HOW WOMEN PROTECT THEIR CHILDREN FROM ENVIRONMENTAL TOBACCO SMOKE: A SMOULDERING ISSUE

by

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Abstract

A growing number of research studies conclude that exposure to environmental tobacco smoke (ETS) has an overwhelming effect on the health of children causing 400,000 episodes of childhood sickness each year in Canada. The home is the predominant site of exposure, and maternal smoking is a primary source of ETS exposure in young children. Little is known or reported about maternal efforts to protect children from ETS. This situation poses a challenge to find ways to assist women in protecting their children from ETS. The purpose of this grounded theory study was to describe the process women use to protect their children from ETS. Open-ended interviews were conducted with nine mothers who smoked or were in contact with people who smoked. The findings of this study indicated that protecting children from ETS was a complex three-phase process that involved “avoiding the judgemental gaze”. In the first phase, starting out with good intentions, the women established rules to protect their children from ETS and projected themselves as “good mothers”. The rules were successfully applied but in the course of everyday life, circumstances presented that tested and sometimes weakened the women’s resolve to abide by their rules. In the second phase, making exceptions, rules were revised to accommodate frequently occurring transgressions or replaced with less restrictive guidelines to appease others’ needs to smoke and to be “socially acceptable”. The new rules were a significant departure from the women’s initial good intentions creating contradictions that they could not ignore. In the third phase, dealing with contradictions, the women used several strategies to manage the dissonance they experienced as a result of their transgressions: seeking agreement from others, minimizing the effects of ETS, hiding their smoking, ignoring
health information, explaining addiction, and living in hope. The process described in this study extends our understanding of how women protect their children from ETS and provides some directions for supporting women in the challenges and difficulties they encounter.
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Chapter 1: Introduction

Background

The origins of tobacco smoking remain indistinct; yet, researchers speculate that smoking commenced either with the peoples of Asia or the First Nations in the Americas (Greaves, 1996). Nevertheless, it is known that early tobacco use was reserved for sacred and medicinal purposes such as giving thanks, protecting travellers, and inducing peace or welcoming guests (Greaves, 1996). In retrospect, it is difficult to contemplate whether smoking presented the health problem that it gives rise to today. Tobacco use is the primary cause of death and disease in North America, today, and the most important cause of premature death in the developed world (Howard, Wagenknecht, Cooper, Kraut, & Toole, 1998; Levy, 1989; McGinnis & Foege, 1993; Ostro, 1989).

Tobacco use, primarily cigarettes, is responsible for the deaths of 3 million people worldwide, 45,000 Canadians and 5,800 British Columbians each year (British Columbia Ministry of Health, 1997).

The health consequences of cigarette smoking are not limited to only those individuals who smoke. Recently, public health concern has broadened its focus to include non-smokers exposed to environmental tobacco smoke (ETS). ETS is a common and harmful form of indoor air pollution emitted from tobacco products. The two types of ETS are: (a) second-hand smoke, the smoke that a smoker actually exhales into the air; and (b) side-stream smoke, the smoke that is emitted from the end of a burning cigarette (Schlapman, 1995). More than 4,000 chemical compounds are found in ETS, and at least 60 of these are cancer causing in humans (United States Environmental Protection Agency (USEPA), 1992). In a 1992 landmark report, the USEPA concluded that 50,000 non-smoking Americans die each year from ETS-related causes such as
cancer, heart disease, and respiratory disease. More strikingly stated, the report determined that one non-smoker dies each year for every 1,000 people who smoke in the United States (USEPA, 1992). Slowly, the public has become increasingly aware of the health hazards of ETS and has sought political and legal protection. While adult non-smokers are winning the battle against ETS, children are not; many children live in homes with their smoking parents. As government sanctioned laws and policies continue to restrict smoking in public places such as restaurants, pubs, and shopping malls, parents are forced to smoke in the privacy of their homes, places they share with their children.

Problem Statement

Forty percent of Canadian households, with children under 15 years of age, have one or more smokers in the home (Ekos Research Associates, 1995). Another 41% do not include a smoker but allow visitors to smoke. This means that only 19% of Canadian homes with children are completely smoke free. In essence, 2.8 million Canadian children, under 15 years of age are exposed daily to ETS in their homes (Ekos Research Associates, 1995). Despite limited attention to the issue of children's exposure to ETS, a growing number of research studies demonstrate that ETS has an overwhelming effect on the health of children, is responsible for 400,000 episodes of childhood sickness each year including: coughs, ear infections, respiratory infections, asthma, sudden infant death syndrome (SIDS), and possibly contributes to cancer and heart disease occurrences in adulthood (National Clearinghouse, 1997).

Smoking is no longer strictly a male-oriented health problem. Canadian men's smoking rates are declining faster than Canadian women's smoking rates, and the numbers of young women who are smoking is alarming. Despite numerous educational
campaigns and government interventions, recent projections indicate that smoking will account for more than 16,000 deaths among Canadian women by the year 2000 (Health Canada, 1996). When Jacobson (1981) and Greaves (1996), two feminist researchers, explored the issue of women and smoking, they concluded that the interventions to support women’s smoking cessation were not working; they recommended that qualitative research is needed to develop theories that are grounded in the lives and experiences of women rather than the judgements and the opinions of non-smokers. Only then will women’s life circumstances and smoking habits be understood and cessation programs be effective. Sadly, their insights remain relevant today. Many women continue to smoke and, for the most part, remain the major caretakers of young children resulting in children’s exposure to ETS. The effects of ETS on the health of children have received less than adequate attention and long overdue interventions are required to reduce exposure to ETS and to enhance children’s right to breathe clean air.

Purpose of the Study

The purpose of this qualitative study was to provide a rich description of the processes that women use to protect their children from ETS. It addressed the following question: What are the methods, techniques, and practices that women use to protect their children from ETS? It was expected that the research would make an important contribution to a currently limited theoretical knowledge base by extending our understanding of women’s efforts to protect their children from ETS, and providing a basis for the development and enhancement of interventions that reduce children’s exposure to ETS.

Summary

While the public is increasingly aware of the health issues associated with
cigarette smoking and ETS, smoke-free environments are not enjoyed by all sectors of the population. Smoking restrictions in public places have effectively protected children from ETS in day care, schools, and restaurants. Nevertheless, adults continue to smoke in the privacy of their homes, which they often share with their children. A growing number of studies document the health consequences of ETS on children, yet, children are exposed to ETS in their homes in large numbers.

Smoking is a women’s health issue, and women remain the major caretakers of their young children. This situation poses a challenge to find ways to reduce children’s exposure to ETS. Understanding the methods, the techniques, and the practices women use to protect their children from ETS provides an important first step towards this goal.
Chapter 2: Literature Review

The intent of this literature review is to provide some background to the study and to summarize what is currently known about women's strategies to protect their children from ETS. While this author searched databases on the subject, including MedLine and CINAHL using search terms such as children, environmental tobacco smoke, women, smoking, protection, passive smoking, tobacco smoke pollution, and asthma, the search did not produce research-based studies or theoretical publications that considered or addressed the specific research question. As a result, this literature review contains pertinent and current literature that supports the research problem but does not specifically address the practices women engage in to protect their children. Rather, the fragments found in the available literature define the current gap in research related to this subject.

The review begins with an overview of the prevalence of smoking and the current social context that envelops this behaviour. Accumulating medical evidence demonstrates that ETS has a substantial impact on the health and lives of children and the nature of this impact is summarized. A limited number of reported intervention studies that test the effectiveness of programs to reduce children's exposure to ETS exist; five of these studies are presented and critically analyzed. To explore the context and challenges women face in relation to their tobacco use and the protection of their children, women's unique situations, experiences, smoking patterns, and behaviours are examined.

Scope of the Problem

As advances in science occur, we are increasingly aware of the adverse effects of smoking on our personal and collective health. Tobacco smoking is the number one
cause of morbidity and mortality in North America and the most important cause of premature death in the developed world (Howard et al., 1998; Levy, 1989; McGinnis & Foege, 1993; Ostro, 1989; Peto, Lopez, Boreham, Thun, & Heath, 1994). Research indicates that smoking is a preventable cause of coronary heart disease, stroke, lung cancer, and chronic obstructive lung disease (Dwyer & Hetzel, 1980; Hanson, 1994; Howard et al., 1998; Levy, 1989; Ostro, 1989). According to the World Health Organization, "Tobacco causes more deaths than all other forms of substance abuse combined; it kills 3 million people a year" (B.C. Ministry of Health, 1997, p. 1). Canada has the 13th highest cigarette consumption in the world, resulting in 45,000 Canadians dying each year. Statistical evidence demonstrates that cigarette smoking is declining in British Columbia: 29% of those over 15 years of age smoked in 1991; 25% and 23% smoked in 1994 and 1997, respectively. Less than one-quarter of British Columbians smoke, yet, that percentage represents 715,000 adults who use tobacco on a regular basis, and the age groups with the most smokers are the 15- to 18-year-olds, the 19- to 24-year-olds and the 25- to 44-year-olds (B.C. Ministry of Health, 1997).

Smoking-related illnesses were once viewed by the medical profession and society as a male health problem, therefore, women's smoking escaped serious medical attention. This view, however, is changing since women now suffer the same smoking-related diseases as men. In fact, lung cancer has surpassed breast cancer as the leading cause of cancer death in Canadian women (Health Canada, 1996). Recent research indicates that smoking plays an important role in diseases and health problems specific to women, such as cervical cancer, early menopause, menstrual disorders and osteoporosis. In the United States, more than 106,000 deaths among women each year are estimated to be related to smoking (Bartecchi, MacKenzie, & Schrier, 1994; Chollat-
Traquet, 1992; Sarna & Brecht, 1996). Comparably, 13,000 Canadian women die annually as a result of smoking-related illnesses (Makomaski Illing & Kaiserman, 1995). Recent projections indicate that this toll will increase and smoking will account for more than 16,000 deaths among Canadian women by the year 2000 (Ellison, Mao, & Gibbons, 1995). A recent national survey (Angus Reid, 1997) revealed that Canadian men's smoking rates are declining slightly faster than Canadian women's smoking rates. Canadian females, 12 to 24 years of age, are slightly more likely to be current or former users than males of the same age. These statistics define smoking as a women's health issue and provide a convincing argument for urgent health sector attention and intervention.

According to a large national survey, 9 out of 10 Canadians aged 15 and over believe that smoking is harmful to both the smoker and the non-smoker (Stephens & Mitchell, 1995). Despite this high level of awareness, 35% of Canadians could name only one health problem caused by smoking, and 53% of Canadians could name only one health problem associated with ETS (Stephens & Mitchell, 1995). As well, 74% agreed that ETS causes disease in non-smokers, yet fewer (58%) believed that ETS causes death in non-smokers. In a survey of attitudes and beliefs related to ETS, one half of the smokers and one third of the non-smokers interviewed stated that the danger of ETS exposure to non-smokers is exaggerated (Brown, Richert, Walker, & Cameron, 1995). These statistics and comments demonstrate that the public is poorly informed about the specific risks from exposure to ETS (National Clearinghouse, 1996).

Legal Efforts to Limit ETS Exposure

While the magnitude of exposure to tobacco smoke has not been fully realized, a war does exist between smokers and non-smokers over the right to control shared space
in all indoor, public places, such as restaurants, bars, universities, sports centres, theatres, and the workplace. This war over rights was fuelled by the USEPA's monumental report, which concluded that ETS is responsible for the deaths of approximately 3,000 Americans each year, as a result of lung cancer, and is a known human carcinogen (United States Environmental Protection Agency, 1992).

Canada has taken a relatively strong position with regard to controlling smoking and exposure to ETS. Provincial legislation prohibits or restricts smoking in public settings and workplaces, and gives municipalities authority to pass by-laws to protect the health of citizens (Stephens & Mitchell, 1995). While provincial legislation sets a minimal level of protection throughout the province of British Columbia, municipalities are empowered to provide additional protection. Indeed, where both provincial legislation and municipal by-laws exist, the most restrictive policies apply. A 1995 survey of smoking by-laws in Canada provided an overview of municipal by-laws that restrict smoking in public places, demonstrating the extent of activity at the local level. The survey revealed that some municipalities, such as those in Quebec, are less proactive in terms of passing by-laws restricting smoking. Other municipalities, such as those in British Columbia, have taken a comparatively stronger position in terms of restricting or prohibiting smoking in a variety of premises and workplaces (Stephens & Mitchell, 1995). Failure to comply with ETS regulations by individuals or organizations, such as smoking in prohibited places, having improper signage, and providing smoking rooms that do not meet size and ventilation requirements are typically fined (Stephens & Mitchell, 1995). Of interest, like the European tobacco houses of the early 1500s, smokers are once again limited to specific locations (Greaves, 1996). Recently (January, 2000), the Workers' Compensation Board of British Columbia passed a regulation
restricting worker exposure to ETS. These regulations essentially meant that there would be no smoking allowed in spaces where workers might be exposed (including pubs and bars). While this policy has been overturned by the British Columbia Supreme Court (March, 2000), it demonstrates the will to address this issue.

While adult non-smokers are increasingly protected from ETS, the children of smokers are less fortunate. As people are less able to smoke in public places, they are forced to smoke in the privacy of their own homes. Unfortunately, these private domains are often shared with young children. A survey of 2,300 Canadian parents revealed that 40% of Canadian households, with children under the age of 15, have one or more smokers in the home (Ekos Research Associates, 1995). Another 41% do not include a smoker but allow visitors to smoke. This means that a mere 19% of Canadian homes with children are completely smoke free.

Population-based data on attitudes and practices concerning smoking in the home in Ontario were published recently and the results are encouraging (Ashley et al., 1998). Data were obtained in province-wide telephone surveys conducted in 1992, 1995, and 1996, and there were notable changes in the attitudes of both non-smokers and smokers. The percentage of non-smokers who agreed that parents should not smoke in the home was 63% in 1992, while in 1996, it was 78%. The corresponding change observed in smokers was more dramatic, increasing from 16% to 43%. Smokers unopposed to parental smoking in front of children declined from 22% in 1992 to 14% in 1996. Although attitudes are more favourable towards smoke-free homes, in practice, most homes in Ontario with daily smokers and children are not smoke-free. In essence, each day an estimated 2.8 million Canadian children, under the age of 15 years, are exposed to ETS in their homes. Three million Canadian children require child care at least once
a week, and 85% of these children are cared for in unlicensed settings where there are fewer legal restrictions against smoking. The result is that each day, millions of Canadian children are forced to breathe ETS outside and inside their homes (Ekos Research Associates, 1995).

Historically, tobacco smoking is an issue charged with controversy, emotions, legal rights and moral ramifications, and the "ETS in the home" issue emulates this pattern. While some argue that individuals have the right to smoke in the privacy of their homes, others ardently insist on government involvement to safeguard the rights and health of children. Over the last 10 years, litigation has been the driving force behind many tobacco control reforms in public-gathering places and the workplace, and may prove to be the deciding factor, once again, in the home. Canadian courts, for example, are considering parental smoking as one of the factors that must be weighed in assessing "the best interest" of the child in custody and access proceedings (National Clearinghouse, 1996).

Morbidity

While the last decade has seen an increase in public awareness about the effects of ETS on adult non-smokers, the effects of ETS on children have received somewhat less attention. Despite this oversight, a growing number of research studies gives credence to the claim that ETS affects children's health. Few studies on this topic have been carried out in Canada. This is an unfortunate occurrence because Canadian children have a higher risk of exposure to ETS than do children in many other countries, for several reasons: Canada has one of the highest tobacco consumption rates in the developed world, Canadian children spend more time indoors because of cold weather, and Canadian homes are designed to prevent heat loss so ventilation is poorer
than that in warmer climates (National Clearinghouse, 1996; Ugnat, Mao, Miller, & Wigle, 1990).

Well documented throughout the literature is the notion that children are more susceptible to ETS than are adults for a variety of reasons: (a) children have more rapid respiratory rates than do adults and inhale more air and more pollutants in relation to their total body weight, (b) children absorb proportionately more substances than adults, (c) children's cells are still developing and are more vulnerable to chemical alterations (e.g., lung tissue), and (d) children's immune systems are less mature (Mohler, 1987; Ugnat et al., 1990). Young children tend to be carried, or sit next to or on parents, family members, and care-givers, which means that they are closer to the source of tobacco smoke and less able to remove themselves from smoke-filled environments.

