Stretched thin with little children: smoking perceptions and experiences of families seeking help with parenting

Abstract

Cigarette smoking is the leading preventable cause of poor pregnancy outcomes. Pregnancy is a trigger for smoking cessation yet, up to 50% of parents will relapse in the early years of their child's life. This study explored the smoking-related perceptions and experiences of 11 parents seeking professional help with the care and parenting of babies and toddlers using semi-structured interviews. Inductive thematic analysis identified three themes: parenting as a change catalyst, smoking as a parenting challenge and smoking as a coping strategy. Becoming a parent is a catalyst to reduce the associated risks and stigma associated with smoking, but maintaining rules and boundaries can be perceived as a further burden for parents who are struggling to care for their infant. When faced with difficulties with parenting, parents may revert to smoking as a coping strategy. Based on these study findings, interventions targeting gender norms may be useful in addressing smoking cessation.

Introduction

Smoking remains one of the most preventable causes of poor health outcomes and mortality, despite significant reductions in adult smoking (World Health Organization, 2015). Cessation before or during pregnancy reduces the risk of adverse outcomes for the developing foetus (Bickerstaff et al., 2012). Exposure to second-hand smoke during childhood is also a risk factor for infant and child morbidity and mortality (Lawder et al., 2019). As a result, significant efforts have been made to promote a smoke-free environment during pregnancy and childhood (Willemsen et al., 2012).

In recognition of the deleterious impact of smoking, many women are motivated to quit smoking before or during pregnancy. However, most are likely to relapse during the first year (Harmer and Memon, 2012; Scheffers-van Schayck et al., 2019). In Australia, currently 11% of women report smoking during pregnancy, with the rate of smoking higher amongst women from disadvantaged backgrounds, including those experiencing psychological distress, single parents, Aboriginal and Torres Strait Islander people or living within a community where smoking is more prevalent (Australian Institute of Health and Welfare, 2018).

Even when women are successful in smoking cessation, their partners and other family members may continue to smoke, and this can hamper efforts to promote a smoke-free home (Harmer and Memon, 2012; Passey et al., 2016).

Moreover, many interventions do not focus on the particular needs of women, particularly depression, stress and anxiety, which may be motivators for smoking (Kurtulus¸ et al., 2020). Given the high rate of smoking relapse after birth, it is important to un- derstand parents' beliefs and behaviours around smoking, to inform the development of effective and supportive strategies for parents.

For some parents, the early months after their baby is born can be difficult (Priddis et al., 2018; Tully et al., 2017) and this can diminish their sense of parenting efficacy and may increase the risk of relapse. Parents can seek initial support with parenting challenges such as sleep and settling, infant feeding or infant crying from primary healthcare providers (Tully et al., 2017). In some instances, parents find these challenges sufficient to require referral to early parenting services (Dahlen et al., 2019; Rowe and Fisher, 2010). In Australia, these secondary and tertiary level parenting services are provided by nurses in day services, home visiting and residential parenting services (Fowler et al., 2017).

Secondary and tertiary parenting services, where families receive support from health pro- fessionals, provide targeted evidence-based interventions to promote attachment and address parent concerns (Rowe and Fisher, 2010). These services focus on strengths-based and attachment ap- proaches to support new families. With support and reassurance, early parenting challenges such as sleep and settling, crying, behaviour and/or feeding can be addressed (Dahlen et al., 2019; Rowe and Fisher, 2010). Referral to the parenting service is commonly made by a health professional, such as a child and family health nurse, general practitioner or paediatrician. The services are primarily funded by public health funding and through private medical insurance. Care is delivered by a multidisciplinary team, using a nurse-led model of care with referral to medical (paediatrician, psychiatrist and general practice) and/or allied health (social worker and psychologist) professionals for individual needs (Priddis et al., 2018; Rowe and Fisher, 2010).

There is a debate and discussion about the role of family-based approaches; therefore, it is important to elucidate factors that help and hinder cessation efforts, particularly in the early parental period (Hubbard et al., 2016). Understanding these factors within the context of parenting services is important in developing targeted interventions.

Aim

To explore smoking-related beliefs and behaviours of parents who are seeking help with parenting challenges from early parenting services.

