

## **Midwives' Interactions with Women who Smoke in Pregnancy**

### **Abstract**

This paper presents the findings from a study examining midwives' interactions with women who smoke in pregnancy. The aim of this study was to find out how midwives currently interact with women who smoke in pregnancy, in relation to their health and well-being. The study used an Interpretive Interactionism design. There were two major findings. Firstly, there is incongruity between midwives' internal discourses and expressed discourses when working with women who smoke in pregnancy. Secondly, smoking cessation advice interactions typically do not involve a dialogue. Smoking cessation advice interactions are predictable, monotonous and non-productive. This type of interaction is best understood as a game with set rules and roles. Midwives need a woman-centred discourse from which to engage in an effective dialogue with women who smoke in pregnancy. Recommendations for practice and education are discussed.

### **Key Points**

- Current interventions and research around smoking cessation and pregnancy are not woman-centred and focus largely on health care workers asking women to stop smoking, with the fetus being the primary motivator.
- Inconsistencies exist between internal discourses and expressed discourses, most particularly between the woman-centred partnership philosophy and the practice of surveillance and ‘telling’ women not to smoke.
- Smoking cessation advice does not involve a dialogue.
- Smoking cessation interactions are based on a computer prompted or institutionally focused line of questioning.
- Midwives must be supported to engage in dialogue and provide woman-centred smoking cessation advice.

**Key Words:** Smoking Cessation, Pregnancy, Interactions, Woman-Midwife, Dialogue.

## **Introduction**

Smoking is associated with ill health for a woman and her baby during pregnancy and throughout the remainder of the lives of both parties (Lux, et al., 2000; McDermott, et al., 2002; Sondergaard, et al., 2001). Continued smoking during pregnancy is compellingly linked with a woman's socioeconomic status and level of education ( Colman & Joyce, 2003; Lindqvist & Åberg, 2001; Lu, Tong, & Oldenburg, 2001; Paterson, Neimanis, & Bain, 2003). Employment status, relationships and socialisation with other smokers and perceived lack of social support impact on smoking rates and quit efforts during pregnancy (Lindqvist & Åberg, 2001; Paterson, et al., 2003; Siahpush, 2004; Siahpush, Borland, & Scollo, 2003b).

The focus of research around women who continue to smoke in pregnancy has mainly centred on health professional interventions designed to cause the woman to quit, usually by pointing out the negative impact of smoking on the developing fetus (Haug, et al., 2000; Lumley, et al., 2004a; Secker-Walker & Vacek, 2003). Few smoking cessation programmes address the unique dynamics of cessation and relapse in the diverse sub-population of pregnant smokers (Devries & Greaves, 2004). This study examines the relationships between women and midwives so that the tensions between the midwives' efforts to improve the women's health through smoking cessation and the need to maintain a relationship throughout the childbearing experience can be considered.

### ***Aim of the Study***

The aim of this study was to find out how midwives currently interact with women who smoke in pregnancy, in relation to their health and well-being. The

research question presented was: *In relation to health and well-being, how do midwives interact with women who smoke in pregnancy?*

## **Review of Literature**

Smoking cessation interventions specific to pregnancy, and women's and midwives' views of smoking cessation strategies employed in pregnancy were the focus of the literature review. A search on smoking cessation in pregnancy was conducted through the Clinical Information Access Program (CIAP), CINHALL, MEDLINE, the Cochrane Library, and the Midwifery and Infant Care databases. The MIDIRS database and the SuperSearch database were also searched using the key search terms *smoking, cessation, midwifery* and *pregnancy*. Sub-headings accessed were; *complications, addiction, social disadvantage, poverty, health behaviour* and *gender*. Individual searches of midwifery and allied health journals were also performed for articles relevant to smoking cessation and pregnancy. Finally, the bibliographies of articles obtained were examined for further relevant articles, publications and books.