Tobacco use is described as a pediatric epidemic because of its widespread, noxious, and long-lasting effects on the health of children (Black, 1985; Kraemer, Richardson, & Weiss, 1983; Malloy, Hoffman, & Peterson, 1992; Stephens & Mitchell, 1995). The first outcome of children breathing smoke-filled air to be recognized and widely-documented in the medical literature is the higher incidence of respiratory tract illnesses. Children less than a year old whose parents smoke are twice as likely to contract pneumonia, bronchitis, acute nasopharyngitis, and sinusitis, compared with children whose parents do not smoke (Cameron, 1967; Colley, Holland, & Corkhill, 1974; Erikson & Bruusgaard, 1995; Harlap & Davies, 1974). Indeed, a review article concluded that 12% of lower respiratory infections, approximately 260,000 cases of bronchitis, and 115,000 cases of pneumonia annually among children less than 5 years old, are attributable to household smoking in the United States (DiFranza & Lew, 1996).
Ten percent of children's coughs are ascribed to household ETS exposure and results in over a million visits to physicians annually. In Canada, ETS is responsible for 16% of all lung infections in children under 5 years of age or 35,000 cases of bronchitis, 15,200 cases of pneumonia, and 167,000 visits to physicians for a cough (National Clearinghouse, 1997).

The prevalence of asthma among children under 18 years of age has increased in the United States. Approximately 8% of all cases of asthma, which equals 307,000 children under 15 years of age, are attributed to ETS (DiFranza & Lew, 1996). ETS is responsible for 11% or 43,000 cases of asthma in Canadian children (National Clearinghouse, 1997). Children with asthma whose parents smoke have more exacerbations, more severe symptoms, and more frequent visits to a physician. With less exposure to ETS, studies show that children's asthmatic symptoms and exacerbations decrease significantly (Chilmonczyk et al., 1993; Evans et al., 1987; Murray & Morrison, 1993; O'Connell & Logan, 1974). Weitzman, Gortmaker, and Sobol (1990) examined the relationship between maternal smoking and the use of asthma medication and related that children under 5 years of age are five times more likely to be using asthma medication if their mother smokes or smoked during pregnancy.

Worldwide research concludes that exposure to ETS is a risk factor for middle ear disease and that approximately 50% of children requiring tympanostomy tube insertion live with a parent who smokes (Black, 1985; Hinton, 1989; Iversen, Birch, Lundqvist, & Elbrond, 1985; Kraemer et al., 1983). Several studies confirm an association between exposure to ETS and children having their tonsils and/or adenoids removed (Black, 1985; Hinton, Herdman, Martin-Hirsch, & Saeed, 1993; Stahlberg, Ruuskanen, & Virolainen, 1986). In Canada, ETS is responsible for 7% of ear infections
or 120,000 pediatric cases, 20% of tonsillectomies and adenoidectomies or 1,800 operations, and 14% of tympanostomy tube insertions or 8,600 procedures (National Clearinghouse, 1997).

A growing body of evidence links ETS exposure as a possible causal factor in Sudden Infant Death Syndrome (SIDS) (Bergman & Wiesner, 1976; Haglund & Cnattingius, 1990; Malloy et al., 1992). SIDS is the most frequent cause of death in infants 1 month of age to 1 year of age resulting in 5,000 infants dying each year in the United States (Ezra, 1994).

The noxious chemicals present in tobacco smoke, which can cause cancer and heart disease in smokers, are also found in ETS. Not surprisingly, a small number of studies link exposure to ETS during childhood with heart disease and cancer risks. Sandler, Wilcox, and Everson (1985) found the risk of cancer to be higher in adults exposed to ETS during childhood than in those exposed to ETS only in adulthood. One recent study reported that approximately one in five instances of lung cancer in nonsmokers can be attributed to childhood ETS exposure (Janevich et al., 1990). When looking at specific cancers, Sandler, Wilcox, Everson, and Browder (1985) found that leukemia and lymphoma among adults is significantly related to exposure to ETS before the age of 10.

While a connection between heart disease and ETS exposure has been more difficult to make, ETS-related heart disease is believed to be responsible for approximately 37,000 nonsmoker deaths each year. Feldman, Shenker, and Etzel (1991) studied adolescents who were exposed to ETS and found that their cholesterol ratio levels were higher than adolescents not exposed to ETS. Evidence that childhood exposure to ETS is a possible precursor of premature coronary heart disease is gaining
strength and cannot be ignored (American Academy of Pediatrics, 1997). Additionally, children whose parents smoke are at greater risk of death or injury from house fires caused by careless smoking. In 1990, 4,345 fires in Canada were initiated by tobacco products and/or the materials used to light tobacco products, and resulted in the death of 10 children and injuries to 38 children (National Clearinghouse, 1994).

Parents are the most important and influential people in a young child’s life. Children listen to, watch, and learn from their parents. Their games often emulate parental roles and behaviours. Thus, smoking by parents can shape the health beliefs of children by discounting the negative effects of tobacco (Aaro, Hauknes, & Berglund, 1981). Parents do not wish a legacy for their children that includes a highly addictive habit associated with ill health and premature death, yet, children who grow up with parents who smoke are more likely to become smokers themselves (Chassin, Presson, Sherman, & Edwards, 1990; Erikson & Bruusgaard, 1995).

The study of risks to children associated with ETS is complicated and can be difficult for the public to understand. While the public is hungry for information on scientific links between smoking and health from sources such as newspapers, television, radio, and, increasingly, the Internet, many supporters of tobacco products indirectly encourage smoking by attacking studies for falling short of conclusive evidence. For them, absolute proof that ETS can harm children does not yet exist. The pediatric risks of ETS dangerously resemble a prior scenario: In the 1930s, smoking was suspected to cause cancer, yet, it took almost four decades before the American Surgeon General announced that smoking could cause lung cancer (Ezra, 1994).

**Interventions to Reduce ETS Exposure**

Despite the growing concern and the mounting number of health implications for
children exposed to ETS, there is a paucity of reported research studies that evaluate health intervention programs dedicated to the reduction of smoke in children’s environments. Of the five identified studies dealing with children and ETS reduction, three studies evaluated interventions to reduce ETS in normal, healthy infants (Chilmonczyk, Palomaki, Knight, Williams, & Haddow, 1992; Greenberg et al., 1994; Woodward, Owen, Grgurinovich, Griffith, & Linke, 1987), and two studies evaluated interventions to reduce ETS in infants and children already diagnosed with asthma (McIntosh, Clark, & Howatt, 1994; Meltzer, Hovell, Meltzer, Atkins, & de Peyster, 1993). None of these studies addressed the practices women use to protect their children from ETS.

In the group of three studies dealing with normal, healthy infants, one tested an intervention that stressed parental smoking cessation to reduce infant exposure to ETS (Woodward et al., 1987), while two tested interventions that emphasized parental smoking reduction in the presence of infants (Chilmonczyk et al., 1992; Greenberg et al., 1994). All three studies provided mothers with health information by administering either a self-instructional kit, a letter, or a booklet that focused on the importance of avoiding smoking around children, and the benefits of reducing or quitting smoking. A health care professional (nurse or doctor) was in contact with the mothers by phone or in person on several occasions within the first six to twelve months following the birth of their child. The success of the interventions was established by measuring urine cotinine levels of the infants. These studies suggested that providing health information to the mothers proved to be unsuccessful in reducing children’s exposure to ETS.

The other two intervention studies identified in this search focused on children with asthma. In the United States, an estimated 3.9 million individuals younger than 18
years of age have asthma and the prevalence is increasing each year. Between 8% and 13% of all childhood asthma, in the United States, can be attributed to household smoking. Among American children under 15 years of age, 300,000 to 522,000 cases of asthma are associated with household smoking (DiFranza & Lew, 1996). Although study findings are not always in complete agreement, mounting scientific evidence presents a convincing case that ETS may increase the incidence of asthma and affect the severity of asthmatic symptoms, even though the underlying mechanism is not clearly understood (Meltzer et al., 1993). Despite the growing number of childhood asthma cases, few intervention studies that examine the effects of ETS counselling for parents whose children have asthma have been reported. Only two studies were found in the literature on childhood asthma that evaluated programs aimed at ETS reduction (McIntosh et al., 1994; Meltzer et al., 1993).

The one study used an experimental design to test a minimal-contact intervention to reduce children’s exposure to ETS (McIntosh et al., 1994). Ninety-two families were randomly assigned to a treatment or control group. Parents in both the treatment and control groups received a standardized counselling session from a physician about the impact of ETS, and were advised to quit smoking or to smoke outside the home. The message was reinforced by a pamphlet on passive smoking that listed practices parents could use to reduce their children’s exposure to ETS. Parents in the treatment group received an additional letter, one month after enrollment in the study, that contained their child’s cotinine level and an explanation of its significance. Although the results were not statistically significant the post-test revealed that 35% of the treatment group smoked outside their home compared to 17% of the control group.

A second study evaluated a parent-counselling intervention developed to reduce
ETS exposure in children with asthma (Meltzer et al., 1993). Mothers and children were visited in their homes at 2, 4, 6, and 10 weeks, lasting 30 minutes by a health promotion professional. They were taught about the dangers of ETS exposure and brainstormed practical ways to reduce smoking that would ensure success. Diaries were used by mothers to help them identify and record their smoking patterns and the location of their child. At each session, questions were answered, successes were acknowledged, and problems were tackled. Based on self-reporting all parents reduced their children's exposure to ETS and asthma symptoms decreased in 30% of the children. Despite the reported success of the intervention the findings should be interpreted cautiously because of the limited sample size (five families) and the lack of a control group.

The five intervention studies discussed had several limitations including: (a) each relied, to some extent, on less than 100% reliable cotinine levels and self-reports; (b) their sample sizes limited their generalizability and were likely to result in a Type II error; (c) their definitions of smoking were often vague; (d) their outcome variables were not always clearly defined; and (e) they lacked comparison of the effects of interventions between healthy infants and children with pre-existing medical conditions.

While encouraging trends found in these studies are important, their failure, in part, may have arisen because they were not grounded in the lives and experiences of families. In these studies, interventions to support parents in protecting their children from ETS were developed based on deductive methods of inquiry. The studies failed to recognize the efforts parents were already making to protect their children from ETS, how they balanced their own needs to smoke with the needs of their children, and the broader context that supported or undermined their efforts.
Understanding the context of parents’ lives is imperative to develop effective interventions and programs that will successfully protect children from ETS. For example, the studies evaluated “prescriptive” interventions that were based on the underlying assumption that parents were ill-informed about the effects of ETS on the health of their children. It was expected that educating parents about the dangers of ETS would alter their smoking behaviour and support them in protecting their children from ETS exposure. The studies suggested that knowledge about the effects of ETS was not sufficient to reduce children’s exposure to ETS (even when this involves biochemical validation of exposure). Prescriptive theory development may be more useful following qualitative research where theory is isolated and relationships are described. In other words, qualitative research methods provide full descriptions, that is, the real experience of the situation from the participant’s point of view so that the goal of perceiving and presenting another’s world is attained (Strauss & Corbin, 1990). Thus far, there have been no qualitative studies focusing on parents, and, in particular, women’s efforts to protect their children from ETS exposure. Little is currently known about women’s smoking in the context of mothering young children and the challenges and difficulties they encounter. The use of a qualitative research method would provide a fresh perspective, and the findings would assist in the development of more effective and appropriate interventions and programs to assist women in protecting their children from ETS exposure.

Women and Smoking Behaviour

Since women are the main caretakers of young children, women who smoke have been the target of health programming to reduce children’s exposure to ETS. The characteristics and experiences of women who smoke, therefore, cannot be ignored. An
abundance of research studies throughout the health science literature offers information, often contradictory and certainly not definitive, regarding the plight of women who smoke. Researchers have endeavoured to define the characteristics of female smokers and to explain women's smoking patterns and behaviours in order to design cessation programs for a health problem that is considered epidemic in proportion. Evidence from this research suggests that women are "negative affect" smokers, meaning that they use smoking to help cope with feelings, such as anger, frustration, sadness, loneliness, anxiety and depression (Blake et al., 1989; Borelli, Bock, King, Pinto, & Marcus, 1996; Solomon & Flynn, 1993; Sorenson & Pechacek, 1987). Women report using smoking to alleviate the stresses of juggling careers and motherhood, or, sometimes, of poverty (Sarna & Brecht, 1996). Socio-demographic factors, such as lack of education, blue-collar occupational status, low income, poor housing, lack of independence, unemployment, and being single, separated or divorced are increasingly characteristic of women who continue to smoke (Chollat-Traquet, 1992; Graham & Hunt, 1994). On the basis of a descriptive study, reasons for the different rates of smoking cessation among men and women have been proposed. Blake et al. (1989) found that women associate a greater part of their self-image to smoking than do men and are thus less likely to quit. While men smoke to relax, women are motivated to smoke to reduce stress, consequently, cessation of smoking is anticipated as a stressful task. Finally, women respond by smoking in special situations or to social pressure, such as spousal smoking, more than men, and women have less confidence in their ability to quit than men.

While researchers have attempted to identify attributes of female smokers, Greaves (1996) is critical of these largely quantitative studies. She argues that
quantitative research, provides limited information about the impact of women's lives, experiences, and situations. Few longitudinal studies regarding women and smoking exist that present critical information on how the meaning of smoking may change for women, over the course of their lives. For these reasons, Greaves suggests that we know very little about the connection between women and smoking. All too often, policies and programs created to solve the problem of smoking by women are not based on input from smokers themselves, but rather, on the agendas of policy makers. Greaves recommends that more qualitative research is necessary to ensure women's voices are heard; women who smoke must talk about their own experiences and interpretations of smoking so that program development is collaborative, appropriate and successful.

Jacobson's (1981) qualitative research on women and smoking is one of the first pieces of work to capture women's stories regarding smoking and its meaning in their lives. Based on an analysis of interviews with women who smoked, Jacobson concluded that "quitting smoking is a process that depends on the interaction of at least three crucial factors: perceptions of stress, self-confidence, and dependence on cigarettes" (p. 87). Her research helps describe women's unique strengths and struggles with smoking and illuminates a society that does not encourage women to value themselves or their work. Women are expected to earn money, manage careers, run households, care for children, absorb everyone's frustrations, and be self-disinterested, attentive, charming, thin, sexy, spontaneous, and forever thankful. These issues are confounded in those who may be single, poorly educated, unemployed, in poor health, or lacking support structures as they raise their children. Regardless of a woman's circumstance, a cigarette can represent escape, a way of suppressing thoughts and feelings, a control practice, a strategy to cope with stress, and a way to reward oneself (Jacobson, 1986).
In a more recent study, Greaves (1996) interviewed 35 Canadian and Australian women, some of them abused women from shelters and some of them feminists employed in a variety of fields. She also held a focus group of First Nations' women from the Canadian North. The interviews recorded women's thoughts on their smoking and gave them an opportunity to talk about how this fundamental activity fits into their lives. Despite the wide range of backgrounds and circumstances, the comments, insights, and feelings recorded were consistent. Five major themes emerged from the interviews that represent a starting point for developing theories on women and smoking. Greaves reported that women smoke for functional reasons including: (a) to organize social relationships, (b) to create an image, (c) to control emotions, (d) as a source of dependency, and (e) to create an identity. These themes provide a deeper understanding of how women understand their smoking behaviour and reveal the different ways women control and adapt to their life circumstances. Greaves contends that women's subjective analyses of the issues, including the meanings and uses of smoking in negotiating their lives, must play a key role in women-focused initiatives. She advocates that qualitative research is required to ensure that women are heard, furthering the development of a theoretical basis for women-specific and women-positive programs. Those who create and promote such programs must learn from women smokers for it is these women who are the experts.

