own smoking could pose a risk to the fetus when the baby was “insulated.” They also believed that the stresses involved with their partners’ quitting was more detrimental to the baby than smoking (Wakefield et al., 1998). In another qualitative study, expectant fathers thought that it was easier to quit during the postpartum period, but only a few followed through on their cessation plan (Oliffe et al., 2010). Other studies indicate that socio-economic status and education play a role, with fathers’ smoking being inversely proportional to their level of education (Mahfoud, Saad, Haddad, & Chaaya, 2010). These findings suggest a need to further contextualize linkages between smoking and masculinities and, in particular, how gender relations influence tobacco use in the context of fatherhood (Oliffe et al., 2010).

2.3.3 Heterosexual gender relations, masculinity and fatherhood

Despite the social-constructionist perspective that gender is relational, the concepts of masculinity and femininity have been effectively delinked (Bottorff, Oliffe, Robinson, & Carey, 2011). In other words, health researchers have focused on associations between femininity and women and between masculinity and men rather than try to account for a continuum of experiences and for changing relations of gender (Bottorff et al., 2011). In addition, while much
health research takes into account a range of social determinants such as gender, ethnicity, and socio-economic status, the interactive effects between men and women on health behaviours have not been fully explored (Bottorff et al., 2011).

Evidence suggests that heterosexual gender relations, men’s and women’s interactions with each other, and the circumstances under which they interact all strongly influence men’s health outcomes (Bottorff et al., 2011; Schofield, Connell, Walker, Wood, & Butland, 2000). For example, compared to single or widowed men, married men live longer, engage in more healthful behaviours, and report healthier physical and mental well-being (Strebel et al., 2006). In terms of smoking, men are more likely to quit if their partner is a non-smoker and more likely to reduce their tobacco use with increased spousal support (Manchón Walsh et al., 2007; Westmaas, Wild, & Ferrence, 2002a). These patterns are attributed to feminine ideals of being the primary family caregiver and nurturer (Bottorff, Kelly, et al., 2010). Other research showed that in a traditional parenting dyad (where the father was the primary breadwinner), women’s actions to be supportive partners facilitated men’s continued smoking whereas, in a shared parenting dyad (where the father played a significant child-care role), both men and women were involved in maintaining a smoke-free home (Bottorff, Kelly, et al., 2010). This study reveals how a shift of masculine performances into traditional feminine roles of being more involved in childcare can help men adjust their smoking behaviours. Nevertheless, understanding the influence of heterosexual gender relations on men’s tobacco use remains nascent in smoking cessation research (Bottorff, Kelly, et al., 2010), and findings from the current thesis will add to the limited body of literature on this topic.
2.3.4 Summary of research evidence

The aforementioned studies highlight the importance of gender relations and masculinities in the context of fatherhood. Since smoking has traditionally been a male domain (Hunt et al., 2004), men may use smoking as a way to strengthen their image of masculinity and gain acceptance from others (Pachankis et al., 2011); as a result, how men internalize and practice masculinity can lead to negative health consequences. Moreover, studies also support Connell’s (2005) assertion that not all men align with dominant masculine ideals. For example, Hunt et al.’s (2004) study showed that high masculine scores were not associated with increased tobacco use for men. These contradictory, inconclusive results suggest that men continuously contest and choose to take up (or not) dominant ideals of masculinity.

Indeed, studies on new fathers and smoking reveal challenging complexities. According to Hobson (2002), traditional roles of fathering have shifted where fathers are increasingly being expected to be responsible for childcare as well as financial responsibilities. These changing expectations are reflected in contradictory experiences of new fathers; fatherhood, for some men, has been reported to be a time to either offset the tensions of competing societal demands with smoking or to change established smoking routines (Bottorff et al., 2010; Kerr et al., 2011). In the context of fathers who smoke, the current study examines how masculinities, fatherhood and heterosexual gender relations interact to encourage the continuation or reduction of smoking.

The current study is based on a Canadian context that privileges heterosexual relationships and masculine ideals. Based on this premise, smoking is seen as one of many social practices that men use to maintain gendered identities as well as power to differentiate themselves from women.
Chapter 3: Methods

3.1 Research questions

There are few studies examining gender and fathers’ smoking. Because of changing societal expectations of fatherhood, there may be an underlying assumption that fathers will be receptive to health promotion messages during their partners’ pregnancy and the postpartum period. In addition, there are inconsistencies in the literature about whether tobacco use becomes more pronounced for men following fatherhood (Kerr et al., 2011); therefore, the importance of better contextualizing fathers’ perspectives of their tobacco use is ever clear. This study aimed to understand:

1. What do fathers’ perceive as their partners’ strategies to assist them to reduce or quit smoking?

2. How do heterosexual gender relations influence fathers’ masculine ideals in the context of smoking?

By exploring the linkages between fathers’ smoking, masculinities, and heterosexual gender relations, the current study contributes to the collective efforts toward developing strategies to support fathers to reduce or stop smoking.

3.2 Methods

3.2.1 Data collection from the primary study

Fathers in the primary study were purposively recruited from prenatal and postpartum units of a hospital in Vancouver, Canada and through advertisements in a local newspaper. Following fathers’ written consent, semi-structured face-to-face interviews were conducted by trained male researchers. At the end of the first interview, fathers were given a camera to take
pictures of places where they smoked during and after their partners’ pregnancies. A follow-up interview was conducted to discuss the meanings attached to each of the photographs. The first and the second interviews were each approximately one hour in duration and conducted between 12 and 24 months following the birth of the child. The interview questions were related to men’s experiences of smoking during fatherhood and included open-ended questions such as, “tell me about your smoking history” and “what aspects of smoking are represented here?” The face-to-face individual interviews were digitally recorded, transcribed verbatim, and checked for accuracy. For participating in the study, each father received $20 cash and a $30 gift certificate from the merchant of their choice for each interview.

3.2.2 Sample

The sample for the primary study was comprised of 20 fathers. The average age was 33 with participants ranging from 22-41 years. The number of cigarettes smoked per day ranged from one a day to over a pack a day, and 4 fathers had quit smoking following the birth of their infants. The average number of years smoked was 16. Half the participants were of European descent (n=10) and the other half were either of Asian (n=6) or of Middle Eastern descent (n=4). All men were residing with their partners and children at the time of the interviews. Men’s partners had varying experiences with smoking: 17 women were non-smokers, quit smoking during pregnancy and stayed quit, 2 reduced smoking during pregnancy but increased their smoking after pregnancy, and one reduced from a full pack to half a pack a day during pregnancy and stayed reduced after pregnancy. In terms of household income, the sample was spread evenly from less than $20,000 to over $100,000 a year with an average income between $40,000 to $60,000. Further demographic information is provided in Appendix A.
3.2.3 Secondary data analysis

Secondary analysis was employed to utilize existing data as a means to pursue a research interest distinct but related to that of the original research (Hinds, Vogel, & Clarke-Steffen, 1997). The current study draws on data collected in a multi-phased research program named Families Controlling and Eliminating Tobacco (FACET; www.facet.ubc.ca). This program explores the social context of smoking behaviours in pregnancy and the postpartum period through a gender lens in order to strengthen support for smoking cessation (Bottorff et al., 2010). Permission was granted to conduct the secondary analysis by the University of British Columbia research ethics board. In addition, I completed the Tri-Council Policy Statement (TCPS2) ethics course on RISe (Researcher Information Services). In this study, the first and second interviews for each participant were analyzed. Photographs were excluded because interviews adequately answered the research questions.