### ***Smoking Cessation Interventions Largely Ignore the Needs of Pregnant***

#### ***Smokers***

Interventions employed to date have focused on the current pregnancy with results fixed largely on fetal outcomes (Haug, et al., 2000; Secker-Walker & Vacek, 2003; Wisborg, et al., 1999). Attempting to have the woman change her smoking behaviour based on the effects on her fetus may be an ineffective strategy for two reasons. Firstly, knowledge of the dangers of tobacco exposure to others does not necessarily result in greater quit rates (Westmaas, Wild, & Ferrence, 2002). Secondly, most women know of the relationship between smoking and poor health outcomes for their babies (Pletsch, et al., 2003). Irwin, et

al. (2005) found women highly knowledgeable regarding tobacco use and the health risks to their infants.

Interventions which are aimed at changing a woman's smoking habits fail to address the poverty, stress and anxiety, low self-esteem and lack of control over life circumstances often experienced by the sub-group of smokers - women who continue to smoke in pregnancy (Abrahamsson & Ejlertsson, 2000; Pletsch et al., 2003). Current smoking cessation programmes largely neglect the link between stressors in women's lives and the self-medication facet of smoking. Devries and Greaves (2004) proposed that few smoking cessation programmes address the unique dynamics of cessation and relapse in the diverse sub-population of pregnant smokers.

Approaches aimed at changing the smoking behaviour of pregnant women are based on strategies employed for non-pregnant smokers. They are brief and delivered didactically (Pickett, Wakschlag, Lanting, & Bennett, 2003). The reasons why pregnant smokers, compared with non-pregnant smokers, access a health care provider is not considered. Pregnant smokers access health care facilities for pregnancy related issues – not smoking. Health care professionals utilise the visit as a teachable moment regarding smoking cessation (McBride, Emmons, & Lipkus, 2003). Pregnant smokers, accessing health care providers, may not be interested in quitting at the time, unlike non-pregnant smokers. This may account for the high relapse rates following birth (Lumley, Oliver, Chamberlain, & Oakley, 2004).

Current interventions do not address the altered physiological processes that occur during pregnancy. Hormonal adaptation during pregnancy is known to change women's taste preferences (Fraser & Cooper, 2003). Many women who quit

spontaneously during pregnancy experience an aversion to the taste and smell of tobacco when pregnant (Pletsch & Kratz, 2004). However, following birth normal taste and smell return quickly. This physiological occurrence coincides with the large number of women resuming smoking within three months after birthing.

Interventions are often based on health professionals' understanding of the risks or harmful effects of smoking and the dissemination of that information. However, smoking behaviour may not be just an issue of information dissemination. The psychological issues related to addictive conduct and behaviour change is more important (Ortendahl, 2006). Women's views of the concept of risk and/or the immediate and long-term harm to themselves, their fetus and family is rarely considered.

Despite smoking cessation interventions and standard smoking cessation advice increasing in intensity over the past two decades, quit rates have not improved concurrently and there are variations in the delivery of individual smoking cessation programmes (Lumley, et al., 2004). Lack of training in smoking cessation support is mentioned by workers as a reason why they are unable to influence smoking behaviour or increase quit rates (Aquilino, Goody, & Lowe, 2003). Although a systematic review by Lancaster, et al. (2000) found enhancing health professionals' knowledge on smoking cessation programmes does not improve smoking cessation rates. Health care providers also stated that competing pressures for time is a reason for poor intervention compliance. The high workloads and large number of staff involved is believed to be the reason interventions are not offered as designed (Walsh, et al., 2000).

### *Perceptions of Smoking Cessation Interventions*

Although women imply that smoking provides relief from their daily stressors, they feel embarrassed and self-loathing about their smoking behaviour (Irwin, et al., 2005). They feel constantly judged by others and guilty from the time their pregnancy is confirmed (Lendahls, Öhman, Liljestränd, & Håkansson, 2002; McCurry, Thompson, Parahoo, O'Doherty, & Doherty, 2002). Women have been found to feel shame at their own lack of motivation to abstain from smoking and disturbed by the anti-smoking warnings constantly thrust upon them while pregnant (Lendahls, et al., 2002).