Method

A qualitative descriptive approach to the research study was taken in order to gain parents' perspectives of smoking behaviours and practices. This approach allowed for exploring multiple, subjective and complex views and meanings related to smoking, from the perspective of a range of research participants (Carter and Little, 2007). The researcher collected data within the parenting service setting and sought to understand and interpret the data in relation to that context (Creswell and Creswell, 2018). The reporting of the study adheres to the Consolidated Criteria for Reporting Qualitative Research checklist (Tong et al., 2007).

Theoretical framework

It is important to consider how parents live within a broader social context, and the factors that help and hinder their intentions to achieve a smoke-free home. The social ecological model (Bronfenbrenner and Morris, 2007) takes into account the range of influences on individual health behaviours of parents including their own beliefs and factors such as gender and self-efficacy as well as the beliefs and values of their social networks. We have also considered perceptions of self- efficacy, based on social cognitive theory, which is framed on the premise that learning (to be a parent and to manage smoking risk) takes place in a social context and is the result of interactions between environmental, behavioural and personal factors (Bandura, 2004). Self-efficacy is domain- specific, but is also contextual. For example, efficacy for managing risk or maintaining cessation may be reduced, when the parent is already experiencing difficulties in their adjustment to parenting, because of infant behaviour or when smoking behaviour is normalised (e.g., in the workplace). Moreover, the economic stressors of parenting may challenge health behaviours, particularly stress management (Schenck-Fontaine and Panico, 2019).

Ethical considerations

Ethical approval to undertake the study was approved by South Western Sydney Local Health District Human Research Ethics Committee (LNR/15/LPOOL/214) and the University of Tech- nology Sydney Human Research Ethics Committee (ETH16-0710).

Participants were informed of the purpose of the study, that participation was voluntary and that they could withdraw from the study at any time. Written consent to participate was obtained. All identifying information was removed at the time of data collection, and pseudonyms have been used in the reporting of results.

Setting and participants

The study was conducted in two early parenting organisations in metropolitan areas of New South Wales, Australia. Parents attending the service with their infant were invited to participate in the study. Screening of eligible parents was undertaken by independent administrative staff during intake procedures prior to admission or by independent nursing education and research staff during an admission. Verbal and written consent were obtained from participants during their admission.

Inclusion/exclusion criteria. Parents were eligible to participate in the study if they were (a) a parent,
(b) seeking services from the parenting service, (c) a current smoker and/or had a partner or family member who smoked and (d) were English-speaking. Parents were excluded if they were unable to speak or read English.

Data collection

Semi-structured interviews were conducted by the lead author either face-to-face or by telephone, depending on the preference of the parent. The interviewer had previous experience as a registered nurse working with children and families and experience conducting qualitative interviews. In- terviews were recorded using a digital voice recorder. Reflective field notes were completed after the interview. Most interviews were completed in 30 min.

Open-ended questions were developed for the interview based on the research aim and previous studies of family-based interventions for a smoke-free home (Brown et al., 2015). These questions involved smoking behaviour in households, beliefs about the potential harms and benefits of smoking, and family and household beliefs and behaviours around smoking. Data collection was deemed completed when sufficient depth and richness of data offering new insights had been achieved (Braun and Clarke, 2013; Malterud et al., 2016).

Data analysis

Analysis of the data was undertaken using inductive thematic analysis (Braun and Clarke, 2006). This rigorous approach was used to identify, analyse and generate themes from the data. Interviews were transcribed by a professional transcribing service, and pseudonyms replaced the names to ensure anonymity in reporting. Transcripts were checked against audio recordings for accuracy by the first author. Rich, descriptive notes were developed and written for each

interview by the first author.

Process used to perform thematic analysis meets criteria for establishing trustworthiness and reflexivity in the research process (Nowell et al., 2017). For example, prolonged engagement with data took place by reading and re-reading the interview transcripts while listening to the recordings, helping to establish credibility. A systematic, inductive, reflexive and complete approach to coding was taken, with coding for as many items of interest to the research questions. The codes were further reviewed, collapsed and refined to generate categories and eventually themes. Analyst triangulation was undertaken during the development of codes, categories and themes, initially by the lead and last author, and finally by all authors (Patton, 1999). Field notes and rich, thick descriptive analysis of interviews encouraged reflexivity. The first author reflected on and made explicit her own background and history in relation to family smoking during analysis.