In 1973, the American Surgeon General report claimed that smoking during pregnancy can be dangerous to the health of the unborn child (Jacobson, 1986). The anti-smoking campaign that followed had no impact on pregnant women's smoking habits. Jacobson maintained that the campaign, for the most part, was emotional blackmail that reinforced women's guilt and trepidation, and fortified their inability to
stop smoking. Since that time, mounting epidemiological evidence has fostered programs designed to support and educate expectant mothers, and recently, fathers, on the dangers of smoking to the fetus. While the percentages of pregnant women who quit smoking before or during pregnancy vary slightly from study to study, no one denies women's readiness to quit is positively associated with pregnancy (Brenner & Mielch, 1993; McBride & Pirie, 1990; Quinn, Mullen, & Ershoff, 1991; Secker-Walker et al., 1995). Not only do more pregnant women express a desire to alter their smoking behaviour, but their more frequent contact with health professionals provides greater opportunities to educate, intervene, and support decreasing or quitting smoking.

One article reviewed 13 smoking cessation intervention trials in pregnancy, 10 of which reported having an effect (Floyd, Rimer, Giovino, Mullen, & Sullivan, 1993). The type of intervention used in most of the studies was one-to-one counselling with a health professional, usually a physician, in a pre-natal clinic. The most successful programs reinforced the counselling sessions by using printed material, home visits, and telephone contacts. When staff were specifically trained to provide intervention counselling, the intervention was more effective. This review article indicated several components associated with higher smoking cessation rates among pregnant women: (a) having an awareness of the health consequences of smoking to the fetus; (b) having the desire to quit smoking or cut down; (c) experiencing increased social pressure to quit smoking; (d) having spoken to a trained counsellor at the first pre-natal visit; (e) having partner support; and (f) having strong support systems, such as telephone buddies or group sessions.

Anti-smoking interventions are designed to capture the attention of women when they consider getting pregnant or upon discovery of pregnancy. Few programs are
designed to deal with the postpartum time or beyond. With the support, attention, and sometimes pressure not to smoke during pregnancy, many women quit for 5 to 9 months, managing to get through withdrawal symptoms and situational experiences associated with smoking relapse. As a result of their efforts over such an extended period of time, these women could remain non-smokers. But, evidence shows that as many as 65-75% of women relapse to smoking during the postpartum period. One half of these women do so within 30 days of delivering their infants (McBride & Pirie, 1990).

Jacobson (1986) makes an astute observation regarding the anti-smoking pregnancy campaign: "In the developed world most women are not pregnant most of the time. Therefore, a campaign directed solely at smoking in pregnancy ignores most women most of the time" (p. 125). Jacobson insists that the issue of women and smoking must be perceived holistically, at the level of women as a whole, by granting women individual and collective voices. Greaves (1996) agrees with Jacobson’s insights. Her recordings of women’s stories give women the rare opportunity to share how smoking fits into their lives, and, in doing so, provides us with important insights. Greaves contends that women’s subjective analyses of the issues, including the meaning and uses of smoking in negotiating their lives, must play a key role in women-focused initiatives. She advocates that qualitative research is required to ensure women are heard, furthering the development of women-specific programs. Those who create and promote such programs must learn from women smokers for it is these women who are the experts.

Qualitative methods and grounded theory, in particular, support the notion that study participants are the experts about their experience and that subjective experience is valid data (Wuest, 1995). Both Greaves’ and Jacobson’s work provides an important
foundation in understanding the complex issue of women and smoking, yet, subsequent qualitative studies are required. These researchers have not addressed women's views on smoking in relation to mothering young children, in great depth. Therefore, further qualitative studies are required to thoroughly explore and understand particular issues, such as how mothers understand and deal with the issue of ETS, how they protect their children from its harmful effects, and the difficulties and challenges this might present.

Summary of the Literature Review

A review of the literature revealed that adults, while poorly informed about the specific risks associated with ETS, are increasingly protected from ETS with the introduction of smoking restrictions. Children, on the other hand, are less fortunate; estimates confirm that 2.8 million Canadian children under 15 years of age are exposed to ETS each day in their home. Researchers have demonstrated that among children ETS is associated with diseases such as pneumonia, bronchitis, sinusitis, asthma, otitis media, SIDS, latent heart disease, and cancer. A limited number of interventions to reduce ETS exposure in children have been evaluated but none was found to produce a significant effect. No reported research studies were found that specifically examined the experiences of women in protecting their children from ETS.

Jacobson's and Greaves' work provides us with important insights into the unique issues of women and smoking. Their work does not delve extensively into women's views on smoking within the context of their children. Because smoking plays an important role in women's lives and women remain the primary caretakers of young children it is important to find appropriate ways to assist women in protecting their children from ETS. Qualitative studies that explore how women protect their children from ETS and the difficulties and challenges they encounter are needed to provide a
foundation for developing new approaches to reducing children's exposure to ETS.
Chapter 3: Methods

In this chapter, the research design, sample selection strategy, data collection procedures, rigour of the study, and ethical considerations are described.

Research Design

Despite the growing concern and number of health implications for children exposed to ETS, less than adequate attention has been granted to this problem. Little is known or reported about public or parental efforts to protect children from ETS. A grounded theory approach was used in this qualitative work to inductively generate a substantive theory that explains the processes women use to protect their young children from ETS.

Grounded theory is a research method based on a symbolic interactionism perspective, which focuses on the meanings that people attribute to events through experience or interaction. In other words, grounded theory is focused on understanding how a group of people define their reality through social interactions (Stern, Allen, & Moxley, 1984). Grounded theory is an inductive, "from-the-ground-up" approach to a problem using everyday behaviours or organizational patterns that allow the researcher to discover and conceptualize the essence of complex interactional processes and generate theory without using a pre-existing theory as an organizing framework (Glaser & Strauss, 1967; Hutchinson, 1986; Smith, 1987). The generation of theory from data puts a high emphasis on theory as an ever developing entity that accounts for relevant behaviour so that the goal of perceiving and presenting another's world is attained (Glaser & Strauss, 1967; Stern et al., 1984).

This qualitative study was consistent with the grounded theory approach because it was oriented to discovery and the generation of theory rather than commencing with a
The focus of analysis centred around participants who shared common circumstances, experiences, meanings, and behaviours which constitute the substance of grounded theory (Hutchinson, 1986). The data was drawn from interviews, in essence, the result of listening to participants tell their stories and "share their world." The analytic process resulted in codes, categories, hypothesized relationships among categories, and a basic social process interpreted to explain how women protect their children from ETS. Grounded theory is based on the assumption that groups sharing similar circumstances also share a specific social psychological problem that is not articulated. This fundamental problem is resolved by means of social psychological processes (Hutchinson, 1986). When this previously unarticulated problem and its resultant basic social psychological processes are uncovered and conceptualized, a resulting theory emerges that explains behavioural differences and similarities among the group. Such was the case in this study where an emergent theory explained the variations in behaviour among the participants and provided clarity and depth to a currently limited body of knowledge.

The work of Jacobson (1981) and Greaves (1996) regarding women and smoking (discussed in Chapter 2) provided an important foundation and recommended that qualitative research is required to give women a voice. Using grounded theory method in this study was consistent with this recommendation because it has several common epistemological underpinnings with feminist theory (Wuest, 1995). For example, while grounded theory was not developed to give women a voice, the basic tenets of symbolic interactionism reflect a respect for people's subjective interpretation of social experience as a source of knowledge; thus the women in this study were considered experts and their subjective experiences were regarded as valid data (Smith, 1987; Wuest, 1995).
Grounded theory method incorporates a collaborative analysis because data collection and data analysis occur concurrently, which means that the researcher is less likely to prejudge what is significant and participants are involved in validation of the findings. Feminists believe that searching for a single truth is an oppressive objectification of participants' experiences (Smith, 1987). Grounded theory is not focused on discovering one truth because the emerging theory captures similarities and differences in participants' experiences. Grounded theory was an appropriate method to capture the rich experiences of the women in the study, to give them a voice, and to generate a substantive theory that may broaden and deepen health-care professionals' understanding of the processes women use to protect their children from ETS exposure and the challenges they may encounter.

**Sample Selection and Criteria**

A non-probability sampling method is used when the purpose of the research is to generate rather than test theory. Such a method is effective to facilitate understanding of a concept, to describe a situation or setting, and to extract meaning (Morse, 1986). Hence, a non-probability sampling method was used for the present study. The assumption of a non-probability sample is that not all informants are equally informed or receptive, consequently, the researcher must maximize opportunities to obtain the most insightful data possible (Strauss & Corbin, 1990). In this light, a combination of non-probability nominated and purposive sampling techniques were used to recruit informants who were the most astute, knowledgeable, and eloquent in disclosing the experience of protecting their children from ETS.

The target population for this study consisted of women with preschool children living at home, who had a previous history of smoking, who smoked or had a spouse,
family member, or friend who smoked, and who was in regular contact with the women. Regular contact was defined as living with the family or visiting at least once a month. The women were over 18 years of age, able to speak English, and able to consent to participate in the study.

A nominated sample, with informants selected on the basis of receptivity and knowledge base, was obtained from two sources for this study. The majority of the informants came from a registry of women who had participated in a randomized clinical trial designed to evaluate an intervention to prevent postpartum smoking relapse (Johnson, Ratner, Bottorff, Hall, & Dahinten, 2000). Although the clinical trial was complete, many women had given their permission to be contacted for further study. A number of these women were approached by a research assistant who briefly explained the purpose of the present study. If interested, the women were contacted by the principal researcher who explained the study in detail and answered questions. Upon agreement, the women signed a consent form (see Appendix A) and an one-hour interview was scheduled. After completion of the interview, some of the informants were asked to introduce the researcher to other women who met the sample selection criteria for subsequent interviews, constituting the second source of nominated informants.

Purposive sampling, the second non-probability sampling technique used in this study, occurred when the researcher was familiar with the setting and the informants (Morse, 1986). In this type of sampling, the researcher deliberately selected informants based on the theoretical needs and direction of the study. In other words, the emerging theory needed validation, confirmation, exploration or contradiction; the researcher was guided by these specific research needs in choosing informants (Morse, 1986). For this sampling technique, women who participated in the larger study and who were in the
registry constituted the majority of informants. Every effort was made to include women from a variety of cultural, socio-economic, and educational backgrounds. Unfortunately, obtaining women from diverse cultural backgrounds was difficult, consequently, eight participants were Caucasian and one participant was a First Nations woman.

Appropriateness and adequacy are criteria used to evaluate samples in quantitative and qualitative research (Morse, 1986). Appropriateness considers the degree of suitability between the method of sampling and the purpose of the study, which is determined by the research question (Morse, 1986). In this study, a qualitative research question was asked; therefore, a non-probability sampling method was appropriate because the study objectives focused on understanding, meaning, and insight. Adequacy, the second criterion, considers the sufficiency and quality of the data (Morse, 1986). In qualitative research, adequacy is evaluated by the quality and completeness of the information presented by participants rather than by the number of participants. An adequate sample is obtained when no new or relevant information seems to emerge within a category, when category development is dense and the relationships between the categories are well established and validated (Strauss & Corbin, 1990). In the present study, a rich data source was obtained from interviews with nine women. While new insights might have been obtained through further interviews, the nine interviews provided a conceptually adequate data set to develop a beginning grounded theory regarding the processes women used to protect their children from ETS.

Data Collection Procedure

Data collection, in keeping with the versatility and creativity of grounded theory,
came from a variety of sources including individual interviews, field notes, and theoretical memoing. Data collection was based on the assumption that people order and make sense of their environments (Hutchinson, 1986). The participants were considered to be the experts and their subjective experiences were considered valid, while the researcher provided a listening ear and then interpreted and analyzed the data to develop a theory.

Upon obtaining written informed consent (see Appendix A), a one-hour audiotaped interview was scheduled at the home of the participant, at a time that was convenient for both the participant and the researcher. Unstructured, informal, face-to-face interviews were conducted using open-ended questions (see Appendix B) designed to prompt participants to share their experiences regarding smoking and the variety of means they used to protect their children from ETS. This method of data collection was beneficial because the relaxed style of the interview allowed the researcher to become acquainted with the participants as individuals and to perceive their experiences from their points of view; it provided the researcher the opportunity to clarify topics and to pursue topics of interest guided by the emerging analytical categories and linkages. Demographic information, if not available from the larger study on postpartum relapse (Johnson et al., 2000), was collected or updated during the interview. If a participant was particularly articulate in sharing her experiences, the researcher asked if she could suggest friends or family she thought would be willing to participate in the study.

Following each interview, the audiotape was transcribed verbatim; the transcript was reviewed with the tape by the researcher to ensure accuracy. Field notes regarding observations about the participants, the setting, and the researcher’s personal reflections were recorded. Coding of each interview and corresponding field notes took place
immediately so that the researcher was able to elaborate on themes or constructs previously identified when subsequently interviewing other participants.

Theoretical memoing is a form of data collection that allows for creative thought, is a storehouse of analytic ideas, points out gaps in thinking, gives direction for sampling, and is a record of various developmental aspects of the emerging theory (Strauss & Corbin, 1990). A memoing binder with a coding system was designed to ensure that the researcher's conceptual thoughts and insights remained orderly, progressive, systematic and easily retrievable for sorting and cross-referencing (Strauss & Corbin, 1990). Memoing was crucial to the study because its conceptual nature moved the researcher's analysis beyond description and toward theory—the purpose of the grounded theory method (Strauss & Corbin, 1990).

Data Analysis

Grounded theory proposes a systematic process for generating and verifying theories (Glaser & Strauss, 1967). The grounded theory method requires that the researcher simultaneously collect and analyze the data. Rather than follow a linear sequence of analysis the researcher works within a matrix. More specifically, this matrix proceeds in three steps: (a) identifying categories, properties, and dimensions (open coding); (b) hypothetically proposing and testing relationships between categories, properties, and dimensions (axial coding) through the use of theoretical sampling and constant comparisons; and (c) identifying the core variable (selective coding) that represents the main theme of the theory. The two analytical procedures basic to each step of the coding process are making comparisons and asking questions (Strauss & Corbin, 1990). The researcher alternates between data collection and the three step analysis process, moving from the concrete to the abstract, until the categories are
integrated into a substantive theory.

Open coding was the first step in the analysis process (Strauss & Corbin, 1990). Interview transcripts and field notes were coded by a word, a phrase, a sentence, a paragraph, an observation, or a similar incident; the initial names for these concepts were written on the transcript (e.g., stress, role model, family tradition, guilt, and expectations). Concepts that pertained to the same phenomenon in the data was grouped into categories and labelled with abstract conceptual names. These categories were further explored through recognition and systematic development of their properties and dimensions and written as code notes in the memoing binder (Strauss & Corbin, 1990). During open coding, the researcher memoed any issues that arose in the code notes. The goal of sampling during open coding was to expose as many categories and their resulting properties and dimensions as possible. Some of the categories that were identified included justifying behaviours, societal expectations, accommodating people, making rules, realizing limitations, dealing with upsets, and beliefs about ETS. The researcher sampled to elaborate on these categories and yet was sensitive to new and emerging categories as data collection and analysis progressed.

This second step, axial coding, was a complex process of inductive and deductive thinking accomplished, as in open coding, by making comparisons and asking questions. The four complex analytic steps of axial coding that occurred almost simultaneously were: (a) developing hypothetical relationships between subcategories and categories through the use of a model; (b) verifying those hypotheses against the actual data; (c) further developing the properties and dimensions of the categories and subcategories; and (d) exploring the similarities and differences among and within the categories (Strauss & Corbin, 1990). In this process, the researcher attempted to relate categories
in terms of the paradigm model: casual conditions, phenomena, context, intervening conditions, actions/interactional strategies, and consequences (Strauss & Corbin, 1990). The use of this model assisted in systematic thinking about the data, related the intricacies of the data, and added density and precision to the analysis. Statements of relationships were deductively proposed, and theoretical sampling focused on uncovering and validating these statements by providing evidence in the field. The researcher used logic diagrams and memoing to demonstrate relationships between the subcategories and the category to which they were related (Strauss & Corbin, 1990).

After open and axial coding, the third step, selective coding worked toward selecting the core category to systematically relate it to other categories, to validate the relationships, and to "densify" categories that required further refinement (Strauss & Corbin, 1990). Sampling in selective coding was direct and deliberate in order to obtain the necessary data until theoretical saturation of the categories was achieved. The core category in this study, “avoiding the judgemental gaze,” was identified and the data was related at the property and dimensional levels of each major category resulting in the emergence of a grounded theory that explained the processes women use to protect their children from ETS.