Women report smoking is less harmful than the possible outcomes of not smoking. Smoking allows for a break from the stressful situations in which they live. Smoking is reported by women to be a means of ensuring their own mental health in the short-term, thereby benefiting their families (Irwin, et al., 2005; Pletsch et al., 2003). The health risks associated with smoking are considered distant in relation to the immediate gratification experienced with smoking (Graham, 1987). Women's perceptions of harm in relation to smoking and short-term health outcomes differ from health professionals' perceptions (Cameron & David, 2006). This view is supported in the work of Condliffe et al. (2005), who found 57% of midwives disagree with women's stance towards smoking as a means of coping.

Smoking cessation advice, according to women, should be introduced and sustained throughout the whole of their pregnancy and delivered by a person whom they respect and have formed a relationship (McCurry, et al., 2002). Midwives are in the ideal position to provide individualised smoking cessation support within the context of midwifery care. Midwives are viewed by women as

important people in their efforts to change their smoking behaviour; however inconsistencies in approaches and support among health care workers, including midwives, causes concern for women throughout their maternity care (Lendahls, et al., 2002). Some midwives nevertheless do not feel confident in their role as smoking cessation providers and are concerned that the woman-midwife relationship will be jeopardized if ongoing smoking cessation advice is provided (McLeod, et al., 2003).

## **Method**

The Constructivist (Interpretive) paradigm underpinned this study. The study design, Interpretive Interactionism, was applied to examine the interactions between midwives and women, identifying and evaluating strategic points within the interaction that are contained by the social situation, as defined by public policies (Denzin, 2001). The six steps in the interpretative process of Interpretive Interactionism are:

- Framing the research question;
- Deconstructing and critically analysing prior conceptions of the phenomenon, in other words reviewing the literature;
- Capturing multiple instances of the phenomenon situated within the natural setting, that is, collecting data;
- Bracketing the phenomenon and removing it from the natural setting to identify and cluster key factors;
- Reconstructing the identified key factors, and constructing a model which demonstrates and explains the interaction under investigation; and

- Contextualizing the phenomenon, resituating the model within the context of contemporary practice, and making recommendations to change practice for the better (Denzin, 2001).

### ***Ethical Approval***

Ethical approval was granted in June, 2006 from the University of Newcastle, Human Research Ethics Committee, Australia (H-232-0606) and the Gosford Hospital, Human Research Ethics Committee, New South Wales (NSW), Australia (06/27). Informed consent was obtained from each midwife upon recruitment to the study.

### ***Selection of Participants***

Gosford Maternity Unit, in the state of New South Wales, Australia, was chosen as the study site because it has a greater-than-state number of women identifying as smokers during pregnancy (Clark, 2005). The midwives identified as potential participants worked within a Community Midwife programme, allowing a degree of continuity of care. Eight midwives were recruited into the study, and all had a minimum of six years' experience as a community midwife.

Midwives were requested to disseminate the information statements and expression of interest forms to all women who met the inclusion criteria whereby they were: greater than 18 years of age or considered to be an independent minor; eligible for a midwifery model of care; self-identified as a smoker or recent smoker (within the last six months); between 16 and 28 weeks gestation; and recipients of a health care card.

It was thought that each participating midwife would be better suited to recruit the woman for whom they would provide care. It was intended that eight midwife-woman dyads were to be recruited, to examine the relationship between midwives

and pregnant women. However, no women were recruited within a six-month period. This finding is not dissimilar to other researchers, who have demonstrated that recruitment and retention of persons from disadvantaged or minority groups and/or smokers are less likely to participate in research (Chiang, Keatinge, & Williams, 2001; Diviak, Curry, Emery, & Mermelstein, 2004; Kaiser & Hays, 2006; McCormick, Crawford, Anderson, & Gittelsohn, 1999; Parry, Bancroft, Gnich, & Amos, 2001). A decision was, therefore, made to continue the study with the midwives only. One midwife could not be contacted after the first interview. Data presented in the findings is, therefore, derived from the seven participating midwives' recounts of interactions with women who smoke in pregnancy.