Findings

Eleven participants were interviewed, all of whom were mothers. The median age of mothers was 30 years with a median infant age of 10 months. Most were Caucasian and born in Australia (Table 1). Seven of the mothers were first-time parents. The mothers either smoked or lived with partners, friends and/or had close family members who smoked.

The following three themes emerged from analysis: transition to parenting before and after birth was a catalyst for change in smoking behaviour and attitude; maintaining rules and boundaries to protect the baby from smoking was a parenting challenge; and smoking was a coping strategy when faced with

Table 1. Participant characteristics.

Participant pseudonym	Age	Smoking status	Partner smoking status	Baby age
Jess	28	Smoking	NA	15 months
Natalie	36	Non-smoking	Smoking	7 months
Caitlin	19	Smoking	Smoking	10 months
Karen	28	Non-smoking	Smoking	7 months
Abila	32	Smoking	Smoking	17 months
Joanne	28	Non-smoking	Smoking	11 months
Gelda	29	Non-smoking	Smoking	7 months
Lisa	41	Non-smoking	Smoking	10 months
Marilyn	30	Non-smoking	Smoking	7 months

Serena	30	Non-smoking	Smoking	16 months
Lillian	42	Non-smoking	Smoking	11 months

parenting challenges. Where fathers' (or other family members) smoking-related be- haviours and beliefs are described in the data, this is as it was perceived by the mothers interviewed.

Parenting is a change catalyst for smoking behaviours

For the mothers and their partners, becoming a parent was an initial catalyst to reconsider smoking and take some action to reduce or cease this behaviour. Mothers' perceptions of smoking and its associated side effects on health, the stigma of smoking, social perceptions of the qualities of a good parent and aesthetics were in conflict with their own and others' perceptions of a quality family life and good parenting. The main driver for this was that smoking was seen as a potential risk to the baby's well-being. The mothers saw the baby as unable to protect themselves from the risks of smoking and were physically vulnerable, to the effects of cigarette smoke. For most, smoking was also perceived as a 'dirty' and unhygienic practice.

All mothers noted that the social act of forming a family unit was a milestone that caused them to pause and reflect on their and others' smoking, although this milestone varied as to whether it occurred – marriage, planning parenthood, during assisted reproductive treatment or during pregnancy. For the mothers that smoked and most fathers, such milestones initiated an attempt to quit smoking:

> *Which I stopped just after I got married. Um, before I fell pregnant, it's like this, "I'm giving up", and ...it was very easy for me. Very easy. I told myself, no you have done it. (Abila)*

Mothers were concerned for the long-term health of the child and themselves, and the potential impact of smoking on their perception of current and future family life during their pregnancy. When older family members developed smoking-related conditions, these premorbid events were directly attributed as powerful motivators for their own health and well-being and their need to be well for the sake of their baby and family. One mother described her smoking cessation success as motivated by an acute, severe exacerbation of asthma requiring admission to an intensive care unit during her pregnancy. Other mothers reported the experience of a relative's cancer diagnosis as a

motivation for a quit attempt, either by themselves or by their partner:

She looked like she'd aged ten years in a matter of hours… it played on my mind for a few months before I quit. Because I didn't want my kids, my grandkids to look at me like that when I was older. I don't want to have them go through the same situation. (Caitlin)

Protecting the child from harm and wanting good health for their own sake and the family's future were powerful motivators to avoid or quit smoking. The growing relationship between the parent and child and the bond a parent felt for a child acted as a strong disincentive to smoke, having a direct influence on smoking behaviour, or as a rationale used by mothers to encourage their partner to quit:

…. Because she will stand there, 'Da Da Daddy, Daddy" like she wants him and he's just standing [outside smoking] *and he goes quickly – sometimes he doesn't even finish it* [cigarette] *all up, because I've told you he's got that soft – and he comes back, crushes that* [cigarette] *to play with her" (Abila)*