Ethical Considerations

Before this study commenced, ethical approval was obtained from The University of British Columbia, Behavioural Sciences Screening Committee for Research and Other Studies Involving Human Subjects. Before obtaining written consent from the participants, the researcher explained the purpose of the study, explained the requirements of participation, and answered any questions. Women who agreed to participate were provided with a written consent form (see Appendix A) that they signed
before the initial interview. The consent included the following information: (a) the purpose of the study; (b) the complete procedure including participation in an audiotaped interview lasting approximately one hour that would be held in a private and convenient place; (c) confirmation that there were no anticipated risks or personal benefits as a result of being in the study except that information from the study would be used for educational and research purposes; (d) that participation was voluntary and refusal to participate at any time would not result in penalty; (e) a statement of the option to withdraw from the study at any time without penalty; and (f) assurance of anonymity and confidentiality. The notes, audiotapes, and interview transcripts had the participants’ names removed and replaced with a code number. The master list of participants’ names and code numbers was kept in a locked place separate from the collected data. The participants’ names were not used in any research reports. At the end of the study, the audiotapes were erased and the master list destroyed. The typed manuscripts were retained for educational purposes and any further research that involved secondary analysis of the interviews, subject to ethical approval.
Chapter 4: Findings

The practices women use to protect children from ETS are presented in this chapter. In order to provide a context from which the findings of the study are generated, a brief description of the participants including their smoking history is offered. Following this discussion, the core category, the main theme of the investigation, *avoiding the judgemental gaze*, is introduced. Finally, the three-phase process the participants used to protect their children from ETS, including the strategies, are explicated. The major findings and the similarities and differences among the participants are illustrated with verbatim statements. To protect the anonymity of the participants, all identifying characteristics have been altered or removed.

Context of the Participants' Lives

Nine participants were interviewed for this study, ranging in age from 21 to 36 years (see Table 1). Five of the participants lived in Vancouver while four participants resided in the Fraser Valley. Eight of the women were Caucasian and one participant was a First Nations woman. The women's educational backgrounds ranged from high school to university degrees; six were homemakers, one was a student, one an engineer, and one a sales representative. Eight of the participants were married, and one woman was a single parent. Only one woman’s husband was a smoker at the time of the interview. While demographic information varied among the participants, the factor that connected them was a history of cigarette smoking.

All of the women, in this study, grew up in families in which the majority of parents, grandparents, aunts, uncles, and older siblings smoked. One woman offered:

> Smokers are all over the family. Let me think now. Out of my whole family, I think there are only two that don't smoke. Almost everyone in the family has smoked for years and years. (Carmen)
<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Education</th>
<th>Occupation</th>
<th>Smoking Status</th>
<th>Number of Children</th>
<th>Age of Youngest Child</th>
<th>Husband/Partner Smoking Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joanne</td>
<td>34</td>
<td>High School</td>
<td>Homemaker</td>
<td>Non-smoker (x 3 years)</td>
<td>1</td>
<td>2 years old</td>
<td>Non-smoker</td>
</tr>
<tr>
<td>Ruth</td>
<td>36</td>
<td>High School</td>
<td>Homemaker</td>
<td>Non-smoker (x 2 years)</td>
<td>2</td>
<td>4 years old</td>
<td>Non-smoker</td>
</tr>
<tr>
<td>Robyn</td>
<td>34</td>
<td>High School</td>
<td>Sales Rep.</td>
<td>Smoker (relapsed 2 weeks after youngest child born)</td>
<td>2</td>
<td>2.5 years old</td>
<td>Non-smoker</td>
</tr>
<tr>
<td>Astrid</td>
<td>25</td>
<td>High School</td>
<td>Homemaker</td>
<td>Smoker (relapsed when child 6 weeks old)</td>
<td>1</td>
<td>2.5 years old</td>
<td>Non-smoker</td>
</tr>
<tr>
<td>Delacey</td>
<td>21</td>
<td>High School</td>
<td>Homemaker</td>
<td>Non-smoker (x 2.5 yrs)</td>
<td>2</td>
<td>2.5 years old</td>
<td>Non-smoker</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(1 child from previous marriage)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vicki</td>
<td>34</td>
<td>High School</td>
<td>Homemaker</td>
<td>Non-smoker (x 3.5 yrs)</td>
<td>4</td>
<td>2.5 years old</td>
<td>Non-smoker</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(3 adopted children)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carmen</td>
<td>29</td>
<td>University</td>
<td>Engineer</td>
<td>Smoker (relapsed when youngest child was 1 year old)</td>
<td>2</td>
<td>2 years old</td>
<td>Smoker</td>
</tr>
<tr>
<td>Maureen</td>
<td>26</td>
<td>High School</td>
<td>Student</td>
<td>Smoker (relapsed when child born)</td>
<td>1</td>
<td>2.5 years old</td>
<td>Not Married</td>
</tr>
<tr>
<td>Elaine</td>
<td>28</td>
<td>High School</td>
<td>Homemaker</td>
<td>Smoker (relapsed when youngest child 9 mo. old)</td>
<td>2</td>
<td>3 years old</td>
<td>Non-smoker</td>
</tr>
</tbody>
</table>
Consequently, these women were introduced to smoking early in life and reported experimenting with smoking between the ages of 12 and 17 years. As teenagers, they began smoking for a variety of reasons including wanting to fit in and "to be cool":

I don't even remember when I first started smoking. I was young. My dad smoked when I was younger. My eldest sister never smoked. The other sister above me, she smoked. I just hung out with her and all her bad friends. I think I got influenced by her; I looked up to her. They all smoked. (Delacey)

Early experimentation was followed by regular daily smoking for all of the women. One woman explained:

I guess I started smoking when I was 14. Both my parents smoked and everyone around me smoked. I didn't smoke very much but I smoked during any kind of social event. So it sort of built up until I was smoking half a pack to a pack a day. (Astrid)

The women admitted that smoking played a significant role in their social life throughout their 20s and, for some, their 30s. It was an activity they enjoyed and often shared with friends and family. One recalled:

There's nothing better than getting together with a bunch of the girls, having a couple of glasses of wine, and smoking like crazy. There's something about those times that was special. (Joanne)

Although the women tried to quit smoking a number of times over the years, they were unsuccessful for a variety of reasons. One participant explained, "Something always seemed to get in the way." Another who tried her best to quit for her nonsmoking partner, believed she was unsuccessful because she had been trying for him and not for herself.

The experience of pregnancy prompted many of the women to reconsider their smoking habit. Except for two participants, all of the women reported they were successful in quitting smoking during their pregnancies.
Well I didn’t find out I was pregnant until I was about two months and then I quit at about three months. I mean the baby’s so small that it only had like three months of smoke, right, so I just quit like that. (Delacey)

Some of the women, however, relapsed following the birth of their infants. Subsequent pregnancies provided a stimulus to quit again, creating a pattern of quitting just for pregnancy. One woman’s experience was typical:

I quit the first time when I was pregnant with my first baby and started again right after he was born. And then I quit again one time in between for only a few months and then I quit before I got pregnant with my second baby and quit for about 18 months. And then I started again when we were in Australia. (Carmen)

The two women who did not stop smoking while they were pregnant cut down the number of cigarettes they smoked for the “sake of their baby’s health.”

At the time of this study, five of the women who stopped smoking during pregnancy relapsed during the postpartum period, and four of the women remained non-smokers. Two of the participants who remained non-smokers admitted to having great difficulties with cravings. These women recognized that having a child supported them in remaining nonsmokers, but it did not suppress the frequent urges to have a cigarette that persisted long after delivery. One woman recounted vivid dreams about smoking and waking feeling guilty and distressed. Another described how difficult it was to put smoking out of her life:

It was afterwards that I craved it [smoking] so much. Even now, the baby is almost three years old and I still crave it. A couple of weeks ago we were driving the car and I had a packed of gum in my hand and wasn’t really paying attention to it. I was just going to grab a piece of gum and I thought it was a pack of cigarettes. I just had this urge to pull out a cigarette and have one. I don’t know why, and I wish it would go away. (Delacey)

During dreams and day dreams, even the most committed to remaining nonsmokers experienced images of themselves smoking. Despite their struggle the women admitted that a number of factors influenced their initial decision to stop smoking. One woman
said she turned "inward" and focused on the needs of the child growing inside of her.

Another elaborated:

Well, I think that you kind of feel like when you’re pregnant everything that goes into your body goes into the baby, right? And you want to keep your system absolutely clean. You’re worried about all those chemicals and things. (Vicki)

The social stigma surrounding smoking and pregnancy helped some women stop smoking while they were pregnant. One of the participants remembered being with her pregnant older sister:

She was pregnant and she would have a cigarette . . . that was a few years ago so it was more acceptable even then. People would look at her and it was so uncomfortable. (Robyn)

This woman quit smoking the moment that she found out she was pregnant to avoid being criticized in a fashion similar to her sister’s experience.

While social aversion towards women smoking during pregnancy had a significant impact on the participants’ smoking behaviour, the results were often disempowering. The women, doing what was expected, stopped smoking but were consumed with self-doubts about themselves as mothers and their ability to stop smoking:

I was 19 and found out I was pregnant. I thought, "Oh my God I am such a loser. I’m such a bad mom. Oh, my God. I was afraid I wouldn’t be able to quit and then what would I do?” It was hard, but I quit. (Delacey)

Others confessed that societal disapproval only served to make them feel guilty and forced them to hide their smoking from others, especially family and friends. Yet, they admitted the fear of reproach contributed to the reduction in the number of cigarettes they consumed. One woman remembered:

One of the ladies at work knew I was smoking because she’s a smoker. We had been out to some company function and she went outside for a cigarette. I went out after her. I said, "I want one." She gave me a cigarette and I said, "You know it’s kind of an embarrassing thing." My working buddy said, "Oh, that’s okay." But it is embarrassing, you know. You’re frowned upon when you’re pregnant and you’re
smoking. It’s just an uncomfortable thing so I didn’t want people to know. . . . I didn’t smoke a lot but I did smoke. (Robyn)

While this participant felt safe with her colleague other women were criticised by other smokers. One participant recalled being surprisingly reprimanded by a “fellow smoker”:

I’m down at the Quay. I just got off work. I was really tired and I was seven months pregnant. I’m smoking and this little kid comes up to me. She must have been about 15, and she asked me to go buy cigarettes for her. I said no. So, she asked to bum one off of me. And then she turned and looked at me and said, "You know you shouldn’t be smoking." I flipped. I lost it. I told her she was under-age and she shouldn’t be preaching to me about what I can and can’t do. I grabbed the cigarette back. (Maureen)

Some participants acknowledged that quitting smoking was “easy” while they were pregnant because most could not tolerate the smell nor taste of cigarette smoke. One woman offered:

I hated cigarettes when I was pregnant. It was part of my pregnancy. The smell of the smoke sent me heaving into the bathroom. I thought this was great, you know. (Astrid)

For some, it was the first time they had successfully stopped smoking and they were determined to remain nonsmokers after the birth of their child.

A variety of themes arose out of the interviews with the participants as they provided candid accounts about the significance of smoking in their lives. Smoking assisted the women in controlling their emotions, the development of relationships, and coping with the stresses of motherhood. The women portrayed smoking as a behaviour imbued with controversy, compromise, contradiction, and guilt. It is within this context that women’s attempts to protect their children from ETS can be understood. Previous studies such as that by Greaves (1996) identify themes describing women’s relationship to tobacco which are mirrored in this study. Greaves reported that women smoked to
organize social relationships, to create an image, to control emotions, as a dependency, and for identity issues. Since Greaves' study excluded the added dynamic of women with children, it does not explore women's efforts to protect their children from ETS. This study investigated women's relationship with smoking in light of their role as mothers and examined the processes they used to protect their children from ETS.

Core Category: Avoiding the Judgemental Gaze

The women in this investigation engaged in a three-phase process to protect their children from ETS; underlying efforts in each of these phases was the basic social process of avoiding the judgemental gaze. Strauss and Corbin (1990) state that the core category represents the central theme of the research, that it should appear frequently in the data, and that every major category must relate to it. In essence, the core category must consist of all the products of analysis condensed into a few words to form an explanatory whole. As well, it should account for variation within the categories and help to explain why and when conditions alter.

The women's actions to protect their children from ETS were strongly influenced by idealistic societal expectations of what it means to be a "good mother." Through each phase of the process to protect their children, the women's focus was on escaping being judged or discredited by themselves and others as a "bad mother" or "uncaring mother." As the core category, avoiding the judgemental gaze, this theme ties together the evolving strategies women used to protect their children from ETS.

During the first phase, starting out with good intentions, the women drew on their knowledge about ETS, their wish for a healthy child, and societal and personal expectations of "good mothering" to establish rules to protect their child from ETS. Their good intentions revealed their values, beliefs, and ideals about what a good
mother "should do" to protect her child. One woman enlarged:

Everyone scrutinizes everything you do now. You know, spanking your kids in public, or disciplining them the wrong way. Like everything is being looked at. . . . Somebody made a comment to me in the mall because I had my little one on a harness so she wouldn't run off. She said something to me about treating my child like a dog or something, you know. (Elaine)

Experiences of others drawing attention to the women’s child-care practices reinforced the participants’ desire to avoid such confrontations at all costs. They reflected on their insecurities as mothers and their desire to do what was "right" in terms of raising their children. All reported that being a mother was, at times, difficult, and they confessed feeling vulnerable when subjected to public opinion and obvious judgement. Yet, evading the criticism of others supported women to establish several rules to protect their children from ETS including establishing a smoke-free home, a smoke-free car, and sitting in the non-smoking section of restaurants.

The participants’ dogged determination to uphold the image of being a good mother by protecting their children from ETS was met with resistance as some friends and family members did not share their enthusiasm. The competing needs of others made it difficult for the women to focus solely on their children and resulted in compromises that exposed their children to ETS. Adjustments to the initial rules marked the beginning of the second phase of the protection process, making exceptions. The women made exceptions to avoid conflict, to appear flexible, to be supportive, and to be sociable. The women broke the rules for the same reason they designed the rules--to avoid the judgements of others. One woman reflected:

Most of my unpleasant situations have been with my family. My father is an extremely heavy smoker. He doesn’t usually listen to other people. I tell him not to smoke in my house and he literally chain smokes. He lives in Asia and isn’t accustomed to our courtesies any more. (Ruth)
She allowed her father to smoke in her home claiming it was the path of least resistance. She "let it go" to escape his disapproval and avoid a possible confrontation. In the privacy of their own home, the risk of being judged by others who would be most critical was overshadowed by needs to appease family members or friends who smoked. To further reduce any dissonance this may cause, the women minimized the effects of ETS during these transgressions. For example, one participant described a family dinner at her mother's home:

All my brothers and sisters smoke. It would be impossible to ask them to not smoke at Sunday dinner! It's a family tradition! I join in and smoke as well. The kids usually play upstairs anyway so they aren't really exposed unless they fight with their cousins and come downstairs. (Carmen)

Paradoxically, being able to smoke without worrying about being reprimanded for exposing their children to ETS was a treat for several participants. Family member's endorsement of smoking around children absolved the women of their dissonance regarding exposure of their children to ETS. The women were free to smoke and expose their children to ETS on these occasions and escape being judged by others as bad mothers.

In the final phase of protecting their children from ETS, dealing with contradictions, the women employed a variety of strategies to explain the presence of ETS in their children's lives. Some women hid their smoking while others avoided specific people to evade criticism. For example, one woman recounted an incident where her best friend was upset because she smoked while breastfeeding her baby:

She was furious with me. I felt about this high. I felt really bad because she was mad at me. She couldn't believe what I was doing. So I tapered [off] but it didn't last long. When she asked if I was still smoking I lied and said, “No.” She lives far away from me so mostly we talk on the phone. If I don't smoke on the phone, I can get away with it. She won't know. (Astrid)
While participants remembered many condescending lectures from people about raising children, none were as resonant as the discussions about smoking around children. Although women tried to avoid confrontations about ETS, they were not always successful. One participant described an incident when her father-in-law confronted her at a party:

He told me that smoking around my children was the worst thing I had ever done. He said it in front of everyone. People at the party were backing him up and I got really defensive. I don't see them [in-laws] as much because of it. (Robyn)

To avoid the judgement of others the participants went to great lengths to be seen and accepted as good mothers. One woman, in her attempt to elude reproach, avoided a mother in the community who had been ostracized because she smoked. She explained:

No one smokes except this one woman. She walks her kids to school with a cigarette in her mouth. She comes to the classroom and literally reeks. People look at her differently. It's a big issue for parents to let their children go over to her house to play with her kids. (Ruth)

Like the other mothers, this woman prohibited her children from playing in the woman's home. She admitted that her decision was made to protect herself from being admonished by the community as well as to safeguard her children.