### ***Data Collection***

The collection of data involved capturing the discourse or moment/s of smoking cessation support provided by the midwife within the woman-midwife relationship. Two in-depth interviews lasting approximately 50 minutes between individual midwives and the researcher (L.E.) were scheduled upon recruitment to the study. Midwives were provided with an interview guide so they were aware of the content of the interview. This allowed the midwife to reflect on a specific interaction prior to the interview. All interviews were audio recorded with permission of the midwives. Understandings were validated throughout the interview process in accordance with responsive interviewing techniques (Rubin & Rubin, 2005).

### ***Data Analysis***

Data analysis specifically involved bracketing the phenomenon, reducing it to its essential elements and removing it from the natural setting to uncover the

essential features, and reconstructing the essential pieces and elements of the phenomenon (Denzin, 2001). Individually recorded interviews, obtained from midwives, were transcribed as a whole. The text from individual transcripts was subdivided into key units - anti-smoking advice, and thoughts on health and well-being.

## **Findings**

There were two major findings from this study. Firstly, there was incongruity between midwives' internal discourses and expressed discourses when working with women who smoke in pregnancy, as later identified. The second major finding was that smoking cessation advice interactions did not involve a dialogue. Smoking cessation advice interactions were predictable, monotonous and non-productive; this type of interaction is best understood as a game with set rules and roles. Figure 1. presents a model of 'least effective smoking cessation interaction'.