3.2.4 Data collection plan of primary study

One of the major challenges to secondary analysis is ensuring the fit of secondary research questions with the data from the primary study (Thorne, 1998). Polit and Beck (2012) called this the “if only” problems: “if only they had asked questions on a certain topic or had measured a particular variable differently” (p. 267). Based on a thorough examination of the primary data and the interview questions asked, however, there was a strong fit between my research questions and the primary research. For example, relevant open-ended interview questions in the primary study included: “What has it been like for you having a baby and becoming a father for the first time?” Or “How would you describe your smoking status now?” The original study interview guide is included in Appendix B.
3.2.5 Ensuring quality in the dataset

Although secondary analysis has potential to enrich understanding of an existing dataset, there are a number of challenges to be addressed. For example, secondary analyses may intensify researcher biases (Thorne, 1998). The secondary researcher may interpret the findings according to preconceived expectations rather than what is occurring in the dataset (e.g., leaving out cases where addiction is the main problem). In addition, since the secondary researcher is somewhat removed from the data source and was not involved with the data collection, some of the contextual features familiar to the primary researchers may be missed (Thorne, 1998). Related to this problem is fitting the secondary question with the primary data as previously mentioned (Thorne, 1998). Each of these challenges may limit the researcher’s ability to accurately interpret and analyze the data. To address these issues, four criteria of rigor developed by Guba and Lincoln (1981) were used: credibility, fittingness, auditability, and conformability. These criteria were used because they are among the most influential and cited by qualitative researchers (Polit & Beck, 2012).

Credibility is evaluated by how well threats to internal validity have been handled (Sandelowski, 1986). According to Sandelowski (1986), to ensure credibility, researchers should be aware of how they are being influenced by the participants. Therefore, I used critical self-reflexivity to remain aware of how my own biases from my particular background, experiences and other related factors might affect data analysis. In addition, I kept a journal and documented my reflections, while I analyzed the data to keep my values and assumptions in check.

Fittingness is how well threats to external validity or generalizability have been managed (Sandelowski, 1986). Some of these threats include “elite bias” in which the majority of participants are high-status members of the group or “holistic fallacy” in which researchers try to
manipulate the data to look more patterned (Sandelowski, 1986). To ensure fittingness, Sandelowski recommends that typical and atypical behaviours and responses should be represented in the findings. In line with this, I included typical and atypical fathers’ responses to smoking to report the patterns as well as reflect upon the diversity in how those actions connected contextually to an array of masculine ideals and gender relations.

Auditability relates to how well other researchers can follow the decisions or the audit trails made by the researcher (Beck, 1993). To ensure auditability, I recorded and documented each decision made and the rationale for those decisions, as well as questions addressed at each stage of the secondary analysis. Furthermore, my documentations as well as my self-reflexive journal were reviewed by my thesis supervisor.

Confirmability is defined as a criterion of neutrality in qualitative research. According to Sandelowski (1986), confirmability should refer to the findings themselves and not to the objectivity or the subjectivity of the researcher. To ensure confirmability, I documented and recorded my interpretations of fathers’ interviews in my journal and highlighted potential biases, motivations and perspectives so that other researchers could judge for themselves how these factors might have influenced the results.

3.3 Methodology

3.3.1 Interpretive description

For this study, interpretive description (ID), described by Thorne, Kirkham and MacDonald-Emes (1997), was used. There were several reasons for my decision. First, ID uses elements from several qualitative methodologies, such as grounded theory, phenomenology and ethnography to generate new insights (Polit & Beck, 2012; Thorne, Kirkham & O’Flynn-Magee, 2004). Second, ID not only recognizes the highly contextual nature of the human experience but
also allows shared realities with thematic patterns (Thorne, Kirkham, & MacDonald-Emes, 1997). Third, ID goes beyond describing a phenomena and into the “so what” to apply what we have learned (Polit & Beck, 2012; Thorne et al., 2004). Therefore, ID was appropriate for my research question, which explores the contextual nature of gender relations, as well as the various thematic patterns reflected by the way new fathers enact their masculinities through their smoking behaviours (Thorne et al., 2004). Finally, by using ID, the findings from my study have application potential to advance the design of gender-specific health promotion programs and tobacco reduction initiatives.

3.3.2 Data analysis and coding

The focus of “coding” is to identify thematic patterns within the data (Polit & Beck, 2012). Thorne (1998) cautions against both a premature coding that could lead to superficial understanding of the data, as well as complex coding systems that overwhelm the researcher with details. Instead, Thorne (1998) recommends asking questions such as “what is happening here?” or “what am I learning about this?” to ensure coherent themes are developed (p. 174). Therefore, as I analyzed each interview, I became immersed in the data, asking exploratory questions while simultaneously challenging my interpretations. Besides trying to find patterns and commonalities within and between the interviews, I also took into account cases in which the responses of fathers were different or unique to their situation to enrich my findings and ensure rigour.

One analytic strategy used in ID is constant comparative analysis (Thorne, 2000). Originally developed by Glaser and Strauss (1967) in grounded theory methodology, this strategy compares one piece of data (e.g., one interview, phrase or theme) to others to discern what may be similar or different and conceptualize possible relations among the data (Thorne, 2000). Similarly, in this study, I analyzed themes derived from one interview to the next as a
means to identifying similarities and differences. The same approach was used for analyzing all the interviews. In addition, I posed analytical questions to ensure common themes and patterns were accurately compared such as “why is this different from that?” and “how are these two related?” (Thorne, 2000, p. 69). Also, my supervisor and committee members reviewed my coding schedule and the interviews for consistency. In addition, I used the NVIVO™ software to manage the interview transcripts and code data.

3.3.3 Ethical issues

Informed consent for the secondary analysis was included in the original consent form signed from the primary study. Any identifiable participant information was removed from the interview transcripts, and the demographic data were coded with a unique number to maintain and protect participant’s confidentiality. All research-related documents including self-reflexive journals were stored in the school lab in a locked filing cabinet. Moreover, my secondary dataset were stored in password protected computer and webserver. Only my thesis supervisor knew the location of the key and the password in case of emergency. In terms of destroying research records, all relevant documents used for the secondary analysis including the self-reflexive journal will be shredded, the secondary dataset deleted and the trash file emptied upon thesis approval. The original data sets will be kept for 5 years as per the original ethics approval for the study.
Chapter 4: Research Findings

The study findings are presented in two sections and correspond with the aforementioned research questions. Several themes were inductively derived to address the first research question, “What do fathers perceive as their partners’ strategies to assist them to reduce or quit smoking?” These themes include: Supporting autonomy in men’s smoking cessation, nagging to challenge men’s freedom to smoke, and contempt for men’s continued smoking. The second research question, “How do heterosexual gender relations influence fathers’ masculine ideals in the context of smoking?” revealed two themes: reconciling to maintain a smoke-free home and smoking to mediate relationships.