In addition to the concern about the impact of smoking for their baby, themselves or other family members, the smell of smoke was a significant concern. For most of the mothers, the pervasive smell of smoking, either on themselves, their partners, in their home or on the baby was frequently raised, perceived as dirty and did not fit with their image of how parents or a family home should smell. Mothers were concerned that the baby may associate the smell of the tobacco smoke as part of their parents or other family members. In order to combat this, mothers described the need to be meticulous with their own and the baby's hygiene and to ask their smoking family members to wash their hands and change their clothes before handling the baby. The additional challenge of ridding the house and body of smoke was tiring and time-consuming. The pervasive and lingering quality of smoke meant that they were unable to keep the smell in check:

I had him [Baby] *screaming in the bathtub one day and he* [partner] *came in from having a cigarette and came into the bathtub to get him from me, so I couldn't get out of the bath unless someone took him. And he took him, and he stunk, absolutely reeked. And so I went into the bedroom and I started getting myself dressed. And when he gave* [Baby] *back to me, his* [Baby's] *clothes smelled. He just had a bath, and being dressed, and he smelled of cigarettes. And I just cried. (Lillian)*

When unable to adhere with smoking cessation or protect their child, the mothers described heightened feelings of shame and an awareness of the stigma of smoking. The perception was that the prevailing social mood was anti-smoking, and their perception that parents who smoked were likely to be judged more severely by others, particularly by other mothers. At the same time, smoking by other people around their own or other children evoked strong feelings of anger in some mothers. The sense of shame associated with smoking extended to seeking help:

> *It's even more embarrassing for a person from my generation to call up* [National Quitline] *and say, I need help, so I have a problem. (Caitlin)*

The idea of having to seek help to quit smoking was embarrassing for the mother, given that the wider public is so aware of the harm of smoking, and had been now for several decades.

Smoking is an additional parenting challenge

Babies and children were seen as vulnerable and helpless to protect themselves from smoking. Mothers attempted to reduce their children's exposure to smoke. While most had house rules about smoking at home prior to pregnancy, these rules were strengthened during pregnancy and following birth. No mothers permitted smoking inside of the home – all reported designated area outside of the house (and away from the baby) where smoking could take place.

> *Oh no, there's no smoking in the house because we're in a rental. And kids in the house and all the rest. And no smoking in cars. With the car seats, and not even if the kids aren't in the car, we still don't smoke….. If there's people out the back having a smoke. I make sure our bedroom windows are shut, because that's where a lot of the smoke goes in. (Jess)*

Even with clear rules in place about smoking at home, mothers were conscious that these may not be sufficient to prevent the child from exposure to smoke and began to negotiate additional rules for friends and family members who smoked. In some families, the rules were clearly established, supported and complied with, while for others, the limitations of these strategies were acknowledged.

Maintaining rules and boundaries regarding smoking required ongoing negotiation that could be challenging. For example, a mother with a new baby and another child with a chronic health problem explained her reasons to try

and reduce the risk to her children. As her partner is smoking, they had agreed on several strategies to reduce risk, including rules about smoking only outside and no smoking in the car. These rules were negotiated with her husband and were, from her perspective, a compromise:

> *He* [partner] *does do it* [smoking] *on the balcony, but I still smell it when he comes into the house. Then he's playing with* [child 1] - *in contact with my other son,* [child 2]*. I mean they're breathing in the passive smoke, which is not good, all the chemicals and everything like that... I'm not really happy with the balcony, but it's better than in the house, slightly …… (Natalie)*

Although negotiating these rules was uncomfortable, mothers persevered with these efforts. The mothers were acutely aware of the concept of third-hand smoke, and how challenging it was to avoid, due to its pervasive infiltration of hair, clothing and the environment. In this situation, the parents were conscious of the need for hygiene and handwashing, prior to handling the infant:

> *I'm worried about third-time smoke, so you know, when it's in, in your clothes and in your hair. And he smells it, it's like a risk for SIDS. (Gelda)*

One mother who previously had children removed due to concerns about child safety, perceived taking precautions to reduce the risk of smoking for her child as integral to keep custody of her current child. The mother reported having a specific garment to wear over her clothes when she went outside to smoke, but over time, when her children were older, these rules were relaxed.