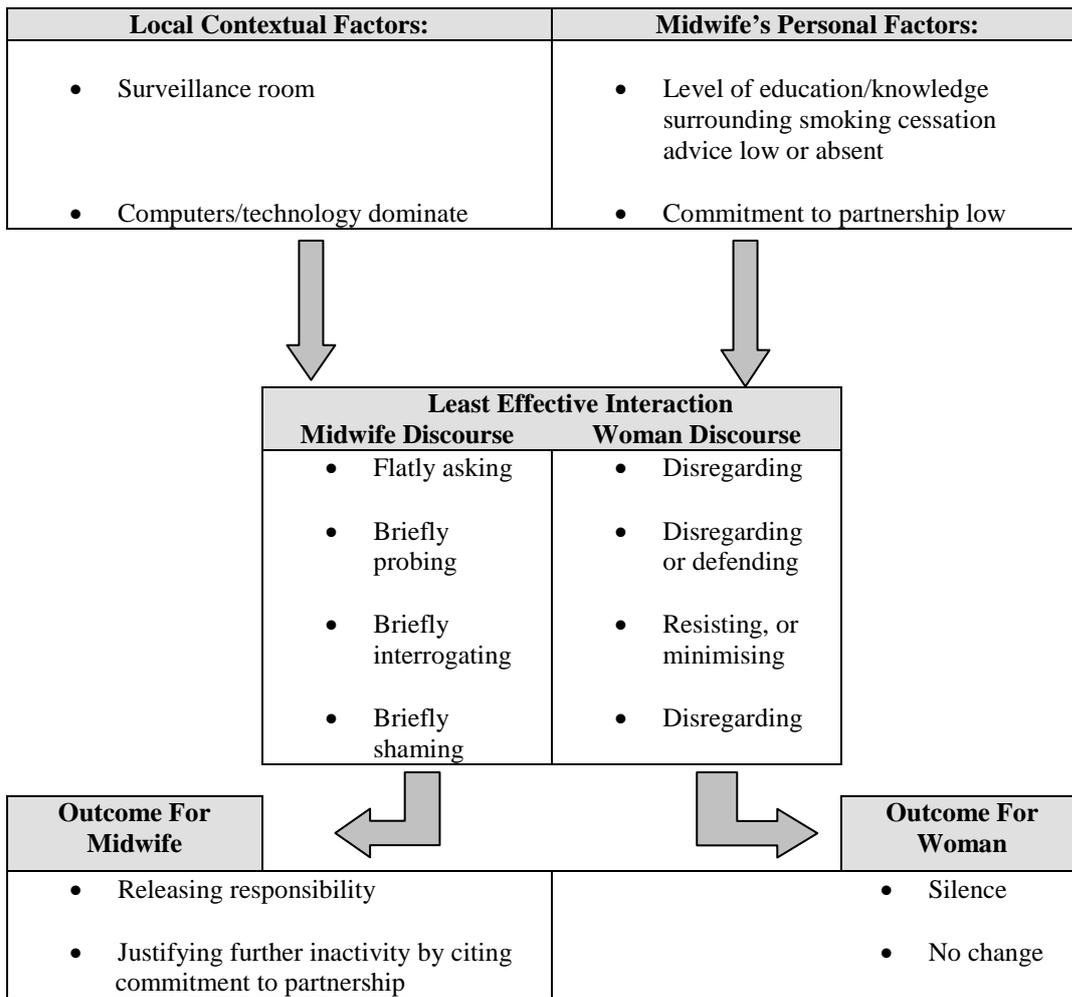


Figure 1. Least effective smoking cessation interaction model

### *Incongruity between Internal Discourses and Expressed Discourses*

Midwives reported their role as facilitating choice and empowering women through partnership and effective communicative relationships (Leap, 2000). This internal discourse was evident within the first interviews with midwives expressing high commitment to the philosophical underpinnings of the Midwifery Partnership model of care (Guilliland & Pairman, 1995).

*I think it's definitely a partnership, it's about sharing knowledge.*

[Midwife 1]

*Definitely it's a partnership, we're there for the mums.* [Midwife 2]

*I think developing a relationship with women is really important.*

[Midwife 3]

Despite the focus of midwifery being 'with woman' and woman-centred, verbal communication styles differ according to location and organisation of care (McCourt, 2006). Midwives working within organisational premises, under the direct supervision of their employer, follow a professional 'client-health care worker' model of communication (ibid). The midwife initiates, controls and concludes the conversation. The client listens, asks appropriate questions and provides relevant information upon request. Verbal communication reflects a task-orientated approach, using language aligned with the corporate body.

This model of woman-midwife interaction was evident during the second interviews. Midwives were asked to provide an example of an interaction in which they supported a woman who smoked. The recounted examples demonstrate a task-orientated, institutionalised approach.

*One of the questions in our booking-in database asked specifically 'Do you smoke?' and if it is a 'Yes', then there are more questions that go on from that and if it is a 'No', then that's it. [Midwife 1]*

*Because we've actually got it on the screen and it says you know, 'Do you smoke? [Midwife 2]*

*Because it is on the database, I just asked her if she was smoking.*

[Midwife 4]

### ***Smoking Cessation Advice Interactions Do Not Involve a Dialogue***

The recounted midwife-woman interactions showed no evidence of appropriately contextualised and individualised smoking cessation dialogue. Midwives asked closed ended questions, such as, 'do you smoke?' prompted by a computer programme. Advice regarding the benefits of quitting was absent within the recounted interactions.

The midwives in this study demonstrated strategic communication patterns accomplishing institutional or personal ends rather than meeting the individual woman's needs. The midwives practised under medical authority and institutional dominance. Contextual factors, surveillance and technology dominated the study environment. Midwives working under these conditions are often termed 'system workers' as their primary relationship is with the organisation or employer and experience discordance when their workplace culture varies from personal or professional ethics. Midwives in this study demonstrated incongruence in their internal discourses or expressed values regarding the woman-midwife relationship and their expressed discourses or clinical practice.