In terms of style, participants’ verbatim quotes are used to illustrate the thematic findings and ellipsis (…) were used to signal omissions to make the quotes more readable. Participants’ words and short phrases were incorporated into the text with quotation marks. Pseudonyms were used to ensure confidentiality.
4.1 Perceptions of women’s strategies to encourage smoking cessation

Although smoking status varied among the men’s female partners, the women encouraged their partners to engage in smoking cessation either directly or indirectly during their pregnancy and the postpartum period. Therefore, the themes listed below captured what the men perceived as their partners’ strategies to assist them to reduce or quit smoking.

4.1.1 Supporting for autonomy in men’s smoking cessation

The majority of participants interpreted their partners’ actions as “supporting” them, whereby men were afforded choice about when and how to reduce or quit smoking on their own terms. A 31-year-old European construction manager, Bill, who recently quit, explained the importance of being able to decide his quit, asserting that not being pushed by others was key to his recent cessation:

My wife never really pushed me to quit I told her, you know, I’ll quit on my own terms and I’ll quit when I, I always wanted to quit and I knew that I would some day.
I think I needed, I just needed to have a reason to quit. And I know I shouldn’t need a reason but I guess I just needed that little nudge....I kept saying, you know, “I will, I will, I will.” And then I said, you know, and I always told my wife I never wanted my daughter to know that I smoked, you know, because when they’re two [years] they don’t know, right, they might know for a week and then at the end of the week they don’t know what happened anyway. So I just said... two is old enough, that’s it.

Implicit here is the “support” role of the wife whereby the participant is left to make decisions about the timing of his quit. Privileged in this narrative is the man’s ability to make good on his promise to quit, and drawing on masculine ideals about doing health for someone else, he quits for his daughter as a means to being a good role model and protective father. The
power and control in this instance resides with the man, and as he describes, his wife as patient and trusting that his smoking will end. In this context, the female partner was complicit, deferring the ultimate responsibility to quit to her husband.

In similar ways, other men espoused their wives as supporting their autonomy, individualism and determination to quit. For example, Charles, a 38-year-old Caucasian working in career development had started to smoke again after a recent quit attempt. He acknowledged that his partner was supportive by having an enormous “faith” in him that he would eventually quit and was nonjudgmental about his recent relapse. In this regard, he was not chastised by his partner for failing to sustain his quit but instead he explained that his partner understood pressuring him would not work, both in terms of his smoking and perhaps in their relationship more generally:

It’s like me telling you to do something. I just don’t have a place for that. I wouldn’t hear that, we just met today right? So I wouldn’t have a place for that, you wouldn’t have a place for me telling you something. And even though she’s my partner I think she would have the power to say “don’t smoke in the house” so, right, “don’t leave the container around.” She has that power but she couldn’t make me quit...And I appreciate that she’s got a lot of faith that I’ll do it [quit] in my own time.

The fragility of supporting was ever present in this excerpt whereby the participant remained autonomous in the how and when of his quit and the internal pressure was deemed enough to drive the change. Moreover, anything other than complicit support from his partner was understood as unhelpful and likely untenable within the relationship. Charles’s assertion that “she couldn’t make me quit,” reflects his alignment to dominant masculine ideals of independence and control over his smoking and, as a result, his partner’s faith is legitimized as
the most helpful proactive way forward. Evident also was Charles’ understanding that his partner had jurisdiction over not smoking in the house or leaving ashtrays accessible to children; but ultimately, this too was positioned as supportive in providing some governance over his smoking to aid the comfort and well-being of others.

Fatherhood also seemed to draw on protector qualities whereby men wanted to be smoke free role models for their children. In this regard, Bill’s reference to a “little nudge” which allowed him to finally quit drew on these protector and provider ideals. Furthermore, although resistant to quit outright, Charles was receptive to his partner’s suggestion to abstain from smoking in the home or leaving ashtrays around. This suggests that fatherhood can compete with traditional masculine ideologies for men to be seen as a good father, and the men in the current study were affirmed by their partners’ faith that they would make good on the patriarchal promise of quitting smoking for their child.

4.1.2 Nagging to challenge men’s freedom to smoke

For many fathers, partners who repeatedly pressured them to reduce or quit smoking, and reminded participants of the smoking-related health risks were unequivocally constructed as “nagging.” Within this context, confrontation emerged to actively contest men’s freedom and autonomy to smoke. This gave rise to increased potential for conflict and dissonance in the relationship. For example, Scott, a 27-year-old Caucasian carpet cleaner who smoked 8-10 cigarettes a day recalled a family meeting about his smoking when his partner became pregnant:

Em, a lot of arguing, a lot of fighting generally anyways, um, I don’t think there was anything good that ever came out of it. It was just people convince, trying to convince me that what I’m doing is bad of me, well my habit, well my craving, convincing me that I shouldn’t listen in a sense….I’m not one to really take orders or advice very well, I like to
try and figure things out on my own....All I’ve seen it as is nagging so I just, just continued on doing it[smoking].

Rather than taking orders or advice from others to quit, Scott refuted the legitimacy of being told what to do. Reactive to being judged, he refused to listen let alone act on the ultimatums he was given. Despite the good intentions of female partners, their efforts to encourage men to quit smoking often led the men to rebel with some participants smoking more. Similarly, Charles, a 38-year-old Caucasian father who worked in career development, explained the negative impact of what he perceived as “nagging,” both from his wife, and more generally from others, about his smoking behaviours:

*It just doesn’t help. All it does is create tension, another tension. I mean if you already have a cigarette problem and now it’s a tension between the smoker and non-smoker. Really it does not help if a non-smoker comes to a smoker and says something like “Do you know that that’s not healthy?” Like come on, I mean the responses smokers have are often humorous. But it is not helpful.*

These comments reveal how efforts to encourage men to quit smoking could create hostile environments and perpetuate the continuation of smoking. In this regard, power struggles emerged, ignited by smoking but often permeating other aspects of the relationship. When nagged by their partners, several fathers strongly defended their smoking behaviours and highlighted the benefits associated with smoking, such as decreasing work stress and pressures around fatherhood, and maintaining emotional stability. Implicitly and explicitly, the men were reticent to quit and rationalized their smoking as deeply ingrained in their lives and as a source of enjoyment. Amon, a 38-year-old Middle Eastern father who smoked one cigarette a day, argued that “a lot of things are bad for me…but we still do it.” He followed up on this disclaimer
suggesting that smoking was his “little enjoyment” in life. In some ways, nagging challenged men’s independence and freedom, which resulted in participants countering and contesting the nagging they encountered.