In the context of their own fatigue and difficulties caring for their baby, mothers expressed some frustration at the relentless need to maintain house rules standards for themselves and others. Factors such as fatigue, loss of motivation and family views about the relative risk of smoking contributed to these difficulties in maintaining standards:

> *Sometimes I don't do it, sometimes, I'm just like, I can't be bothered.*
>
> *……. because we're stretched thin with little children, emotionally and physically. (Lisa)*

Smoking is a coping strategy when dealing with parenting challenges

Parents described smoking as a means to relax or take a break when faced with difficulties with their infant. As the participants were seeking help with parenting challenges, it is not surprising that they described several sources of stress in their current lives – factors that they perceived contributed to their current challenges coping with the transition to parenting, including the reasons for seeking help from the parenting service. Factors included assisted reproductive treatments, high demand employment responsibilities, managing a business, coping with blended families, having a child with a chronic condition, poverty and prior history of child removal. The mothers identified that smoking was a strategy used as a way to relax when overwhelmed with the difficulties of being a parent.

So, um, after I had [Baby]*, um, he'll say, "come have a cigarette with me, a glass of wine", because for the last seventeen months, it was so stressful, like, with* [Baby]*, she was so unsettled. (Abila)*

When fathers began smoking again, mothers were inclined to accept the status quo of their partners' smoking. Their current situation, struggling with a new baby, was perceived as a sig- nificant factor in their smoking relapse or the relapse of their partner. Until such time as the current stress had resolved, there was an acknowledgement that smoking cessation was unlikely to be achieved. Frequently, smoking as a form of relaxation was normalised within their social context.

And then also stress. It's a habit of how he releases stress. Which, you know, would be great if he could exercise, or ... But he says he's ... he doesn't have enough time cause of two children. But, either way, I think he's ... It's a just habit. He can't see how to make that time. When I say, "I can mind the kids. You go and do your cycling or something." But, it never happens. Because he's tired. (Lisa)

Smoking as a coping behaviour to manage stress or as part of the fabric of social interaction was seen to have been modelled within families, with the perceived end result that smoking was habituated within the context of family:

They (my parents) feel they're less stressed - however I think it's more of a habit because I pick up on things like that whenever my stepdad calls my mum when she's at home she'll go outside and have a cigarette….So every time she's on the phone, anytime that she is ranting about something to someone she'll have like 10 cigarettes within an hour. (Joanne)

In contrast, the ritual of taking time out to smoke was seen by some as excuse that smoking family members could use to have 'time out' from the baby. When this occurred, it was perceived as time lost to support of the mother and time for the family:

> *I think he actually used it as a reason not to go near him* [Baby]*, as well, because he's not really helpful with my baby. I think he used it as a reason, "I can't because I've just had a cigarette", "I can't go pick him up", "I can't go change his nappy". (Lisa)*

Discussion

Findings from this study provide the first in-depth description of the smoking-related perspectives of new parents experiencing parenting challenges and seeking help from early parenting services. Planning a family and becoming pregnant were key factors influencing parents' attitudes, beliefs and behaviours in their decision to quit or reduce smoking. Drivers for these actions were perceived risks to the health of the baby and mothers' perceptions of what constitutes good parenting practices. However, during early parenthood, smoking also provided a coping strategy that made abstinence difficult to maintain.

The stigma of smoking can act as a further burden for parents that can influence and moderate their attitudes, behaviour and beliefs (Grant et al., 2020) especially for those families already struggling with the parenting. For these parents, the stigma of smoking, maintaining rules and boundaries were additional parenting challenges for them, while they learnt to understand, care for and respond to their baby. While rules around smoking were strengthened, negotiating these rules was an additional responsibility that could be somewhat burdensome, depending on the beliefs and attitudes of their partners and extended family members (Robinson et al., 2011).

Fatigue as experienced by these mothers meant that at times the rules were relaxed, or smoking was seen as an aid to relaxation and relief of stress. For mothers with parents and partners who smoked, justification for their family members smoking was in part seen as a compromise, while they both dealt with the difficulties of parenting, and seemed to indicate a reluctance to challenge their partner or family members smoking at this time. Passey et al. (2016) reported that a lack of agency can act as a barrier to promoting a smoke free home. It is likely that mothers who are struggling with the early parenting challenges of feeding and sleeping have diminished agency. Negotiating

smoking for mothers struggling with parenting challenges may have reduced their own sense of agency to intervene or challenge their partner's smoking.