## **Discussion**

Denzin (2001, p. 139) defined an interaction as “symbolically taking the perspective of another and acting on that perspective” (p.139). Midwives are, therefore, required to assume the perspective of the woman who continues to smoke in pregnancy, and build a relationship with that consciousness. This level of awareness was largely absent during the recounted woman-midwife interactions.

Byrd (2006) proposed that relationships are able to persist with trust and attachment developing as long as people fulfil perceived obligations of behaviour and communication. Relationships, however, differ in terms of their functions, timing and frequency of interactions. Within interactions recounted by midwives, relationships develop with a trust that the topic of smoking in pregnancy does not advance any further than required by the institution. The midwife’s role is to follow the standard procedure as dictated by the computer programme, using an impersonal, task-orientated process. The midwife completes her duty, providing information, entering the data required by the organisation and maintaining a relationship with the woman. When the midwife sticks to her designated role of organisational data collector the woman can easily participate in the game.

The woman’s role is to allow the midwife to collect sufficient data to ‘do her job’, to maintain her side of the relationship by answering brief, impersonal questions upon request, and to not question the authoritative powers regarding her personal needs. The organisational ritual of smoking cessation advice, absent of appropriately contextualised and individualised interactions, allows women to disregard impersonalised information provided by health care workers, in this case the midwives.

The environment within which the woman-midwife interaction occurs is created out of policies and procedures dictated by Federal, State and local authorities. Women and midwives enter into a unique relationship and yet are bound by a set of socially constructed rules and perspectives about behaviours expected and accepted throughout their partnership. They initiate and play the game 'Doing My Job'. Both parties require certain patterns of behaviour for the partnership to be deemed successful (Callan, Gallois, Noller, & Kashima, 1991). In co-operation the woman and midwife follow the game plan. Midwives undertake the role of 'just doing my job' while the woman reciprocates with the 'I'm quietly disregarding you' role until the game ends when the baby is born and the partnership is completed.

### ***Limitations of the Study***

Only after failure to recruit women was it considered that power relationships might already be in existence between women who smoke in pregnancy and the midwives with whom they attempt to form relationships. Asking midwives to recruit women for whom they are providing care now appears to be injudicious.

### ***Recommendations for Practice***

It is recommended that a Clinical Midwife Consultant - Smoking Cessation be appointed to individual Area Health Services. Midwives should work in partnership with the woman and in collaboration with the Clinical Midwife Consultant – Smoking Cessation. The focus of smoking cessation support and dialogue would be on the woman's needs, with the woman central to the decision-making process. Women who identify as recent abstainers or current smokers should have a choice in the level of support and the provider/s of support. Women should have the option of discussing their smoking and cessation efforts with their

midwife only, with the Clinical Midwife Consultant - Smoking Cessation only, or obtaining advice and support from both the midwife and Clinical Midwife Consultant - Smoking Cessation.

A woman-centred approach to smoking cessation support, in line with the philosophical underpinnings of the Midwifery Partnership model of care (Guilliland & Pairman, 1995), requires less institutional and technological dependence on the part of the midwife. Interactions should occur outside the hospital environment and without a computer being the initiator, prompter and terminator of discourse.

### ***Recommendations for Education***

Midwives fail to effectively interact with women because they express a lack of self-confidence in their ability to converse with women about sensitive issues such as smoking (Aquilino, et al., 2003; Condliffe, et al., 2005). Smoking cessation strategies, discourse and practice must be part of the core educational requirements of student midwives (WHO, 2001). It is recommended that all midwifery programmes include matter relevant to smoking during pregnancy within their curriculum. Health facilities should provide mandatory education during orientation with ongoing education throughout the professional life of the midwife. This should increase the midwives' confidence and knowledge in supporting women who smoke in pregnancy.