Fathers would also placate their partners with half-hearted quit promises in an attempt to avoid fighting. Luke, a 35-year-old Caucasian smoker of 13 years, explained that he agreed to his partner’s ultimatum that he quit after the baby was born on “principle” but he qualified the agreement as provisional, “I never really agreed to it [partner’s ultimatum to quit] with her, I’ve been saying I would do it but, yes, I did agree with it in my head.” Protecting manly virtues around being true to his word – the terms and conditions under which agreements were made were interrogated – rather than any admission of wrong doing or straight out lying. For Luke and many participants, their partners’ nagging continued, fueled by the failure to deliver on promissory ‘quit’ notes as well as their continued day-to-day smoking.

4.1.3 Contempt for men’s continued smoking

Some fathers suggested that their partners persisted in sending clear but somewhat indirect messages of contempt or disapproval for their continued smoking. A 37-year-old European father commented on his partner’s reaction whenever he went outside to smoke:

*You know she always gives me the cold evil eyes or whatever, right, you know, you stink or whatever right.*

Another father, 31-year-old Iranian, working as an information technology consultant who had smoked for 8 years, spoke about the tension in his relationship following the birth of his child, whenever he smoked:

*Yeah I think just that urgency to quit ever since she became pregnant it just seems to be more, more a push towards it. It’s unsaid, but it’s there.*
The men recognized their partners’ disapproval but nothing was directly said or stated. In turn, the men resorted to compensatory behaviours such as keeping their smoking out of sight of their partners and away from their infants. For example, several fathers concealed their smoking from their partners by smoking at work, in the car during their commute to work, or when their partners were sleeping. In this way, the men portrayed smoking as a masculine activity by compartmentalizing their smoking away from home and family life.

Many fathers also perceived that their partners showed contempt for their continued smoking behaviours by refusing to buy them cigarettes. While fathers initially denied problems of asking their partners to buy them cigarettes, they later admitted that they only asked their partners on rare occasions or not at all. Peter, a 35-year-old Caucasian skilled trade worker who smoked for over 13 years stated:

She [partner] would [buy me cigarettes] if I, if I really asked her to. But rarely would I get to the point where I’d ask her to buy smokes. It would be a very rare thing....I might sneak a pack in when we’re at the Safeway line up that sort of thing but generally no, she wouldn’t buy them for me.

Although fathers were well-aware that their partners thought that smoking was not something that “good fathers” do, many participants continued to smoke or found a way to conceal their smoking activities from their partners despite potential negative consequences for the relationship. There was also evidence that men would dismiss or disregard their partners’ contempt about their smoking as typical of how women look after the health of their men. Luke, a 35-year-old Caucasian in skilled trade, elucidated:
I’d tell her I’m going to get smokes and I’d hear [makes high pitched garbled sounds like someone complaining about something]. “Smoking is bad for you, it’s going to kill you, you know.” [Researcher: So this is what she would be thinking in the background?] Yeah, I’d get that.

In some instances, men explained that the contempt demonstrated by female partners was unexpected and difficult to understand. For example, Greg, a 28-year-old Caucasian in skilled trade, who thought that he always got along with his partner, was surprised to find out that she was offended when he did not quit during her pregnancy. Moreover, participants suggested that they either did not remember having discussions about smoking cessation with their partners or did not take their advice seriously. When asked whether there was anything difficult in regard to smoking during pregnancy, Luke, a 35-year-old Caucasian in skilled trade, commented:

*Other than her telling me that I’ve got to quit before the baby comes....That was it.*

*I don’t know, honestly I don’t think I changed my habits at all when she was pregnant.*

In summary, these narratives reveal how the men responded to their partners’ contempt for continued smoking and the potential for creating tension in the relationship but also compensatory behaviours in men to support their smoking. In some ways, contempt appeared to stall some men’s smoking temporarily but ultimately, it did not push men toward quitting.

### 4.2 Heterosexual gender relations and masculine ideals in the context of smoking

Fathers’ smoking and quit efforts permeated relationships and other social contexts, including domestic duties and childcare (Bottorff, Kelly, et al., 2010). The influences of heterosexual gender relations on fathers’ masculine ideals in the context of smoking are
highlighted in two themes: reconciling to maintain a smoke-free home and smoking to mediate relationships.

4.2.1 **Reconciling to maintain a smoke-free home**

Implicitly and explicitly, the majority of fathers reported reconciling with their partners to have a smoke-free home. Although a few fathers attested that it was ultimately their decision to smoke outside, the decision-making process was made within the relationship with their partner. A 39-year-old Caucasian father who worked as an administrative office worker explained this process:

> I think I’d still do the same [smoking outside] even if there wasn’t [a baby]....My wife doesn’t really like to be in a smoky room either so I don’t think the baby affects it at all.

[Researcher: Okay. Again sort of looking at how you negotiate that like you’re outside, has that negotiation changed at all?] I don’t, I wouldn’t call it negotiation. I think it’s just a given, it’s just logical, right, you know. I don’t think we had to discuss I’m going to smoke on the balcony. I mean it’s pretty given that I didn’t want to smoke inside anyway right? So we were in agreement, there was really no negotiation to have.

In this example, the father suggests consensus with his partner about not smoking in the house; nevertheless, his partner’s dislike to be in a ‘smoky room’ influenced him to smoke outside on the balcony. Moreover, while some fathers stated that maintaining a smoke-free home was a continuation of previous arrangements, other fathers, like Bill (27-year-old Caucasian carpet cleaner), reported that smoking outside “comes with the territory” of fatherhood. Bill and his partner who were interviewed together explained:

> [Partner: Well, going outside is a rule now that the baby was born....That’s really the only rule about [smoking].] [Bill: Yeah, pretty much, pretty much just, just the
one rule like I, I have been pretty good with it even before like I’m not, I wouldn’t just kind of like have a puff on a smoke and then blow it at people’s faces or anything, that’s definitely a rule then because I know how mad some people can get if you blow smoke in their direction.]

Regardless of whether the rule of smoking outside was clearly articulated with their partners or not, the majority of fathers reported altered roles and gender relations to garner a smoke-free home. For example, a 31-year-old information technology consultant talked about a post-smoke cleaning ritual following his partner’s pregnancy:

*Mouthwash...*yeah, that’s what I do if I’m at home or somewhere else, every time I have, mostly at home actually, because you hold her [baby] so close and you’re so close to her that if she gets that scent of smoke, if you’re just coming from outside I think she’d be affected by it. So, you know, wash my hands, use mouthwash, brush my teeth, so it’s just the whole routine there.