Because the women often exposed their children to smoking, to reduce their dissonance they justified their behaviour to themselves and, sometimes, to others. For example, they minimized the effects of exposure to ETS with statements such as: "It [smoking] only happens when we take long trips in the car," or "Once in a while isn't going to kill them," or "How bad is it really anyway?" However compelling these justifications were to some, they did not reduce the guilt experienced by most women. The women who could not excuse or ignore the guilt they experienced had few options.

In summary, the process of protecting children from ETS involved avoiding the
judgemental gaze of others. Each of the three phases of this process is described in greater detail in the following sections.

**Phase I: Starting Out with Good Intentions: Establishing the Ground Rules**

In this study, the women engaged in a complex three-phase process to protect their children from the ill effects of ETS. The following section describes the initial phase of the protection process, starting out with good intentions. The strategies used by the participants in this phase are explicated and supported by verbatim statements.

Starting out with good intentions began for all of the participants when they decided to become pregnant or found out that they were pregnant. All but two of the women stopped smoking during their pregnancies. Avoiding the judgements of others was most influential in having the women remain nonsmokers. Living up to personal and societal expectations of "good mothering," their desire for a healthy baby and their limited knowledge of the dangers of ETS supported the women in designing rules to protect their children.

Recognizing the susceptibility of children to ETS played a significant role in the "good intentions" phase of the protection process. The women drew on their knowledge about the ill effects of ETS which they acquired from the radio, the television, and the newspaper. While some of the women could not name more than one health consequence related to ETS exposure, they were convinced that ETS was unhealthy and this created a need to protect their children. One woman stated, "The effects of second-hand smoke are just as harmful as if children are smoking. You might as well put a cigarette in their mouth if you're smoking around them." Some of the women's convictions about the impact of ETS on children's health were ill-informed, yet, these unfounded beliefs and social sanctions related to smoking reinforced the participants'
desire to protect their children. One woman explained:

It’s a lot worse than if you were smoking yourself, because if you smoke yourself you can always exhale it out but when you’re just breathing it in you can’t breathe it out. It stays in your system and you can get cancer. (Delacey)

The health consequences of ETS exposure provoked a wide range of emotions and feelings among the women when they observed others smoking. They expressed frustration when observing children placed in vulnerable situations with few laws to protect them:

I just look at people driving their cars with the windows rolled up, and they’re smoking with little kids in the car. It’s not fair. It should be against the law. Why punish kids like that? They’re breathing it in and that’s just awful. (Vicki)

The "thoughtless behaviour" of others reinforced their commitment to protect their children.

All of the women started out with good intentions, motivated by a desire to have a healthy baby and to be a good mother, and established several ground rules. Most decided to institute three specific rules: maintaining a smoke-free house, a smoke-free car, and sitting in the non-smoking section of restaurants. The exact nature of the rules varied with women’s understanding of how ETS affected children, their personal circumstances, and the women’s smoking status. Along with establishing rules, the women developed strategies to ensure that the rules were followed. In all instances these rules and strategies reflected each woman’s best effort to minimize her child’s exposure to ETS.

Women decided as soon as their babies came home from the hospital to establish a smoke-free environment in agreement with and, in some cases, insistence from their spouses. To create a smoke-free home the women did whatever was necessary to convey this message to visitors:
There is no smoking in the house. There's an area set up out there with a couple of chairs and a table. I have an ashtray I pull off the shelf when a smoker comes. Visitors all know they have to go outside and smoke. (Joanne)

After the baby was born, I put non-smoking stickers in the house and on the front door. . . . There was no mystery as to the smoking status of our home, and there were no exceptions or my husband would be really upset. (Joanne)

I left my ashtray outside the front door and on the back deck so people had a choice--outside or outside. (Vicki)

Whereas in the past visitors may have smoked inside, through the presence of a new baby and the women's efforts most visitors automatically went outside to smoke. A friendly "nudge," a "knowing look," or a quick "let's go" ensured that everyone went outside for a cigarette. Friends accommodated the new rules because they "shared the same mind-set" and followed similar practices in their own homes.

Some women went through elaborate and complex routines to accommodate their own need to smoke and to maintain a smoke-free home:

I would get up 10 or 15 minutes before I knew the baby would wake and go outside, stand in the cold, and have a cigarette. And then, other times, I'd be cooking her dinner or I'd be playing with her and I'd want a cigarette. But, because I'm not smoking in her presence, I'd stop playing with her, go outside and have a smoke. She would be standing at the sliding door watching me or crying, "Mummy come in, Mummy come in." That was enough to break my heart. I would quickly finish the smoke and come in. It's so inconvenient but at least I'm protecting her. (Astrid)

I go out to the carport and have a couple of puffs and then put it out and then come back in the house. Than half an hour later I run out and have another couple of puffs or finish the cigarette. It really depended on what the kids were doing. They're still pretty little and need a lot of supervision. I feel like I spend half my life running between the house and the garage. It would be great if my husband built a glass room in the middle of the living room. I could sit there, watch the kids, and smoke away. (Robyn)

Despite the inconveniences and difficulties in following the ground rules, initially women were very motivated to do so. In some instances, the women believed they had no other choice:
I wouldn’t want to have him [husband] upset with me. We agreed that smoking was okay as long as I never smoked around our daughter. It’s the rest of the family that are dead set against my smoking. They are really ugly about it. So I don’t want to have my husband be on their side. (Astrid)

Some participants established less restrictive ground rules for themselves to accommodate their own or others’ smoking:

If my husband is home there is definitely no smoking in the house. I go out to the garage . . . I’ve got an ashtray out there . . . if he’s at work and assuming it’s fairly nice out, we spend a lot of time on the back deck with the kids and so I can smoke out there. . . . If it’s really miserable and stuff, I’ll stand in the kitchen with the window open and have a cigarette there while the kids are playing down in their rooms. So that’s as bad as it gets. (Robyn)

Attempts to minimize their children’s exposure to ETS was a common phenomenon among women who concluded their home was "partially" smoke-free. They rationalized that a "partially" smoke-free home was better than no protection at all. One said:

My mum comes over every couple of weeks to watch the kids and when she’s there we usually smoke in the house and, if I go out or whatever, she knows to either keep the window open and smoke by the window or go outside and smoke. Like I don’t want the house to fill up with smoke and stuff. I always tell her, "If you’re smoking in the house keep the back door open." (Robyn)

Another woman explained the limits of her generosity regarding smoking in her home:

If it was a big party here I would tell people to smoke outside, but if it’s one or two friends then I’m okay with it. They are pretty considerate. They stand by the kitchen window, and then we turn the big fans on, and I have vaulted ceilings. . . . The children weren’t breathing in a lot of smoke. Like, I didn’t think it was an extreme amount. (Ruth)

Clearly, these women believed that exposure to a small amount of occasional smoke was unlikely to be harmful. Sometimes the participants’ good intentions were motivated by factors other than safeguarding their children’s health. One woman confessed:

It’s social pressure. As the years go on it becomes a bigger pressure. It’s everywhere. You think everyone is looking at you all the time. . . . Generally it doesn’t bother me but it’s the main reason why I smoke outside, you know, what other people think. (Elaine)
The baby's room was mentioned by all of the women and on several occasions as a kind of sanctuary. The women were particularly vigilant about keeping smoke from their sleeping infants. Some recalled having seen a television commercial that illustrated the effects of ETS. One woman explained:

I can still see that commercial where the smoke is in the baby’s room circling around the crib. That was a great advertisement. I can’t let anyone smoke in the house 'cause I can see the smoke going under the door of the baby's room and swirling around just like in the commercial. (Joanne)

Another woman, whose husband smoked in the basement after the birth of their son, realized that she needed to intervene to preserve her baby's private space:

I could still smell it [smoke upstairs] and if I could smell it then that means it’s getting to the baby. You know, coming up the vents into his room. I explained this to my husband. He took a chair and put it in the garage so he could smoke outside. (Carmen)

Despite their best efforts sometimes when participants did not have complete control over smoking in their homes, the rules were broken. At these times, the women were upset and did their best to eliminate the resulting ETS in their homes. Underlying this response, however, was concern about themselves and what others would think if they found out. One woman recounted an upsetting incident that occurred while her mother was babysitting:

She was looking after my son . . . she was sleeping in the baby’s room because that’s where the spare bed is. . . . After she left the next day, I went in there to fix something and it smelled of smoke! I was really disappointed about that because it’s one thing to smoke downstairs in front of the window but I didn’t want her smoking in the baby’s room because he’s sleeping right beside her. . . . For the longest time I couldn’t get the smell out of the room. It drove me crazy. Like I got special stuff for the carpet and I did the walls, I did everything. I got air fresheners. . . . I didn’t want people walking into the baby’s room and smelling the smoke. I was embarrassed by that. (Robyn)

For most, an accepted rule was "no smoking in the car with children." The women had a variety of routines to protect their children. Two women offered these accounts:
Oh, we never smoke in the car. . . . We have friends who smoke, and we’ll stop
the car a couple of times going somewhere and let them get out and have a
cigarette. (Vicki)

If I have to have a cigarette I would stop the car on the side of the road and smoke
it outside. I talk to my daughter through the window, "Hi honey, mommy’s here.
I’m just having a cigarette, you know." (Astrid)

They reasoned that because a car was small and enclosed, passengers were particularly
vulnerable because they could not escape from the smoke. Two women remarked:

Can you believe that people will have their children in the back seat, windows
rolled up, and they’re puffing away? It’s a crying shame. I think parents shouldn’t
be allowed to get away with that. What are they thinking? (Delacey)

I want to grab kids out of the car and dust them off when I see parents smoking in
front of them. It is really, really disgusting and so unnecessary. . . . Poor kids.
(Ruth)

While most agreed that smoking with children in the car was an unacceptable
behaviour, a few women confessed that they did, in fact, smoke in the car with children
present. They abhorred their behaviour, but maintained they needed that cigarette to
ease the stresses and pressures of the day. One woman claimed smoking in the car was
her only luxury and helped her to be a more tolerant mother. Her rules for smoking in
the car were, therefore, more lenient than most of the other women. Nevertheless her
rules were clearly laid out, along with carefully thought out strategies to minimize her
children’s exposure to ETS.

I won’t smoke if we are doing short trips but if we are going quite a ways then I’ll
smoke. . . . I’ve actually figured this one out. I don’t roll the kids’ window down,
because if I do the smoke goes towards their window. But the smoke will always be
drawn from the window that’s rolled down. So, if I want the smoke as far away
from them as I can I just adjust my window. I roll it down half way and I keep my
hand sticking outside so most of the smoke will be drawn out. The worst part is
when you stop at a stop-sign because nothing is drawn out. It [smoke] sort of
circulates. (Robyn)

The final rule accepted by most of the participants was that they chose to sit in the
non-smoking section of restaurants when they were out with their children. This rule is reflected in these women's comments:

I don't want my son around it... My friends always eat with me in the non-smoking section and when they're done they go outside to smoke. I just sit with him and wait. (Delacey)

We always sit in the non-smoking section. There is no question about that. The only exposure my children have had to smoke is from the fireplace, and I intend to keep it that way. (Vicki)

As well as safeguarding their children's health, other factors had a significant impact on the participants' decision to sit in the non-smoking section of restaurants. Some women confessed that observing this rule helped them feel good about themselves since they were doing "the right thing" and, most importantly, they escaped the judgements of others:

I just don't smoke when we're out with the children. It's probably the guilt thing. You know, I couldn't sit at a restaurant with the kids and smoke because then I'd feel like I was being judged so we always try to get seats in the non-smoking section. (Elaine)

It's best to sit in the non-smoking section. Smoking with kids is simply taboo these days and people can give you the dirtiest looks. (Robyn)

Most participants were content to sit in the non-smoking section. Only one participant voiced a concern about the effectiveness of non-smoking sections, saying:

We always sit in the non-smoking section. What good does it do 'cause you can smell smoke as you eat. The smoking and non-smoking sections are in the same room and smoke travels, so I wonder. (Joanne)

This phase, starting out with good intentions, began with pregnancy and with a desire to do whatever was required to have a healthy baby. Most stopped smoking at this time and focused on the needs of their child; with the best of intentions they established rules for themselves and others that protected their child from the ill effects of ETS. The rules varied between the participants and were based on the women's
expectations about what constitutes "being a good mother," the wish to protect their children, and their own needs related to smoking. The rules reflected a desire to avoid the judgements of others.

Phase II: Making Exceptions: Coping with Everyday Life

In the second phase, the women made exceptions even as they strove to protect their children from ETS. The rules that women established were inevitably tested as they coped with everyday situations. These rules were successfully applied, but, occasionally, conditions and circumstances were encountered that weakened the participants' resolve to abide by their rules. As the women struggled to meet the competing needs of their children, their families, their friends, and themselves, at some point, the need to make exceptions arose. In this second phase, several strategies were used by the participants that reflected the phenomenon of making exceptions; giving in, keeping the peace, and accepting limitations.

Giving in was a strategy used by most participants. While family and friends were discouraged from smoking around their children, the participants occasionally bent the rules. The women sometimes "gave in" to meet the needs of others in what appeared to others as a gesture of goodwill. One woman, who had a strict no-smoking policy in her home, explained:

No one is allowed to smoke in the house. I don't smoke in here . . . except my mom smokes in my house when she is visiting. . . . It's hard for me because I think my daughter may never get to know her grandma. . . . But it's just that I see my mother dying of cancer, and I want the two of them to know each other a little bit, you know . . . and my mother is really, really good about it . . . she'll only have the needed cigarette. We have the windows open . . . it's like the wind is blowing throughout here. So I feel pretty good about that. (Astrid)

The participant justified that the benefits outweigh the costs in this situation; her child was able to visit with her grandmother and the measures taken to protect her from ETS
minimized her exposure.