### **Conclusion**

A Midwifery Partnership model of care (Guilliland & Pairman, 1995) has the potential to provide support and build relationships with women who commence pregnancy as a smoker. Smoking during pregnancy must be addressed from a

broader socio-political context, with women central to the process. The recommendations made in this article will assist in improving outcomes, coordinating efforts, and standardising practice in relation to smoking cessation support for pregnant women. Forming partnerships with women, and working collaboratively with them to offer appropriate support, will improve women's health. Improving the health of women will inevitably have a positive effect on the health of their babies and families.

## References

- Abrahamsson, A., & Ejlertsson, G. (2000). Smoking patterns during pregnancy: Differences in socioeconomic and health-related variables  
10.1093/eurpub/10.3.208. *Eur J Public Health*, 10(3), 208-213.
- Aquilino, M., Goody, C., & Lowe, J. (2003). WIC Providers' Perspectives on Offering Smoking Cessation Interventions. [Article]. *MCN, American Journal of Maternal Child Nursing*, 28(5), 326-332.
- Byrd, M. (2006). Social Exchange as a Framework for Client-Nurse Interaction During Public Health Nursing Maternal-Child Visits. *Public Health Nursing*, 23(3), 271-276.
- Callan, V., Gallois, C., Noller, P., & Kashima, Y. (1991). *Social Psychology* (2nd ed.). Sydney: Harcourt Brace Jovanovich.
- Cameron, J., & David, E. (2006). Risk Perception and Analysis in Australia. In A. Symon (Ed.), *Risk and choice in MATernity Care An international perspective* (pp. 123-137). Edinburgh: Churchill Livingstone Elsevier.
- Chiang, V. C., Keatinge, D., & Williams, A. K. (2001). Challenges of recruiting a vulnerable population in a grounded theory study. *Nursing & Health Sciences*, 3(4), 205-211.
- Clark, R. (2005). Data Collection records: Wyong Maternity Unit Birthing & Smoking Statistics [Data Collection records]. Wyong.
- Colman, G. J., & Joyce, T. (2003). Trends in smoking before, during, and after pregnancy in ten states. *American Journal of Preventive Medicine*, 24(1), 29-35.
- Condliffe, L., McEwen, A., & West, R. (2005). The attitude of maternity staff to, and smoking cessation interventions with, childbearing women in London. *Midwifery*, 21(3), 233-240.
- Denzin, N. (2001). *Interpretive Interactionism* (2nd ed. Vol. 16). Thousand Oaks: Sage.
- Devries, K., & Greaves, L. (2004). Smoking Cessation for Pregnant Women: Current Canadian Programs and Future Development. *Canadian Journal of Public Health*, 95(4), 278.
- Diviak, K. R., Curry, S. J., Emery, S. L., & Mermelstein, R. J. (2004). Human Participants Challenges in Youth Tobacco Cessation Research: Researchers Perspectives. [Article]. *Ethics & Behavior*  
*Ethics & Behavior* 11 - *Ethics & Behavior*, 14(4), 321-334.
- Fraser, D., & Cooper, M. (2003). *Myles Textbook for Midwives* (14th ed.). Edinburgh.: Churchill Livingstone.