Other fathers explained how they changed their clothes, took additional showers, and hyperventilated to expel residual smoke in their lungs. These cleaning behaviours within the domestic sphere were linked to the health of the child and responded to the domestic jurisdiction of their partners. In this regard, the men not only inhabited the home, they invested in their cleanliness and efforts not to contaminate the space because of their smoking. With respect to this, a 29-year-old Chinese man who worked as a courier suggested that being at home and involved in childcare had reduced his smoking from a pack a day to only three to four cigarettes a day. He commented:

*If I was staying home all day I smoke like three to four cigarettes, that’s it, morning, lunch, sometimes coffee break, that’s because I’ve got something to do. Like I take*
care of the baby. It is very busy.

Nevertheless, within the domestic sphere, there were interconnected structures of gender relations regarding the divisions of labour related to smoking. For example, fathers completed outside duties such as taking out the garbage, mowing the lawn, cleaning the gutters and walking the dog which provided them with opportunities to smoke. A 28-year-old Caucasian father highlighted how his smoking was influenced by gendered division of domestic labour:

*I mean I go outside. I’ll toss the ball for fifteen minutes, twenty minutes. There’s a great park just down the way and, yeah, I go and hang out with them [dogs], and have a smoke. This is usually after dinner...and they [dogs] love it and I like it too and, um, I’ve got my rain pants and I usually come home muddy and with my soccer cleats on...and it’s usually a good time that I run out and have one [cigarette].*

By smoking outside, the man fulfilled his duties to protect his children from the harmful effects of second-hand smoke, while doing his part in completing a household chore (e.g., taking care of the family pet). In some way, going outside provided fathers with an “unregulated” environment that afforded them autonomy to smoke but also preserve a smoke-free home. In terms of heterosexual gender relations and masculine ideals linked to men’s smoking, there were evidence of significant shifts. Participants drew on protector ideals in conceding their smoking could no longer be an individual, autonomous decision. However, these concessions did not prompt resolutions to stop smoking, but rather influenced strategies for smoking away from their child and partner. In this regard, an array of masculine ideals influenced men’s reduction efforts as well as their smoking.
4.2.2 Smoking to mediate relationships

Many fathers constructed smoking as an aid not only to offset the pressures of work and fathering responsibilities but also to mediate relationships. By positioning smoking as beneficial to their family life, fathers could preserve their smoking practices. Luke, a 35-year-old Caucasian skilled trade worker who has smoked for over 13 years, explained:

*My biggest problem with quitting smoking is that I get very, very grumpy, very moody....My wife will tell you, I snap on people and that’s not my usual persona. I’m usually pretty laid back and relaxed but as soon as I start losing the nicotine in my system I get very, very grumpy and irritable and I don’t like to be around people.*

For Luke, by positioning quitting smoking as not a viable option because of the negative behaviours associated with nicotine withdrawal, he was able to frame smoking as essential to maintaining harmony in relationships by providing emotional stability. Like Luke, many participants believed that smoking improved their ability to be a good partner and father because it ensured that they were amenable and agreeable. Therefore, smoking was constructed as an unfortunate but responsible choice considerate of their partner and child’s well-being.

Although participants did not talk about harming their partners or children due to nicotine withdrawal, some fathers implicitly suggested that possibility in justifying their continued smoking. Mike, a 31-year-old Caucasian who worked in construction and had smoked over a pack a day for 15 years, explained the importance of smoking to him and those around him:

*It’s importance [smoking]? That I don’t blow up on society and that I end up not wanting to hurt somebody. Like I say like I’ve very low tolerance for stupidity*
and ignorance...even if it’s blind ignorance....I try very hard to make sure that I don’t 
[blow up]. But when people do it to me I just get right fed up....Just stupid things set me 
off....I have a smoke and I’m through it. Right now it’s more of a stress leverage for 
me....I have that cigarette and I count to ten.

Some fathers also suggested that their partners recognized the potential for aggressive 
behaviours, and encouraged them to smoke to prevent violent behaviours and dissonance in the 
household. Mike continued to explain how his partner used smoking as one of the strategies to 
mediate their relationship:

_I want to kill her [dog] when I find my garbage across my house because she’s gotten 
no reason to do it, her dish is always full....And then [wife] kicks me out here and 
makes me go have a cigarette because I just, I want to get rid of the dog. There’s been 
times where she’s had to literally stop me from phoning somebody to come and pick 
up the dog, come and get this mutt out of my house. So...while she cleans up the 
mess...I just ignore the dog for like half a day._

These data illustrate the importance of gender relations in which men’s management of 
their stress, mood, and smoking was affirmed by their partner. Moreover, the partner encouraged 
Mike to smoke rather than enduring his aggressive behaviours. Therefore, this specific example 
illustrated how the dominant feminine ideals of caring for men’s health by preventing their 
smoking were overruled to preserve harmony in the household; as a result, fathers’ smoking 
could disrupt or sustain conciliatory heterosexual gender relations by triaging fathers’ need to 
smoke (or not), depending on the context.
Within heterosexual relationships, gender relations influenced men’s smoking behaviours, and were often dependent on the smoking status of women partners. For example, women’s potential for relapse or continued smoking had a direct influence on the men and their smoking practices. Greg, a 31-year-old married, east European project manager who recently quit smoking, explained what he would do if his partner started to smoke again:

I told her [wife] if she starts smoking I’ll smoke, it’s not worth it for her so don’t even Bother....I just kind of threaten her with it....But you know what, I don’t, I don’t want to smell it either now. It does revolt me that smell so I don’t want her to come home stinking like an ashtray. It’s kind of rude....I know it’s pretty selfish of me to keep smoking while she was pregnant but, you know, what do you do [laughter]. When you’re not that addicted it’s, its, uh, it’s easier to quit. But when you’re smoking a pack a day it’s a pretty big adjustment just to, to drop it.

The subtext of tension and potential conflict in their relationship was evident in which masculine ideals of dominance were used to sustain a co-quit. Regardless of the reasons for his threatening response to smoking, there was evidence in the narrative of downplaying his partner’s successful quit. Because he believed his partner was “not that addicted” in the first place, he asserted that it was easier for her to quit, while his quit demanded greater effort. Similar accounts from fathers who labeled their partners as ‘social smokers’ suggested that they did not perceive their addictions to cigarettes equally with their partners; therefore, how the men perceive their partners’ addictions with their own adds another layer of complexity in revealing how heterosexual gender relations affect fathers’ decision to smoke, quit or co-quit.
The findings show that men who continued to smoke struggled to incorporate the norms and values of contemporary fatherhood, leading to new behaviours and rationalizations (e.g., smoking to mediate relationships and to prevent nicotine withdrawal symptoms). As a result, this finding highlights that the internal conflict that the men experienced with respect to masculine ideals, smoking and fatherhood, and the resulting complex process that reproduces gendered identities that, at times, defy the logic of smoking cessation.
Chapter 5: Discussion

In this chapter, I discuss the study’s findings within the limited body of literature on gender relations, masculinities, and fatherhood. In addition, specific attention is given to how heterosexual gender relationships engage and contest dominant masculine ideals in relation to smoking.