Another participant recalled making exceptions to her rule regarding a smoke-free home whenever her brother-in-law visited:

No one smokes in our house. . . My brother-in-law has just reconciled with his wife and he’s having a tough time with clinical depression . . . he quit alcohol and all those things, and you have to quit smoking eventually, but that’s kind of low on his list right now and so we don’t want to make it any harder on him and so we let him smoke in the house. We [participant and her husband] smoke too. So we kind of open the doors and have a smoke. (Carmen)

When women believed that their no-smoking rules interfered with being a supportive family member or cordial hostess, they were willing to relax the rules. Women were more willing to make these exceptions when it also gave them an opportunity to smoke in their home, an event they considered to be a "well-deserved treat." Relaxing the rules for visitors also reduced interruptions in conversations and activities because trips outside to have a cigarette were not required. This kind of giving in was a strategy used more frequently with family members than with friends. One woman attempted to explain:

Our friends, we don’t have a problem telling to go outside. . . . Times have changed and attitudes toward smoking have changed. . . . Our friends have children and smoke outside; but it’s a little harder with your relatives. . . . My relatives are older, are heavy smokers, and have always smoked in the house. They expect to smoke in here. (Ruth)

Only one participant reported not giving in to others. She presented herself as confident enough to handle a variety of difficult situations. She recalled a time when a guest walked into her living room with a cigarette in his hand:

I didn’t know him well but that wasn’t going to stop me. I told him he couldn’t smoke in here. He made some joke about it and I had to tell him again that there was no smoking in the house. I was a bit embarrassed but I wanted him to get the point. He realized I wasn’t kidding and went outside. (Vicki)

Her strong beliefs about smoking supported her rules and strengthened her resolve that
she was "doing the right thing." Standing her ground allowed her to avoid the
d judgemental gaze of her most significant critic—herself. Her critical observations of
others secured her convictions:

I just shake my head. To each their own. They [smoking mothers] just probably
don't understand a lot and they probably think the way I thought years ago. . . . I
was around smoke since I was a kid and my father smoked until he was 73 and he
didn't die from lung cancer and I survived. . . . It's just known to be bad. I just
don't want to be a part of all that. (Vicki)

The strategy of keeping the peace was used by many of the participants to justify
their allowance of some smoke in their child's environment. Throughout the course of
their day, the women in this study encountered people who did not uphold the same
values and beliefs as they did about protecting children from ETS. They faced
potentially arduous and confrontational circumstances and keeping the peace was a
strategy used to diffuse these difficult situations. Unlike giving in, this strategy was not
based on being considerate of others, but, rather, a practice the women effectively
employed to avoid conflict or confrontation. During the interviews, the women recalled
countless episodes where they felt they had to "grin and bear it" or "be a good sport"
and make exceptions to their rules for protecting their children from ETS. The women's
need to keep the peace outweighed their best intentions to protect their children. This
conflict was agonizing for many participants as each attempted to rationalize her
behaviour in the face of guilt, anger, and resentment. One participant described an
instance when she felt she had no other choice but to make an exception to her no
smoking rule to keep the peace. During a drive to take their children camping, the
participant's sister lit a cigarette in the car:

She just opened the window and smoked. . . . It wasn't great but I kept my mouth
shut just because I didn't want to start a problem. . . I'm not with her in a vehicle
very often. . . . It's better sometimes not to say anything and let it pass instead of
having an issue. . . . Last time I criticized her we didn’t speak for three years. (Ruth)

Another woman recalled that keeping the peace was the principal motivator for allowing her brother to smoke in her home:

My brother is very opinionated, and he’s very outspoken. . . . He gets very hot-under-the-collar about smoking laws and that kind of thing. . . . So it depends on where he’s at. If he’s having a good day and he’s happy and it’s a social occasion and everybody’s stepping out on the balcony or onto the deck for a cigarette, he would follow along and not be concerned. But, if he’s irritated or tired or for some reason something is bothering him, it could be an issue, and it’s just not worth the fight. It just really isn’t, given the frequency of the occurrence. It’s not worth it. . . . He might get angry and yell and perhaps storm off. I mean, I’ve seen him storm off and leave a situation where he considers that somebody is being unreasonable. (Carmen)

Rather than deal with potential conflicts related to smoking, the women relaxed their rules. Confrontation, especially with family members, was an issue most of the women preferred to avoid. Most justified their decisions by explaining that small and infrequent amounts of ETS exposure were more palatable than dealing with the onslaught of family members' tempers. As one participant concluded (Elaine), "anything for a quiet life."

**Accepting limitations** was the third and final strategy in the making exceptions phase. Most participants agreed vehemently that when they visited other people's homes with their children, even thinking about asking someone not to smoke was "overstepping their boundaries." Under such circumstances, the participants accepted the limits of their ability to protect their children. One woman thought it simply bad manners to ask people not to smoke in their own home. She explained:

I would never do that . . . I think that’s rude. . . . I’m not going to make that choice for someone else. . . . I guess it’s the sort of manners that we were brought up with. My father was very old world in his manners. He wore a tie every day, even when he retired. You sat at the dinner and you didn’t put your elbows on the table and you used the right cutlery and all that kind of thing. That’s the sort of manners you use as a guest in another person’s home. There is a way you behave
as a guest in someone’s home, and you don’t tell them not to smoke in their own home. I mean, it’s just bad manners. (Carmen)

Women who believed they did not have the right to ask others not to smoke in front of their children had few options:

When the whole family visits grandma everyone smokes. The baby is around smoke the whole time we are there. We’ve never said anything. I guess it’s because it’s someone else’s home and we don’t have the right. (Delacey)

Thanksgiving is this weekend and we’re going over to my mum’s for dinner. It’s kind of an interesting situation because my husband won’t allow smoking in our house, and, yet, he’ll take the kids over to grandma’s house. She smokes like a chimney. He never says a word because it’s her house. (Ruth)

Others believed the only alternatives were to keep their children at home or limit the duration or frequency of visits to the homes of smokers:

If my husband and I visit people who smoke then we don’t take our kids with us. We don’t even like to stay long. It’s a good thing most of our friends don’t smoke anymore. (Vicki)

It’s not my place to tell them they can’t smoke in their own home. I wouldn’t say anything. We aren’t going to be there with the kids for long, anyway. A quick visit, a few hours. The kids are usually playing outside or downstairs anyway so they aren’t getting much smoke. (Joanne)

Interestingly, the women tended to accept these situations as beyond their control. No one questioned the actions of smoking relatives or friends or their lack of consideration for the health of young children.

One participant had a myriad of measures to protect her children from ETS, believing exposure was a form of "child abuse." Nevertheless, she remained silent when her children visited their grandmother, a heavy smoker, who made some attempts to reduce ETS exposure. She explained:

There is nothing I can really say, right? It’s [the grandparents’] house . . . I mean it’s a kind of respect. It’s not like they would sit this close and smoke. They usually do it [smoke] with the back door open or the kitchen fan on. (Elaine)
Like others, this woman considered it important to be "socially acceptable." Only one participant protested the "social norm." She was adamant that she would not take her children to another's home if they smoked while her children were present.

Interestingly, she felt that it was not "asking too much of people" since protecting her children's health was her first priority:

> We don’t have any friends who smoke in their house. If someone did smoke in their home I would ask them if it wouldn’t be too much trouble if they not smoke in the house. . . . I would say, "I know it’s your house, but you invited us here or we’re here for this reason and we don’t want our kids to be around the smoke." . . . If they got nasty about it I would just leave. (Vicki)

While this woman was confident that she could ask others not to smoke, she had not been in a situation where she had to do this.

Women’s efforts to control exposure to ETS in other people’s homes were sometimes assisted by the actions of children themselves. Unrestrained by social norms children were often vocal about the harmful effects of cigarette smoke, directly confronting smoking adults. For example, one woman (Delacey) recalled a time when her family visited people who smoked in their home. Her son protested, “You can’t smoke in front of me and my brother!” and took his brother into another room. The pleas of children were difficult to ignore and usually resulted in smokers putting out their cigarettes or smoking away from children.

Besides accepting their limited ability to control exposure to ETS outside of their home, the women who smoked were also confronted with their own limitations related to personal addiction. The women sometimes made exceptions to their smoking rules and their children were exposed to ETS. One woman’s experience with personal addiction was typical:
We don’t smoke in the car when the children are in the car because we don’t want to do it. We know it’s wrong, and the kids hate it. Our six year old is certainly old enough to tell us so. And, there’s the battle. That addiction battle that you’re doing all the time. We’ll go to the rest stop, and the kids can go and walk and we’ll have a smoke, and then we’ll get back in the car and keep going. But, sometimes you get caught, right? . . . The worst is going to my in-laws and you’re driving, and there’s no opportunity to have a cigarette, and you’re going, "Okay, okay, okay, just open the window, smoke a quick one, and then we’ll get there." (Carmen)

The initial good intentions of the participants to protect their children were constantly tested. The women struggled to meet the competing needs of their children, their families, their friends, and their own needs. Accommodating these needs resulted in the participants making exceptions to their rules and practices and exposing their children to ETS. Making exceptions was necessary for the women because they wanted to be flexible and supportive family members, cordial hostesses, and attentive friends; they needed to diffuse potentially difficult situations, relieve stress, and avoid conflicts. In essence, the women succeeded in avoiding the judgemental gaze of those they accommodated. Yet, there were consequences to making exceptions to the rules they established to protect their children from ETS. The women exposed their children to ETS more frequently than they realized and non-smoking family members and friends frequently criticized the women for exposing their children to ETS.

Phase III: Dealing with Contradictions: Making Room for ETS

When there is dissension between one’s thoughts and behaviours a contradiction is experienced (Greaves, 1996). The women in this study experienced such contradictions as they protected their children from ETS. Dealing with contradictions was the third, and final, phase of the protection process. All agreed that exposing their children to ETS was undesirable, yet, a variety of conditions and circumstances were experienced that thwarted the women’s intentions to protect their children. Making exceptions to
their smoking rules gradually undermined the good intentions women initially held to protect their children from ETS. Over time, rules were revised to accommodate frequently occurring transgressions or simply replaced with less restrictive guidelines to make room for ETS. The “new” rules were a significant departure from the women’s original intentions, creating contradictions that the women could not ignore. In response, they used several strategies to deal with the dissonance they experienced: seeking agreement, meeting their needs, minimizing the effects of ETS, hiding smoking, explaining addiction, ignoring health information, and living in hope. From the women’s perspective these strategies defended their actions and relieved their guilt about exposing their children to ETS, allowed them to continue to view themselves as good mothers, and protected them, somewhat, from the harsh judgements of others.

*Seeking agreement* was a strategy the women used to justify exposing their children to ETS. They felt less guilty about their decisions and actions when they recognized that other mothers exposed their children. One participant (Elaine) claimed, “You make exceptions and feel bad until you find out you’re doing what everyone else is doing.” Some women actively sought those who would agree with their point-of-view. One woman postulated that others, like herself, became indifferent about exposing their children to ETS over time:

“I’m getting lax. I used to be more strict about not letting any smoke get at my daughter. I’m much more lax than I used to be... Well, I think it happens to everybody though. At least everyone I’ve talked to. (Astrid)

Many participants talked to “older mothers” to discover the precautions they had taken to protect their children from ETS exposure. Participants were comforted to know the children of these women had been exposed to ETS all of their lives, and now, as young adults, appeared to be healthy. One woman whose daughter was two years old at
the time of the interview recalled:

I was talking to my girlfriend. She’s 45 and her parents smoked the whole time they were kids and they still smoke. She smoked around her kids and her kids are teenagers and they’re fine. So she thinks it’s not that bad. That got me thinking it’s not such a big deal. (Maureen)

All the women in the study were exposed to ETS as children, and had grown up in families where parents, siblings, and most relatives smoked. They reflected on those experiences to defend exposing their children to ETS. One woman recalled:

I remember sitting in the back seat of the car while my parents smoked. It made me feel like throwing up. Sometimes I just about did. I turned out and I was heavy-duty exposed. (Robyn)

She explained that her children’s exposure to ETS was minimal compared to her own exposure as a child. She determined that if she was in excellent health then her children were "probably safe." This typical rationalization reflected concern for the health of her children and confirmed some exposure to ETS was, indeed, acceptable.

Women acknowledged that personal and idealistic societal expectations encouraged mothers to place the needs of their children above their own needs. Yet, the cost of protecting their children from ETS, on occasion, was too great and did not allow them to meet their own needs or the needs of others. One woman believed, “Always putting them [children] first and not dealing with yourself, in the long run, doesn’t do them [children] any good.” This reasoning was further illuminated in the following quotation:

To be able to go to a restaurant, have a nice meal, and have a smoke after dinner. That’s a treat. And so we’re [participant and husband] doing that for ourselves and we’re putting ourselves above our children in that case. We’re striking a balance there. Yeah, it’s bad for them to be in the smoking section in a restaurant, but how bad? Well, it’s not going to kill them; it’s not terrible. (Carmen)

Another participant explained her yearning to do something “just for herself” began seven months after her child’s birth:
I had it. I just wanted my body to myself, to do what I wanted to do. It's my body and it's not to share with anyone else. I could make my own choices about my own body because I wasn't pregnant anymore. I could smoke again even if I didn't want to. (Robyn)

Some women believed smoking helped them to cope with the stress, the anger, and the frustration of being a mother. They admitted that smoking supported them to be more effective parents, a need that compensated for the minimal ETS exposure their children received. One woman offered:

Having a kid is stressful. Sometimes I'm ready to snap. I have to put her in her room, sit in the living room, and have a cigarette to calm down. I need that five minutes to myself before I really lose my temper. (Maureen)

Minimizing the effects of ETS was a related strategy used extensively by the participants to defend their actions and be perceived as good mothers by others. One participant spoke about her daughter:

She's much older now. If you smoke around children that are much younger they're much more likely to get ill from it and have respiratory problems. She's nearly three and she hasn't had any problems. I think because she's getting older that it's okay to smoke around her now. (Maureen)

Her logic, while faulty, justified her allowance of smoking by others in her once smoke-free home. One woman remembered being warned about the "evils" of ETS when her first child was born. Feeling vulnerable, she listened to the advice of others to ensure that she was doing everything to protect her child. With time, she re-evaluated her beliefs about ETS and was angry because she thought she had been misled:

There's no asthma. There's no allergies. Nothing. You know all those things that could happen didn't, so I probably don't think about second-hand smoke as much. I was told all these things and none of them ever happened. It's simply not as bad as I thought. (Elaine)

She reacted by "not being obsessed" about ETS exposure since her children were healthy.
Other women minimized the putative effects of ETS by comparing it to the many pollutants and toxins that were present in the environment. A participant who allowed others to smoke in her home defended her actions this way:

I think that there is a hell of a lot more pollution outside that they're breathing in than there will be by sitting in my house. I’d be more concerned with the pollution outside, quite honestly. (Carmen)

In the same light, another woman minimized the ill effects of ETS by comparing it to the potentially countless environmental hazards:

It’s probably more dangerous driving behind a diesel truck than the frequency my child is exposed to second-hand smoke. . . . I’m concerned about other toxins as well, like the slug bait I use in my garden. There are lots of things that are around our home and our city that I am concerned about. Second-hand smoke is just kind of on the list and you do your best to keep it down, right? (Joanne)

Hiding their smoking was a common action among women. They concealed their smoking habit from family and friends who disagreed with their inconsistent protection of their children. Not smoking around those who objected allowed the women to escape the “endless lectures” and bypass the harsh judgements. One woman did not smoke around her mother-in-law in an attempt to avoid a “frosty reception”:

I don’t smoke when my husband’s mother is here at all because it’s not worth the effort. It’s not worth the guilt trip. She goes on, "Oh, you’re still smoking. I thought you’d quit. I hope the kids never smoke." And blah, blah, blah. She just goes on and on. She never stays for more than a couple of hours so I just don’t smoke. It’s the path of least resistance. (Elaine)

Another participant avoided the disapproval of her neighbours, whom she has lived beside for ten years, by smoking in her garage. She (Robyn) claimed, “They don’t know I smoke. It’s socially unacceptable. Not that they would say anything but I hate that knowing look.” Women made efforts not to smoke in public places to avoid the castigation of complete strangers. One participant sitting with the children in a restaurant explained her position:
I'll sit in the smoking section but I won't smoke at the table so it makes it totally OK to be there. It's probably the guilt thing. I couldn't sit at a restaurant with the kids and smoke because then I'd feel like I was being judged. I don't put myself in situations where I would feel guilty. (Elaine)

One of the most difficult situations for women was explaining their own or other people's cigarette addiction to their school-aged children. Their children, learning about the dangers of smoking in school, found it difficult to understand why anyone would do something that was "bad for them." Their honest and candid questions and concerns about smoking were overwhelming for the guilt-laden mothers. Despite these difficulties the women's explanations included that quitting was "not easy" and that they were, in fact "trying really hard to stop." One woman recalled an incident that "broke her heart":

The school wanted parents to talk to their kids about smoking. I told him [son] he shouldn't smoke and he understands that it's hard [to quit] and I do try and I will try. He knows that I'll quit when the time is right. . . . At New Year's it came out that at school he [son] had to write New Year's resolutions and he wrote one for me saying that I should quit smoking. It made me feel really bad because he knows I'm doing something that is not good for you. (Elaine)

Women worried that smoking would interfere with their ability to be good role models for their children or effective parents. One woman described an incident where she lost control in disciplining her child because of her smoking:

I told my son that he had to limit his TV watching and if he didn't then there would be a week without TV. And so he snapped back at me, "Well, how about a week with no smoking?" And then I just go, "Oh well. Never mind that. Watch the TV." I mean, it's so stupid. How do you explain addiction? (Carmen)

Maintaining the respect of their children and avoiding their judgements was a goal of all the mothers.

Some women who exposed their children to ETS countered the dissonance they experienced by ignoring health information. Avoiding this information was the only way
some participants could relieve their guilt, anxiety, and thoughts of being bad mothers. One woman recounted hearing about ETS on the radio and immediately tuned into another station. She explained that the information was confirmation of the damage she may be causing her children:

I don’t have to know all the details of it. I know it’s bad for a number of reasons. I think by hearing it, I’m not ready to quit yet. It makes me feel worse. It makes me feel more guilty. It makes me want another cigarette. (Maureen)

_Living in hope_ was the final strategy the participants used to deal with their dissonance. Living in hope allowed the women to be future oriented and set goals which alleviated their guilt and gave them some degree of peace. One woman (Robyn) insisted that she was going to quit smoking, “when the kids are older and the stress isn’t so bad” and another (Maureen) was certain that “my smoking days will be over in five years when I graduate from university.” Another participant (Carmen) offered, “I’m hoping to tell my brother not to smoke around the kids when we see him at Christmas.” In addition, living in hope allowed the women to deflect the judgemental gaze since those who disapproved of the their transgressions were also given hope that positive behaviours were in sight.