Experiencing difficulties with parenting is likely to be associated with lower parenting self- efficacy. Of the two early parenting services included in this study, only one has reported parenting self-efficacy, using a domain-specific parenting confidence measure (Khajehei and Lee, 2017). As might be expected, over three quarters of mothers seeking help from this service reported low parenting confidence (Khajehei and Lee, 2017). No statistically significant association was found between parenting confidence and maternal smoking, but as the number of mothers smoking in the published study was less than 10 (Khajehei and Lee, 2017), the study had limited power to detect significance. Dealing with sleep and feeding issues and possible lack of social support moderated by smoking partner and family members may mean that mothers have more 'work' to do to protect their child and advocate for their partner to stop smoking, and this may further deplete their parenting confidence. Referral of families to smoking cessation programmes may further help support families to promote a smoke-free home environment.

While parenting confidence is heightened with social support (Khajehei and Lee, 2017), a strong social network, where smoking is acceptable and prevalent may act as a reinforcement for smoking (Oh et al., 2010). These contrasting characteristics of families can be seen in cultural groups where smoking is considered a cultural norm. Smoking, as an act of social engagement and hospitality, may prevail over the risk to the health of others including children (Jackson et al., 2016; Jochelson et al., 2003). In such situations, it can be difficult for parents to challenge or persuade other family members to reduce or stop smoking.

Limitations

Although smoking-related perspectives of new parents seeking help from early parenting services have not previously been explored, the current study has some limitations. No fathers participated in this study despite being invited. This may be due to recruitment occurring during business hours of the service. Previous studies of residential parenting services have noted the focus on mothers as the primary caregiver (Berry et al., 2015; Matthey and Speyer, 2008). Fathers who smoke may have been unwilling to talk about their smoking behaviour, due to concerns about the stigma of smoking as a parent (Greaves et al., 2010).

Implications for practice

Findings from this study contribute to our understanding of mothers who have

parenting challenges as they seek to promote a smoke-free home environment for their children. Early childhood healthcare professionals should consider that promotion of smoke-free homes is still an important goal for parents seeking help with parenting, but that additional support is needed. This support includes a need to engage fathers, so that mothers do not bear a disproportionate burden for achieving a smoke-free home (Greaves, 2015). Given the high burden of responsibility as well as shame and guilt experienced by mothers, there is a need to consider a gendered-based approach to smoking cessation, particularly considering elements of intersectionality (Potter et al., 2020), where there is a cumulative manner in which the effects of discrimination combine or overlap. Con- sideration should also be given to intervening with fathers and potentially other extended family members, as well as mothers, in this setting. Focussing on gender norms may also be a useful target for future interventions (Bottorff et al., 2014). Interventions need to be tailored to the needs of individual families and their unique circumstances, including social and family norms around smoking that may be generational and gender-related. Early parenting services, such as residential units, where strengths-based and attachment approaches are already a feature of the model of care are well placed to leverage and support parents in their efforts.

Implications for research

The potential link between parenting self-efficacy and smoking warrants further exploration. For example, interventions that work on parenting self-efficacy and attachment may strengthen parents' resolve and strategies to address their smoking. Moreover, given the burden felt by mothers, there is a need for gendered-based research, particularly focussing on elements of intersectionality.

The study highlights the urgent need for further research that is inclusive of fathers. There is a risk that mothers feel further stigmatised and burdened if only they are charged with the responsibility for promoting a smoke-free home. While the study was able to reach and explore the perspectives of mothers, further research with fathers who smoke and are struggling with the challenges of par- enting in the early years of childhood is warranted. Furthermore, exploration of their specific needs and preferences for interventions for smoking cessation or risk management should be addressed.

Conclusion

Smoking and its inherent risks, including stigma, can be perceived as a further burden for new parents who are already struggling with parenting and often

facing social and economic challenges. Further investigation of the support and intervention needs of parents in the context of parenting services is warranted, to enable the development of individualised and tailored strategies that include alternative coping strategies as well as smoking cessation and reduction options. The study highlights the lack of research with fathers and the urgent need for further research that addresses gender-based norms.

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