5.1 Men’s perceptions about efforts to support smoking cessation

Although fatherhood may be a transformative experience to improve health, in this study, only four participants stopped smoking. In fact, many female partners’ strategies to encourage cessation, from the men’s perspectives, were ineffective. For example, nagging fathers to quit increased potential conflict within relationships and among some men resulted in increased smoking. In a study by Bottorff et al. (2006) with a different group of new fathers, similar findings were reported. Men who were cajoled or “nagged” to stop smoking by partners were not perceived as supportive and instead resulted in disharmony in the relationship. The authors explained that men’s continued smoking despite pressures from their partners may reflect ambivalence towards responsibilities of fatherhood, and that emphasizing choice and acknowledging feelings may promote sustained behaviour change. Another study by Bottorff et al. (2010), which examined the female partners of the men from the same dataset, also found that women, frustrated with men’s stubbornness and broken promises to quit, resorted to nagging, which increased conflict and often worsened the situation. These women were often at a loss about what to do and found their role of regulating men’s smoking frustrating; as a result, the women accommodated men’s smoking and balanced their interventions to prevent further disharmony in the relationship (Bottorff, et al., 2010). The analysis of gender relations in this
study, as well as the findings in this thesis, point to the importance of gender-related influences in extending our understanding of the complexities underlying smoking patterns and smoking cessation.

This study also revealed that female partners’ contempt for men’s continued smoking often led participants to conceal their smoking. Similarly, Greaves, Oliffe, Ponic, Kelly and Bottorff (2010), based on the sample of men from the same dataset, reported that the conscious awareness of stigma, both external and internal, forced the men to manipulate and adjust their smoking locations and practices by self-removal and segregation. Greaves et al. explained that fathers perceived a disapproving and punitive gaze from others, which appeared to be gendered. For example, compared to women who are often blamed for hurting the foetus or the infant through smoking or exposure to second-hand smoke; the men perceived their smoking was viewed as undermining their responsibilities of protector and provider role (Greaves et al., 2010). What is particularly important with respect to the findings of this study is that in some contexts, fathers who smoke may not be able to escape disapproval of their smoking – even within their homes.

Although perceived support from the partners, which afforded men some freedom and control over their quitting behaviours, was considered helpful to an extent, this alone was not enough for the participants to quit on their own. Rather, participants who constructed smoking cessation as important to fulfilling fathering roles and aligning with masculine ideals of quitting for someone else seemed to be more successful. This reflects hegemonic masculinity as men shift their masculine ideals to take up fathering. According to Mullen (1993), family life and taking care of children provide men with alternatives to smoking, which draw them ‘towards
responsible conviviality’ (p. 177). Other studies have found that fathers who showed concerns about the effects of their smoking and wanting to be a role model for their children were associated with smoking reduction (Westmaas, Wild, & Ferrence, 2002). Therefore, this study adds to the body of literature by showing that men can reconstruct masculine norms to be compatible with fatherhood, which can act as a leverage toward men’s smoking cessation.

5.2 Gender relations on smoking and fatherhood

Increasingly, fatherhood is recognized as holding many unexpected challenges (Draper, 2003). Not only are men expected to be more involved with domestic responsibilities, they must also re-negotiate relationships with the children and, more important, with their female partners (Bottorff et al., 2006). As this study revealed, the influence of gender relations on fathers’ smoking behaviours were ever present. For example, to preserve an image of a contemporary, ‘good’ father and to prevent disapproval from their female partners, participants tried to separate their smoking behaviours from their family life and maintain a smoke-free home. This finding is consistent with Blackburn et al.’s (2005) study in which the majority of fathers (82.3%) reported active attempts not to smoke in the infant’s home and over 60% were successful. In this study, the key influence on fathers’ smoking behaviour in the home was female partner’s smoking status, suggesting that non-smoking partners were more likely to demand a smoke-free home than partners who smoke (Blackburn et al., 2005). Nevertheless, fathers’ willingness to smoke outside to keep homes smoke-free should be viewed favourably as an important contribution to reducing children’s and female partners’ exposure to secondhand smoke and responsible fathering.
In addition, just as fathers could ‘opt in and out’ of fathering responsibilities (e.g., due to the physical distance from pregnancy experiences), participants negotiated dominant masculine ideals to draw support for their rationales for continued smoking. Like findings reported by Bottorff et al., (2006), the men in this study justified their smoking by pointing to benefits such as decreasing work stress and pressures around fatherhood, and maintaining emotional stability. This finding is congruent with Bottorff et al.’s (2006) study in which the men considered smoking as essential for preventing negative behaviours associated with nicotine withdrawal, and that they could better fulfill their fathering responsibilities. Therefore, the current study highlights how individual men ‘opt in and out’ of masculine ideals to justify their smoking practices, revealing further complexities in the context of fatherhood and smoking.

In the current study, participants’ smoking behaviours were also influenced by female partners’ smoking patterns. For example, there was evidence to suggest that fathers would smoke again if their female partner relapsed and they downplayed their partners’ attempts to quit as being easier compared to their own quitting efforts. Bottorff et al. (2010) also observed this pattern when they analyzed couples parenting patterns in their analyses of the original data set that included men’s interviews as well as interview data from their female partners. In traditional parenting, in which women were the primary caregivers for the child, the couple who remained smoke free was vulnerable to relapse. In shared parenting, in which the father and the mother shared childcare, both couples were more likely to quit and maintain a smoke-free home. In non-smoking dyads, in which the mother, father, or both reduced or stopped smoking, there was potential for conflict in the event that either the mother or father relapsed. Together, these findings support the notion that heterosexual gender relations are an important factor influencing smoking behaviours of new fathers (Bottorff, Oliffe, et al., 2010). Therefore, the findings
highlight the importance of interventions that take into account couple dynamics (e.g., how men’s and women’s interactions with each other and the circumstances in which they interact affect men’s smoking) in addition to stresses related to financial and domestic responsibilities (Bottorff et al., 2006).

5.3 Limitations of the study

The findings need to be considered in light of several limitations. Not all men’s experiences are represented in a sample of 20 participants. For example, absent are men who do not make any efforts to change their smoking practices since they are least likely to volunteer, and men with significant life events, such as being diagnosed with a medical condition. The primary study was cross-sectional in design, and caution is warranted in interpreting what can be said about changes over time. The study setting, of western Canada, is known for its strong smoke-free culture and tobacco regulations in public places, and this needs to be taken into account in light of the men’s strong defensive stance related to their smoking. As a result, the findings might not be generalizable to men in different contexts or to sub-groups of men. Nevertheless, the findings of this thesis provide important insights into fathers’ smoking that can guide targeted tobacco cessation programs.

5.4 Recommendations

The findings of this study provide useful directions to support smoking cessation among new fathers. Interventions are clearly needed to motivate and support men’s smoking cessation. The lack of interventions to encourage men’s tobacco reduction has the potential to increase relationship tension, and inadvertently place continued responsibility on women to regulate fathers’ smoking (Bottorff et al., 2010). Instead, a tailored smoking cessation intervention is
recommended that can directly address the masculine ideals that encourage men’s continued smoking.