Several strategies were used by the women to reduce their experience of dissonance as they exposed their children to ETS. Their defence eased their guilt, allowed them to remain good mothers in their own eyes, and countered the judgemental gaze of others. The strength of their defences against a perceived judgemental gaze was perhaps equal to the strength of the criticism found in that gaze. Those who managed either infrequent or continued exposure of smoke to their children did so only with stronger justification and sometimes faulty reasoning.
Summary

This study provides a glimpse into the processes that participants used to protect their children from ETS. The processes began with the women’s good intentions to protect the health of their children; they created rules to guide their decisions and behaviour. The participants encountered many conditions and circumstances that undermined their best efforts to follow these rules. Often, the most difficult to comply with their wishes were the people closest to them--their own families. The women made exceptions to the initial rules and justified their decisions with convincing explanations. The women established the rules and broke the rules for the same reason--to avoid the judgemental gaze of others--the common theme throughout the process. The women in this study wished to protect their children from ETS in order to safeguard their children’s health and therefore be perceived as good mothers.
Chapter 5: Discussion

The purpose of this study was to describe the processes women use to protect their children from ETS. The findings indicate that the complex process of protecting children was comprised of three interrelated phases: starting out with good intentions, making exceptions, and dealing with contradictions. These phases and the strategies that accompany each phase were directed toward avoiding the judgemental gaze, the core category of the study. Avoiding the judgemental gaze accounted for the similarities, as well as the variations, within the process of protecting children from ETS.

In the following chapter, three aspects of the study are examined. First, a brief summary of the findings is presented. Second, the findings are discussed in light of the published literature. Because the literature that relates to women's protection of children from ETS is sparse, scholarly works are drawn from several fields of inquiry. The discussion elucidates broad-based social issues that encourage women's smoking and challenges their ability to protect their children from ETS. Five elements are explored: cognitive dissonance theory, smoking cessation programs, social conditions as causes of risky behaviour, the role of motherhood, and government initiatives to protect children from ETS. Throughout the discussion, implications for nursing practice, education, and further research are identified. Finally, the strengths and weaknesses of the research method used in the study are analyzed and the significance of the study is articulated.

Summary of the Findings

A variety of themes arose from the interviews with the participants as they provided candid accounts about the significance of smoking in their lives. Smoking assisted the women in managing their emotions, the development of relationships, and coping with the stresses of motherhood. They portrayed smoking as a behaviour imbued
with controversy, compromise, contradiction, and guilt. It is within this context that the
women’s attempts to protect their children from ETS were understood.

The women in this investigation engaged in a three-phase process to protect their
children from ETS: The underlying effort in each of these phases was the basic social
process of avoiding the judgemental gaze. The women’s actions to protect their children
from ETS were strongly influenced by idealistic, societal expectations of what it means
to be a good mother. Through each phase of the process to protect their children from
ETS, the women focused on behaviours that evaded the “bad mother” image. As the
core category, avoiding the judgemental gaze ties together the evolving strategies women
used to protect their children from ETS.

During the first phase, the women drew on their knowledge about ETS, their
wish for a healthy child, and societal and personal expectations of "good mothering" to
establish rules to protect their child from ETS. The competing needs of others and
everyday life made it difficult for the women to focus solely on their children and
resulted in adjustments to the initial rules that exposed their children to ETS. These
adjustments marked the beginning of the second phase of the protection process, making
exceptions. Making exceptions to smoking rules gradually undermined the good
intentions women began with to protect their children from ETS. Over time, the rules
were revised to accommodate frequently occurring transgressions or were simply
replaced by less restrictive guidelines to make room for ETS in their homes and in their
lives. The new rules were a significant departure from the women’s initial intentions and
created contradictions that the women could not ignore. In the third phase of the
protection process, the women used several strategies to deal with the contradictions and
to respond to the dissonance. These strategies included: seeking agreement from others,
meeting their own needs, minimizing the effects of ETS, hiding smoking, explaining addiction, and living in hope that they would one day quit smoking. From the women's perspective, these strategies defended their actions and relieved their guilt about exposing their children to ETS, allowed them to continue to view themselves as good mothers, and protected them, somewhat, from the harsh judgements of others.

**Significance of the Process**

The process women use to protect their children from ETS has not been previously described. Until now researchers have focused on women's experiences of smoking, smoking cessation, and patterns of relapse (e.g., during the postpartum period), but little attention has been given to women's smoking in the context of mothering young children (Bottorff, Johnson, Irwin, & Ratner, in press; Greaves, 1996; McBride & Pirie, 1990). The current study uncovered the process women used to protect their children from ETS and extended our understanding of the role of smoking in women's lives. This study illustrated that women who relapsed to smoking during the postpartum period continued to make an effort to protect their children from ETS. Images of being a good mother influenced the woman's decision-making, however, "prescribed" solutions to protect children from ETS were difficult to carry out. Even for women who did not relapse, protecting their children from ETS was a challenge because their efforts were often undermined by family members and friends. The findings from this study are notable because of the insights gained into the difficulties encountered by women regardless of their knowledge of the effects of ETS. These findings have implications for supporting women in protecting their children from ETS.

The following discussion focuses on contextual issues that influenced and challenged the women in protecting their children from ETS. Current gaps in research
related to protecting children from ETS are addressed and suggestions for nursing practice, education, and further research are offered.

**Cognitive Dissonance Theory**

The women initially established ground rules to protect their children from the harmful effects of ETS. They encountered difficult circumstances that influenced them to make adjustments or revise the rules resulting in their children being exposed to ETS. The departure from their initial good intentions created contradictions that the women could not ignore. They altered their behaviour to deal with the contradictions and to respond to the dissonance they experienced. The women's behaviour is described by Festinger's (1957) theory of cognitive dissonance.

The theory of cognitive dissonance deals with the inconsistency between one's knowledge or belief and one's behaviour (Festinger, 1957). The inconsistencies between belief and behaviour produces a state of dissonance, the experience of psychological discomfort. For example, if a person is aware of the health dangers of ETS, but exposes their child to ETS, an unpleasant state of cognitive dissonance is expected.

When people experience a state of dissonance they are motivated to reduce it (Festinger, 1957). Research evidence, while often contradictory and inconclusive, suggests that smokers use a variety of strategies to reduce dissonance. Behavioural changes such as stopping smoking or reducing smoking are methods of reducing dissonance (McMasterson & Lee, 1991). Smokers, who find behavioural changes too difficult, adopt cognitive changes regarding the effects of smoking: they misinterpret smoking information, deny the validity of it, or otherwise distort the information to reduce dissonance (Halpern, 1994). Cognitive changes regarding smoking are well documented throughout the research literature. While most smokers believe smoking to
be dangerous, they often minimize their risk of disease or assume that their chance of smoking-related ill health is less than that of other smokers (McMasterson & Lee, 1991). Some researchers have concluded that smokers have the same knowledge about smoking as non-smokers (McMasterson & Lee, 1991), while others have found that smokers have less knowledge and demonstrate increased forgetting ability (Pervin & Yatko, 1965; Swinehart & Kirscht, 1966). To reduce dissonance, smokers are more likely to question, criticize or ignore smoking-related information (Tagliacozzo, 1981). A study by Pomerleau (1979) reported that smokers trying to quit are more receptive to information about the negative effects of smoking. Swinehart and Kirscht (1966) found that smokers who intend to stop were more likely to acknowledge the ill effects of smoking. Olshavsky and Summers (1974) failed to find such a difference, but did report that people wanting to quit endorsed fewer positive reasons for smoking. Another strategy used by smokers was to adopt a belief of personal immunity to reduce the dissonance they experienced as a result of smoking. Weinstein (1987) found that smokers were unrealistically optimistic about avoiding the health hazards of smoking.

Similar to the published research literature, women in this study whose children were exposed to ETS, minimized, denied, or avoided information about the dangers associated with ETS to reduce the dissonance they experienced. No studies were found that explored dissonance reduction among women protecting their children from ETS. The principles of cognitive dissonance theory shed light on the behaviour of the participants in relation to their children and ETS exposure. The women appeared to have notions that were mutually inconsistent; they recognized the susceptibility of children to the ill effects of ETS, yet, exposed their children to their own smoke or the smoke of others. Dissonance was experienced by the women and they responded by
making several cognitive changes to ensure consistency between their knowledge, beliefs, and behaviour. For example, some questioned and criticized ETS related information in an attempt to minimize the health hazards of ETS. Others denied or diminished the length of time and the degree of ETS exposure their children received. These women associated with like-minded mothers who also exposed their children to ETS; they observed that the children of these women appeared healthy and concluded that the children were unaffected by ETS. Some women avoided or ignored information about ETS, claiming, "What I don’t know can’t hurt me," or emphasized the positive effects of smoking, "It helps me to be a better parent." Several women made extensive attempts to hide their smoking. Others found it important to explain their smoking habit to their school-aged children in order to reduce their dissonance. Many participants acknowledged that protecting their children from ETS lost its significance over time. Once the issue lost its importance to the women, the internal disharmony generated by cognitive dissonance became less significant and could be ignored.

Cognitive dissonance theory describes a complex relationship between beliefs, attitudes, and behaviour and has provided important guidance for health educators. It is expected that when good health education is provided and accepted, behaviour change will occur. This presupposition was evident in the studies that evaluated interventions to reduce ETS exposure in children (reviewed in Chapter 2). These studies suggest that educating mothers about the consequences of smoking and ETS is insufficient to motivate them to stop smoking or to find ways to protect their children from ETS. The information is more likely to induce or increase dissonance and be “tuned out” by various means such as inattention or avoidance.

Understanding cognitive dissonance theory may help health-care professionals,
program directors, and government officials begin to understand why information on smoking and ETS is necessary but not sufficient to alter women’s behaviour. Research is required to capture the complex issues of motherhood that encourage women’s smoking and exposure of children to ETS. Professionals can direct their efforts to designing more appropriate programs that focus on broad-based contextual issues that contribute to women’s smoking and exposure of their children to ETS.

**Smoking Cessation Programs**

Many women in this study relapsed in the postpartum period despite prolonged periods of smoking abstinence during pregnancy. A recent study revealed that women maintained their smoking abstinence for approximately 33 weeks during pregnancy (Johnson et al., 2000). Women who relapsed in the first year of the newborn’s life remained abstinent, on average, for a further 12 weeks following delivery. The women in this recent study reported that smoking cessation was motivated by concern for their unborn child and physiological changes caused by their pregnancy. All the women were convinced that they would not resume smoking after the birth of their child. The women’s confidence in their ability to remain non-smokers waned as they confronted the stress of multiple roles and the issues of everyday life. Most women in the study relapsed within six months of the birth of their child.

One possible way to support women in smoking cessation in the postpartum period and to reduce their children’s exposure to ETS is to have more appropriate smoking cessation programs. Increased availability of smoking cessation programs for the women in this study may not have helped them to deal with smoking cessation or to protect their children from ETS given the focus of most of these programs. With a few exceptions, most smoking cessation programs fail to address women’s continuing need
for support for cessation during the postpartum period. Smoking cessation programs and resources have been developed for the general adult audience. Typically, cessation programs offer cognitive- and behavioural-based solutions to facilitate behaviour change. These programs offer information about the health consequences of smoking, coping with withdrawal, receiving information on healthful lifestyle behaviours, and finding incentives for staying smoke free (Best, Wainwright, Mills, & Kirkland, 1988). While these programs can be effective for some, they reflect a model that demonstrates little appreciation for the role of smoking in the lives of women.

In the current study, women’s smoking is intertwined with their social, economic, cultural, and personal experiences. Most smoking cessation programs do not address the social context of women’s smoking patterns and gender-related issues are completely ignored (Greaves, 1990). For example, many cessation programs have complete abstinence as their goal. Even during relatively stable periods in women’s lives, however, smoking is often viewed as a dependable way of handling ongoing stressors (Graham, 1994). Women in this study reflected that being a new mother, being isolated, and dealing with family issues and friends were associated with smoking; complete abstinence was not feasible for them. For many, smoking was an effective means of diminishing stress in their lives. Consequently, it might be practical for smoking cessation programs for women to include discussions about smoking in relation to the broader context of women’s lives. It may be feasible to re-evaluate whether smoking reduction rather than smoking cessation be the criterion for the success of such a program. Programs that provide social support (e.g., small group interactions with other women) may help women to feel more comfortable and to increase the quality and quantity of their participation (Gilchrist, Schinke, & Nurius, 1989). In addition, the
structure and content of smoking cessation programs often lack features that women want, including social and peer-support, nonjudgemental approaches, and contact with others in similar socioeconomic circumstances (Stewart et al., 1996).

A few “women-centred” programs, offered in Canada, have provided potentially useful models for effective women-centred approaches to smoking cessation and health opportunities (Greaves, 1996). For example, a community-based pregnancy outreach program in a northern Canadian city was based on an alternative approach to tobacco reduction for clients (Browne, Shultis, & Thio-Watts, 1999). Lay counsellors, under the supervision of nurses, delivered the program using solution-focused principles and strategies that emphasized client strengths. The program was successful for a number of reasons including: (a) the clients’ life circumstances were respected, (b) small achievements were considered successes, and (c) women developed self-efficacy with relation to smoking reduction and cessation.

Research is required to build a strong theoretical basis for women-centred cessation programs. Researchers can help illuminate women’s experiences so that healthcare professionals, policy makers, and program developers can incorporate this invaluable information into cessation programs. Listening to women’s experiences may assist us in recognizing that women’s smoking is a reflection of larger societal issues. Understanding the broader-based societal issues may provide some direction for supporting women in smoking reduction and cessation, which in turn will reduce children’s exposure to ETS.

Social Conditions as Causes of Risky Behaviour

The women who participated in this study spoke about the difficulty they had in dealing with smoking and ETS exposure in light of the risks to their health and the
health of their children. Despite their desire to be good mothers and to be seen as good mothers, they exposed their children to ETS through their own smoking or the smoking of others. To understand how women think about and make sense of exposing their children to ETS, their behaviour was examined in the context of the social conditions of their lives in order to provide direction for supporting women in reducing or stopping their smoking, and protecting their children from ETS.

Epidemiology has been successful in identifying "proximal" and "distal" risk factors for major diseases. Most epidemiological research has focused attention on risk factors that are proximal causes of disease such as diet, exercise, and cholesterol levels (Logan & Spencer, 1996). Social conditions are considered to be distal causes of disease because they also affect individuals but are largely determined by the structures of society such as race, gender, housing, income, occupation, and local environment (Logan & Spencer, 1996).

Smoking and ETS exposure are considered proximal causes of women's and children's morbidity and mortality (Link & Phelan, 1995). The danger of examining these risk factors from an exclusively proximal cause approach (individually-based and individually-controlled) is that an exclusive focus on behaviour modification places the responsibility for stopping smoking solely on women and may lead to victim blaming. This perspective was evident throughout the current study as the women talked about different strategies they used to stop smoking or to protect their children from ETS. They acknowledged that their efforts were daunting especially when they lacked effective social support. They were frequently admonished for their failures and the people in their lives proposed solutions that required the women to change their own behaviour because they were seen as the source of the problem. Needless to say, the women
accepted the blame for their transgressions, felt guilty, and developed strategies to avoid the judgements of others.

One way to explore the social origins of risk behaviour is to contextualize individually-based risk factors, which may reveal the broader-based social conditions that are at play, and cultivate an understanding of the reasons some people cannot avoid risk (Link & Phelan, 1995). For example, steps have been taken to educate the public, especially smoking mothers, about the dangers of exposing children to ETS exposure. Despite these efforts, one-third of Canadian children under the age of 12 are exposed to ETS, in their homes, on a daily basis (Stephens, 1999). Contextualizing the risk factors, in this instance, can be done by asking, "What is it about these women’s life circumstances that prompted them to smoke and expose their children to ETS?" For example, participants in the study referred to smoking as: a way to relieve stress, something to do at night when their child was asleep, or as providing time-out from their busy schedules. The women’s remarks help us begin to understand the social context and the processes that encourage participation in this risky behaviour.