Recently, many health promotion programs and campaigns have started to appeal to men and their masculine breadwinner and protector ideals—“Be More Man…Be More Healthy,” used by the Men’s Health Center in Baltimore, being a prime example (Whitley, Jarrett, Young, Adeyemi, & Perez, 2007). However, Greaves, Oliffe, Ponic, Kelly, and Bottorff (2010) criticized these programs as being unlikely to sustain a behavioural change because of their underlying message to do health for someone else. A more promising approach has been developed in the research program, “The Families Controlling and Eliminating Tobacco” (FACET). In this program the approaches to support father’s smoking cessation were based on three principles for men’s health promotion programs (Oliffe, Bottorff, & Sarbit, 2012):

1) Use positive messaging to promote change without amplifying stigma, guilt, shame and blame.

2) Foster connections between masculine ideals (e.g., strength, decisiveness, resilience, autonomy) and being smoke-free.

3) Privilege the testimonials of potential end-users (i.e., fathers who smoke but want to quit).

According to Robertson (2007), positive messaging approaches are essential to mobilize men toward smoking cessation. In Oliffe et al.’s (2012) study, rather than being labeled as fathers who chose to continue to smoke, participants wanted to be viewed as committed fathers who wanted to smoke less. Sensitivity to judgment is particularly important in this context because British Columbia is known for strong tobacco control policies and low smoking rates compared to other provinces (Oliffe et al., 2012). As a result, clinicians should use positive,
encouraging messages to support tobacco reduction and cessation. In addition, based on men’s perceptions of their partner’s efforts to support their smoking cessation approaches that promote and protect men’s autonomy in deciding when and how to quit smoking is likely to be important.

Although smoking has been aligned with masculine ideals, being smoke-free also can be linked to men’s strength, autonomy and resilience. These ideals can be used as a leverage to motivate men to reduce or quit. For example, health professionals can accentuate the positives of being smoke-free by suggesting to men that they can improve their own health as one way to fulfill their responsibilities as fathers. Health professionals can also help men to think more relationally and to consider how their smoking might affect the relationship with their partners (McBride et al., 2004) as well as their partners’ smoking cessation efforts and ability to remain smoke-free (Bottorff et al., 2006). Similarly, addressing ways that withdrawal symptoms can be controlled during the cessation process (e.g., using nicotine replacement therapy) as well as other ways to reduce irritability such as exercise may be beneficial. By being aware of the link between masculine identity, gender relations, and smoking during the transition to fatherhood, clinicians can work with men and facilitate smoking cessation.

Since tobacco reduction is associated with men’s increased involvement in childcare, programs that offer information on how to quit but also resources to support men in fathering are a promising new direction. Oliffe et al. (2012) booklet titled The Right Time…the Right Reasons and an 8-week face-to-face program, Dads in Gear (DIG) provide a model for the approach. One of the main features of the DIG program is the variety of interactive activities, including discussions and exercises to support men in becoming engaged and confident fathers. Building men’s confidence and skills with respect to fathering early on in their partners’ pregnancies in
addition to providing information on how to reduce or quit would be a useful extension to this work.

In conclusion, the descriptions of fathers’ smoking experiences in relation to heterosexual gender relations during their partners’ pregnancy and postpartum provide new insights that could serve as a basis for research and for tailoring smoking cessation interventions. In particular, future research should closely examine how couples interact, both implicitly and explicitly, to influence each other’s smoking behaviour. While health promotion programs specifically for fathers are not yet fully developed and will require formal evaluations to assess their effectiveness, principles derived from their perspectives provide a guiding framework for the design and implementation of gender-sensitive smoking cessation programs.
References


http://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/effects_cig_smoking/


doi:10.1093/her/cyg061


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## Appendices

### Appendix A - Demographics of Participants

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Fathers (n=20)</th>
</tr>
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<tbody>
<tr>
<td><strong>Age, in years: M (range)</strong></td>
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</tr>
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</tr>
<tr>
<td>High school complete</td>
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</tr>
<tr>
<td>Postsecondary-some university</td>
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<tr>
<td>Postsecondary-university degree</td>
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</tr>
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<tr>
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<tr>
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<tr>
<td><strong>Ethnicity</strong></td>
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<tr>
<td>Asian Canadian</td>
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<tr>
<td><strong>Annual household income</strong></td>
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<tr>
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<tr>
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<td>--------------</td>
<td>-------</td>
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<tr>
<td>$90,000-$100,000</td>
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</tr>
<tr>
<td>&gt;$100,000</td>
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**Cigarette consumption**

<table>
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<th>Count</th>
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<tr>
<td>Quit smoking</td>
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</tr>
<tr>
<td>1-2 cigarettes a day</td>
<td>2</td>
</tr>
<tr>
<td>3-4 cigarettes a day</td>
<td>3</td>
</tr>
<tr>
<td>5-7 cigarettes a day</td>
<td>1</td>
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<tr>
<td>8-12 cigarettes a day</td>
<td>3</td>
</tr>
<tr>
<td>Half a pack a day</td>
<td>1</td>
</tr>
<tr>
<td>A pack a day</td>
<td>1</td>
</tr>
<tr>
<td>Over a pack a day</td>
<td>2</td>
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**Years smoked, M**

<table>
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<th>Count</th>
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<td>8-11</td>
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</tr>
<tr>
<td>12-15</td>
<td>7</td>
</tr>
<tr>
<td>16-20</td>
<td>3</td>
</tr>
<tr>
<td>&gt;20</td>
<td>4</td>
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**Occupation**

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<tr>
<th>Occupation</th>
<th>Count</th>
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</thead>
<tbody>
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<td>Unemployed/on disability</td>
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<td>Construction/laborer/trades</td>
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</tr>
<tr>
<td>IT/admin/marketing/human resources</td>
<td>6</td>
</tr>
<tr>
<td>Courier/driver</td>
<td>1</td>
</tr>
<tr>
<td>Carpet cleaner</td>
<td>1</td>
</tr>
<tr>
<td>Tour operator</td>
<td>1</td>
</tr>
<tr>
<td>Retail clerk</td>
<td>1</td>
</tr>
<tr>
<td>Student</td>
<td>1</td>
</tr>
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</table>

**Cigarette brands used**

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<th>Cigarette Brand</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Du Maurier</td>
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<tr>
<td>Player</td>
<td>5</td>
</tr>
<tr>
<td>Foreign brand (Chinese/Japanese)</td>
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</tr>
<tr>
<td>Marlboro</td>
<td>1</td>
</tr>
<tr>
<td>Brand</td>
<td>Count</td>
</tr>
<tr>
<td>------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Belmont</td>
<td>1</td>
</tr>
<tr>
<td>Dunhill</td>
<td>1</td>
</tr>
<tr>
<td>Hand-rolled cigarette</td>
<td>1</td>
</tr>
<tr>
<td>No specific brand</td>
<td>2</td>
</tr>
<tr>
<td>Not answered</td>
<td>1</td>
</tr>
</tbody>
</table>
Appendix B - FACET 2 Interview Guide – Father

Family Dynamics
- Please remind me how old your child is now.
- I would like to begin by learning more about what it has been like for you having a baby and becoming a father for the 1\textsuperscript{st} (or 2\textsuperscript{nd}, 3\textsuperscript{rd}) time? Is it what you expected?
  - How would you describe your responsibilities in the home as a father over the past year?
  - Can you give me an example of when you feel most like a father?
- What has changed in your household between when your baby was born and now that she/he is # years old? [Probes: how have you found the transition in terms breastfeeding? work/employment? Childcare? Any major events or crises? Planning more children?]
  - What change has had the biggest impact on your family life?
  - Can you give me an example on how this change has affected your family life?

Current Smoking Status
- How would you describe your smoking status now? How would you describe your partner’s? Has your (or your partners’) smoking status changed from when your baby was born to now?
- [if quit] What has taken the place of smoking in your (or partner’s) life?
- Have any changes in family routines over the past year affected your (or partner’s) smoking decisions? Who or why not? Can you give me an example?

[if smoking or having occasional slip:]
- What are your plans about smoking now that your child is # years old? (ie. stay the same?, reduce? quit? Etc.)
  - IF PLANS TO REDUCE OR QUIT: Probes: when and how? Do you hope to quit by the time your child is certain age? What age and why that age?
- Can you tell me about times in the last year that you have been particularly vulnerable to returning to smoking or smoking more than usual?
  - How has your desire to smoke or cravings changed in the past year?
  - What type of events make you want to smoke again or more? Can you give me an example of such an event?
  - [If quit] Have you smoked at all (even puffs) during this period? Can you describe this situation?

[ask all fathers:]
- Do you think that there are different expectations on you to be smoke free now that your baby is ## months/ys old?? What are they? How have they changed since your baby was newborn? (Probes: do you think you should be more or less protective about your child’s exposure to second hand smoke now that she/he is older?)
  - Do you think the expectations related to smoking are different for mothers and fathers? In what ways and why? What about in your situation?
Do you get pressure to smoke or not smoke from particular people? Can you give me an example? How do you feel about that?

Changes in Family Dynamics about Smoking and Child’s Exposure to Secondhand Smoke

- [If father smokes or smoked] How has your partner influenced your efforts to reduce/remain smoke free? Or to keep your home smoke-free? Can you give me an example?
- Have you noticed a change in the way you and your partner deal with smoking issues during the past year? How is it different from when your child was first born? Can you give me an example?
- We have learned that some couples do not always think the same way when it comes to second-hand smoke. How do you and your partner feel about your child being around secondhand smoke? (Probe: are you concerned about it? Why or why not?)
- How have these feelings/concerns changed, if at all, as your baby is getting older (moving; beginning to communicate; more alert)?
- [If concerned about baby being around secondhand smoke] What kinds of strategies have you and your partner developed to keep him/her from secondhand smoke when this is possible?
  - How have these strategies affected your smoking activities? (Probe - are you/partner able to go out for a smoke in the same way/places/times?)
  - Do you have any rules about smoking (for yourself, partner, or other people in your immediate circle of friends and family) in your home and/or car? What are they and why are they important to you?
  - Are the rules different for you and your partner? Or for other people in your immediate circle of friends and family?
  - Have these rules changed in the past year? How so and why? Can you give me an example?
  - We know that sometimes these rules are difficult to stick to all of the time and that exceptions need to be made. What has it been like trying to stick to the rules you have? Can you tell me about any times when you bent your rules or made exceptions for particular people or situations?
  - How would you describe the roles you and your partner each play in creating and maintaining rules about smoking in your family? (Probe - is one of you more strict or relaxed with the rules then the other?) Can you give me an example?
- We have heard from other parents that keeping their children away from secondhand smoke can be difficult or impossible in some situations. Can you tell me about any instances when you’ve found this to be the case? Has it become more or less difficult as your child develops (e.g. engages with others, walks, mimics, etc)? How have you handled such situations in the past? How would you like to handle such situations in the future?
- By age 1, parents usually come to some decisions related to childcare (regular childcare and special occasions); how did smoking and secondhand smoke play a part in your discussions/decisions about childcare, if at all? Please explain.
- What kinds of places outside of your home is your child most likely to be exposed to smoke? Some parents are not concerned about this and other are. What do you and your partner think
about this? [If concerned] How do you and your partner deal with those instances? Can you give me an example?

- Can you tell me about any other situations where your child is around smokers but their exposure to second hand smoke is minimal?
- How would you summarize your current interaction style as a couple around smoking? (For example, some moms describe their partners’ actions and conversations related to smoking as “accepting.” For others there is tension in their interactions with their partners about tobacco; and for others it is a non issue because smoking is not something they usually do together).

As a couple, do you think you deal with tobacco issues differently than any other issues? (i.e.; finances).

**Children and “modeling”**

We are interested in when children become aware of smoking. To what extent is your child aware of your (or other people’s) smoking?

- Tell me about the first few instances when your child saw somebody smoking? How did you handle these situations?
- If your child is not currently aware of people smoking, why do think that is? When do you think he/she may become aware?

When do you think the smoking behaviour of others begins to influence the way children think about smoking?

- Has smoking ever come up in interactions or talks with your child? Has your child ever asked about smoking? Can you give me an example?

- How does your child’s personality influence their reactions to seeing cigarettes or someone smoking?

- How and at what age do you think parents should explain smoking to children?
- Has your child’s awareness or reactions to smoking influenced your smoking (or your partner’s smoking) or your efforts to keep your child away from secondhand smoke as much as possible? How so? Can you give me an example?

**Closing questions/Interventions**

- Some people believe that exposure to some second hand smoke now and again is unavoidable and not likely to be harmful to children. Others think that any amount of second hand smoke is not good for children’s health. Where do you stand on this issue?
  - [IF concerned] What strategies do you see yourself using to cope with this concern, especially as your child gets older?
  - [If not concerned] In what kinds of situations do you expect your child to encounter acceptable amounts of second hand smoke in the future? Are there any times that you think they might encounter too much second hand smoke?

- We are interested in learning from parents what information and assistance that they think will be helpful in keeping their children from second hand smoke to the extent they think necessary.
  - Probe: programs to help you/your partner quit or reduce smoking, or take smoking outdoors more often? Support groups for learning how to manage friends or family members who smoke? Support groups for you as a couple to deal with your challenges around smoking and secondhand smoke?)
What advice would you give other couples who are dealing with smoking issues or concerned about the amount of secondhand smoke their child is exposed to in some situations? What kinds of challenges can they expect as their children get older?

What advice would you give other couples about how to respond to questions small children might ask about smoking?