Being a woman in society is fundamentally linked to disease because women often have limited access to resources. These resources include money, power, prestige, and social support. Only woman who are best positioned in terms of access to resources are most likely to avoid risks, disease, or the consequences of disease (Link & Phelan, 1995). In the current study, one woman who had stopped smoking and refused to expose her children to ETS claimed her success was due, in part, to her husband. He was a former smoker, understood the difficulties of smoking cessation, and used an empathetic approach in supporting his wife. Many of this woman’s friends had stopped smoking so her exposure to smoking was less than other women’s in the study. In addition, she was
the only participant who had talked with her doctor to become more informed about the effects of ETS on children’s health. She recounted a poster in his office that depicted the effects of ETS on the body of a child. This poster had a profound effect on the woman and strengthened her resolve to protect her children from ETS. As well, the woman’s husband worked in the afternoon so she was able to attend exercise classes each morning, which she claimed was an effective stress release. This participant’s access to resources helped her to remain smoke-free and to avoid exposing her children to ETS.

This qualitative study captured women’s stories about the significance of smoking in their lives and the difficulties they encountered to protect their children from ETS. Their confidence in remaining non-smokers waned after the birth of their children and the complexities of everyday life made it difficult to uphold their original decisions to protect their children from ETS. The women spoke about the difficulty of coping with stressful lives, being isolated with children, suffering from loneliness and boredom, and the lack of social support after the birth of their children. Further research is required to understand and address the social issues that shape women’s lives so that they are supported in their intentions to remain non-smokers and protect their children from ETS.

While public concern for protecting children from ETS is critical, this debate may obscure women’s smoking as a health issue. Addressing the social context of women’s smoking is the most appropriate and effective means to protect children from ETS since women remain the major caretakers of children. Program directors, policy makers, and health-care workers may need to expand their concept of women’s health by looking beyond the proximal causes of disease. From this perspective, the opportunity to adopt broad-based social interventions that could produce substantive
health benefits for women and children can be implemented.

The Motherhood Role

Theories and research on the role of motherhood emphasize that women consider having children as basic to the meaning of life and essential to their view of themselves as women (Ingram & Hutchinson, 1999). Most women regard children as a source of love, pride, and a legacy for the future. Society "romanticizes" motherhood by placing unrealistic expectations on mothers and on the relationships women have with their children (Eyer, 1996). The ideal mother is characterized as a selfless, ever-nurturing, blissful creature who is a stranger to rage and boredom. Mothers represent comfort, warmth, safety, and prove their love by their willingness to sacrifice. This ability to sacrifice for their child is a quality that has remained the most appealing and most resonant ideal throughout history, and cuts across class, race, and culture. In fact, we have created cultural icons that are unyielding and unrealistic because they are a product of fantasies we cling to even as adults. The good mother lives in everyone's first grade reader: the bland, suburban homemaker, mother of Sally, Dick, and Jane. The perfect mother lives in the television set: Mrs. Cleaver, the ever-aproned, ever-available mother of Wally and Beaver. These childhood memories, that many cherish, make motherhood a powerful symbol that shapes unrealistic societal and individual expectations (Chira, 1998).

Society expects mothers to orient themselves to their children's needs regardless of their social circumstances. This theoretical perspective on mothering may not capture the complexities of women's experiences especially for woman who deviate from the "accepted norm" regarding maternal identity and experience (Ingram & Hutchinson, 1999). The women in this study deviated from the acceptable mothering norm because
they smoked or exposed their children to ETS. The women’s behaviour caused misgivings because their transgressions conflicted with their image of themselves as good mothers and others’ images of them as good mothers. A recent study reported that deviations from the normal concept of mothering resulted in profound doubt about the women’s competence and self-worth as mothers (Ingram & Hutchinson, 1999). In the current study, women's doubts about themselves were reflected with descriptions such as, “I’m so bad,” “Some mother I am,” and “I’m a total loser.” Constant comparison of themselves to the ideal mother caused them stress and anxiety which, for some, increased their desire to smoke. Other people contributed to the women’s doubts about themselves with stigmatizing comments such as, “this is the worst thing [smoking in front of their children] you’ve ever done,” and, “you should be ashamed of yourself.” The study provided some insight into how these mothers made sense of smoking and exposing their children to ETS. Women responded to the negative attitudes of others with several strategies including hiding their smoking, associating with other mothers who exposed their children to ETS, speaking positively about the effects of smoking on parenting skills, minimizing the effects of ETS, and living in hope that they would eventually stop smoking. Their experiences must be understood to find ways to support women in protecting their children from ETS.

The “nuclear family” is responsible for the day-to-day care of children. In other words, parents are the exclusive caregivers of their children regardless of the resources needed to carry them out (Swift, 1995). Although parents are responsible for their children, traditionally, the actual work of caring for children has been allocated to women. In a two-parent family it remains the mother’s role to care for the children and a father’s role to be the breadwinner (Swift, 1995). This may explain the behaviour of
the women's husbands in the current study. While their husbands supported the idea of protecting their children from ETS (some were adamant), they did not actively intervene when others smoked around their children. It appeared that women had the difficult task of asking others not to smoke in front of their children, even when it involved the husband's family or friends.

Family members frequently undermined the women's efforts to protect their children from ETS. While the women found this to be a challenging task in their own homes, it was impossible in others' homes. Perhaps the popular notion that parents (mothers) are the exclusive caregivers of children has diluted the influence of the extended family (Swift, 1995). Extended family members may feel that their input is less valued and even discouraged. This growing separation between the nuclear family and the extended family may enhance extended family members lack of responsibility for the health and welfare of the children within the family sphere. This theory could be one possible explanation for family members continued smoking in the presence of children in the current study.

Health initiatives, smoking cessation programs, advertisements, and media coverage should stress that protecting children from ETS is everyone's responsibility. Education and smoke cessation programs could support parents in maintaining smoke-free environments by discussing creative solutions that deal with family members who undermine their efforts to protect their children.

Although being a mother confers many rewards it also increases psychological distress for women (Chira, 1998; Swift, 1995). The demands of child-rearing, combined with other role commitments as wife, worker, and family member increase women's stress. Health-care professionals need to discard the view that women's health is solely
biological and embrace the view that women's health is a sociocultural phenomenon. Health-care professionals working with women might begin to understand the societal expectations placed on motherhood, and their experiences of multiple role strain by working with and listening to women. Women who report role dissatisfaction could be supported to make adjustments in their interpretations of others' expectations of them and in their own self-concept so that they develop an awareness of their situation and master their environment (Thomas, 1997). For example, health-care professionals can be resource persons and resource mobilizers for women by organizing "coping groups" to listen to women and empower them to relinquish unrealistic societal expectations of their role as mothers (Miller, 1976). These topics could be explored in smoking cessation programs to empower women as they reduce or stop smoking.

Instead of criticizing the narrow focus and patriarchal practices that characterize women's health care, researchers need to move toward a broader focus on women's wellness, vitality, and overall quality of life. Researchers need to continue to explore the meaning of gender membership and social role-enactment for individual women in their environmental contexts (McBride, 1993).

Government Initiatives

In view of the significant health risks imposed on children by ETS, there is increasing pressure on government to intervene and protect this vulnerable population (Ashley & Ferrence, 1998). Government action to protect children from ETS exposure includes a health promotion effort that concentrates on education and legislation. Education consists of public information, debate, and advocacy, all designed to encourage behavioural change. Legislation includes regulatory approaches to ban smoking in public places and especially in places that children frequent. In recent years,
there has been a progression from health education to legislation and ultimately enforcement; history reveals this evolution is the best method to enforce compliance. The introduction of regulations regarding the use of car seats for children and seat belts are good examples of this effective strategy (Cushman & Robertson-Palmer, 1998).

Government programs and policies to reduce children's exposure to ETS in public places across Canada and the United States have been widely implemented. However, for infants and young children, the home is often the most prominent site for ETS exposure and maternal smoking remains a particularly important determinant of that exposure (Cook et al., 1994). The rise in the number of children who take up smoking and the halt in the decline in adult smoking reinforces the case for new government action. In an effort to increasingly protect children from ETS exposure, attention has turned to program and policy options for ETS control in private homes as a public health priority (Ashley & Ferrence, 1998).

Government interventions to control matters of the home is a difficult and sensitive issue since the home and family life are considered by most to be "private sanctuaries." Moreover, smoking is a legal activity, and many believe government does not have the right to interfere in areas of personal choice in private homes. Some fear interventions will not stop with ETS control policies in the home, and government interference in people's private lives will become customary.

The effects of government interventions to control ETS in the home are not gender-neutral since these policies will, most often, have the biggest impact on women. An understanding of the connection between smoking and the realities of women's lives is essential to recognize and appreciate the potential implications for women if policies were enacted to control ETS in the home. The participants, similar to most women,
smoke for functional reasons including stress reduction, as a coping mechanism, for comfort and companionship, and to maintain control. For those women who smoke, not allowing them to smoke in their homes may impair their ability to cope with their already stressful lives. Women in this study, as with many women, would face increased difficulties providing smoke-free environments for their children since they are often home alone all day with their children. They would be forced to take their children outside with them each time they smoked a cigarette (Ashley & Ferrence, 1998). The alternative would be to leave children inside and unattended, which may increase the likelihood of unintentional injuries. Women also may be expected to control the smoking behaviour of others in their homes and in other people’s homes, a difficult and unrealistic task. In essence, women and their children would be especially penalized if policies were implemented to control smoking in the home.

Enshrined in society is the belief that children need to be protected. Equally believed is the notion that government intrusion in people’s homes is inappropriate. Consequently, children are afforded less protection from ETS from their parents than from strangers. Yet, society’s ability to protect children who are adversely affected by ETS exposure in the home has been demonstrated in the law courts. The legal system has devised a number of strategies to ensure children are protected. The consideration of parental smoking is a factor in custody battles, and the application of child abuse and neglect laws to control and punish parents who smoke near their children (Ezra, 1994). Nevertheless, some health professionals fear that the courts will discriminate against women. They will be harassed, or worse, their children will be removed because the women have failed to provide smoke-free environments. Although well intentioned, placing concern for children ahead of mothers may make matters worse for mothers and
children. Perhaps we need to focus on interventions that would focus on both women and children.

It is important to protect children from ETS exposure and legislation to control smoking in the home may be a possible answer. Towards this end, the current research base is inadequate to fully support policy development in this area. Research is required to assess public support for regulatory changes, to consider the attitudes and intentions of health professionals and policy makers, and to understand the potential applicability of harm-reducing strategies in the home (Ashley & Ferrence, 1998).

Concern for the health and protection of children from ETS conceals the underlying problem—women’s smoking, and ultimately, women’s inequality. Women smoke for purposeful reasons in a social context of gender inequalities (Daykin, 1993; Graham, 1994; Greaves, 1990). The Canadian Advisory Council on the Status of Women (1994) identified a number of factors that confirm the inequality of women: women earn 70% of what men earn, the wage gap leads to a pension gap, women are under-represented in the majority of occupations, 61% of families living below low-income cutoff are single-parent families headed by women, Aboriginal women have the lowest incomes in Canada, 35% of women are impoverished by separation or divorce compared to 9% of men, child care is not consistently available and affordable, and 29% of women are assaulted by their spouses. These areas could be fertile ground for the implementation of government programs and policies to enhance and improve women’s social conditions and life circumstances. Addressing these issues of inequality could be an important part of a comprehensive strategy to reduce smoking among women and, eventually, decrease children’s exposure to ETS.
Discussion of Research Method

The focus of grounded theory research is to understand how a group of people define their reality through social interactions (Stern et al., 1984). Grounded theory methodology was consistent with the objective of this study which was to capture, analyze, and present the perceptions of women in protecting their children from ETS. Using this method resulted in the identification of a core category, avoiding the judgemental gaze, that described the social and psychological variation in the experiences of the women as they employed various methods to protect their children. Further analysis of the process of protecting children from ETS resulted in a framework for the emerging theory. The following discussion emphasizes the measures taken to ensure methodological rigour, and highlights the recognized limitations of the study.

Rigour

Several strategies were implemented to ensure rigour in theory development throughout the study. These strategies are discussed as they pertain to four criterion measures of rigour: credibility, fittingness, auditability, and confirmability (Sandelowski, 1986).

Credibility and fittingness were ensured through a variety of measures. Empathy and intuition were skills used by the investigator throughout the interview process. These skills were imperative in developing relationships with the participants, becoming involved in the participants' perspectives, and in interpreting their experiences. Paradoxically, the closeness of the researcher-participant relationship could have been a potential threat to the study. The researcher, a former smoker, kept a journal prior to and during data collection to explore her biases and assumptions. This facilitated openness during data collection and analysis, separated the researcher's experiences and
behaviours from that of the participants, and helped avoid the premature attachment of meaning to the perceptions of the participants. Participant validation of the data and the findings occurred throughout the interviews. This allowed the emergent theory to mirror the perspectives of the participants including the typical and atypical elements, to provide a rich and extensive theory. A possible limitation of the study was the researcher’s relative inexperience as an interviewer. This may have inhibited significant discourse.

The sample size of the study was small but included women with extensive smoking histories, of different ages, and from a variety of socioeconomic and educational backgrounds. The combined experiences of all of the participants were represented in the findings which facilitated an initial understanding of the process women used to protect their children from ETS. The relatively small sample size and the specific characteristics of the group limit the theoretical generalizability of the findings to other populations. For example, women who had never smoked but who had family members who smoked were not included in this study; the findings of this study may not apply to those women. While every effort was made to include women of colour and different ethnic origins, all but one of the participants were white. Further research is required to capture, analyze, and compare the experiences of women of colour or diverse ethnic origin with the findings of this study.

There were other limitations of the study imposed by the representativeness of the sample. A non-probability sampling method was used to recruit participants who were astute, knowledgeable and eloquent in disclosing their experiences. This "elite bias" might potentially threaten the validity of the research findings if these descriptions were not placed within their proper perspective (Sandelowski, 1986). During the interviews,
the participants had to recall circumstances, decisions, and actions from the past; recall bias may have had an effect on the rigour of this study since individuals sometimes remember past events in a manner that justifies their decisions and actions (Wagener & Taylor, 1986). Therefore, the participants in the study may have recalled or emphasized their experiences of protecting their children rather than the events that actually took place. Another limitation of the study was that the participants knew that the investigator was a nurse and, because of the sensitive nature of the subject matter, they may have related their experiences based on what they believed the investigator wanted to hear.

Throughout data collection and analysis, the researcher used several strategies to ensure credibility and fittingness. Validation was sought from participants regarding the emerging theory. Constant comparison of hypotheses against the data, searching for typical and atypical elements of the data, and deliberately trying to disprove a theory or conclusion were used during the process of data analysis to ensure the emerging theory fit the data.

Significance of the Study

An abundance of research studies throughout the health-science literature offers information, often contradictory and certainly not definitive, regarding the experiences of women who smoke. These studies have been largely quantitative and provide important information but they are not well grounded in the lives and experiences of women. Several qualitative studies have been conducted that provide candid accounts about the significance of smoking in the lives of women. The studies confirm that women's relationship to tobacco is one filled with controversy, compromise, contradiction, and guilt; these experiences were also reflected in this study. All of the
studies excluded the added dynamic of women with children; they do not explore women’s efforts to protect their children from ETS. This study investigated women’s relationship with smoking in light of their role as mothers and examined the process they used to protect their children from ETS. The emergent theory revealed that protecting children from ETS is a complex issue affected by the social context of women’s lives and provided some directions for supporting women to protect their children from ETS.
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Appendix B

Sample Trigger Questions

The following is a sample of trigger questions that were used in this study.

1. How has your initial decision to stop smoking changed since the birth of your child?

2. What prompted you to be concerned about smoking in the presence of your child?

3. Describe, in detail, a time when you wanted a cigarette and your child was present. How did you manage the situation?

4. What have other people said to you about smoking around children?

5. Who can smoke in your home? Do you make exceptions for visiting family and friends?

6. Can you describe a time when you asked someone not to smoke around your children and it was a problem for them or you? How did they react? How did you handle the situation?