- Graham, H. (1987). Women's smoking and family health. *Social Science and Health*, 25(1), 47-56.
- Guilliland, K., & Pairman, S. (1995). *The Midwifery partnership: A Model for Practice*.
- Haug, K., Irgens, L., Skjaerven, R., Markestad, T., Baste, V., & Schreuder, P. (2000). Maternal smoking and birthweight: effect modification of period, maternal age and paternal smoking. [Article]. *Acta Obstetrica et Gynecologica Scandinavica*, 79(6), 485-489.
- Irwin, L., Johnson, J., & Bottorff, J. (2005). Mothers Who Smoke: Confessions and Justifications. *Health Care for Women International*, 26(7), 577-590.
- Kaiser, M. M., & Hays, B. J. (2006). Recruiting and Enrolling Pregnant Adolescents for Research. [Article]. *Issues in Comprehensive Pediatric Nursing*  
*Issues in Comprehensive Pediatric Nursing J1 - Issues in Comprehensive Pediatric Nursing*, 29(1), 45-52.
- Lancaster, T., Silagy, C., & Fowler, G. (2000). Training Health Professional in Smoking Cessation. [Cochrane Review]. *Cochrane Library Issue 2*, 2004(Issue 2).
- Leap, N. (2000). Journey to midwifery through feminism: a personal account. In M. Stewart (Ed.), *Pregnancy Birth & Maternity Care* (pp. 185 -201). Edinburgh: Books for Midwives.
- Lendahls, L., Öhman, L., Liljestrand, J., & Håkansson, A. (2002). Women's experiences of smoking during and after pregnancy as ascertained two to three years after birth. *Midwifery*, 18(3), 214-222.
- Lindqvist, R., & Åberg, H. (2001). Who stops smoking during pregnancy? [Article]. *Acta Obstetrica et Gynecologica Scandinavica*, 80(2), 137.
- Lu, Y., Tong, S., & Oldenburg, B. (2001). Determinants of smoking and cessation during and after pregnancy. *Health Promotion International*., 16(4), 355-365.
- Lumley, J., Oliver, S., Chamberlain, C., & Oakley, L. (2004). Interventions for promoting smoking cessation during pregnancy. *Cochrane Database of Systematic Reviews*(4), Art. No.: CD001055. DOI: 001010.001002/14651858.CD14001055.pub14651852.
- Lumley, J., Oliver, S., & Waters, E. (2004a). Interventions for promoting smoking cessation during pregnancy. *Cochrane Library Issue 2*, 2004(2).
- Lux, A., Henderson, A., & Pocock, S. (2000). Wheeze associated with prenatal tobacco smoke exposure: a prospective, longitudinal study. ALSPAC Study Team. *Archives of Disease in Childhood [NLM - MEDLINE]*, 83(4), 307.

- McBride, C., Emmons, K., & Lipkus, I. (2003). Understanding the potential of teachable moments: the case of smoking cessation. *Health Education Research.*, 18(2), 156-170.
- McCormick, L., Crawford, M., Anderson, R., & Gittelsohn, J. (1999). Recruiting adolescents into qualitative tobacco research studies: Experiences and lessons learned. *The Journal of School Health*, 69(3), 95-100.
- McCourt, C. (2006). Supporting choice and control? Communication and interaction between midwives and women at the antenatal booking visit. *Social Science & Medicine*, 62(6), 1307-1318.
- McCurry, N., Thompson, K., Parahoo, K., O'Doherty, E., & Doherty, A. (2002). Pregnant women's perception of the implementation of smoking cessation advice. *Health Education Journal*, 61(1), 20-31.
- McDermott, L., Russell, A., & Dobson, A. (2002). *Cigarette smoking among women in Australia*. Canberra.
- McLeod, D., Benn, C., Pullon, S., Viccars, A., White, S., Cookson, T., et al. (2003). The midwife's role in facilitating smoking behaviour change during pregnancy. *Midwifery*, 19(4), 285-297.
- Ortendahl, M. (2006). Smoking as a decision among pregnant and non-pregnant women. *Addictive Behaviors*, 31(10), 1806-1819.
- Parry, O., Bancroft, A., Gnich, W., & Amos, A. (2001). Nobody home? Issues of respondent recruitment in areas of deprivation. [Article]. *Critical Public Health*  
*Critical Public Health 11 - Critical Public Health*, 11(4), 305-317.
- Paterson, J., Neimanis, I., & Bain, E. (2003). Stopping smoking during pregnancy. *Canadian Journal of Public Health*, 94(4), 297.
- Pickett, K., Wakschlag, L., Lanting, D., & Bennett, L. (2003). Fluctuations of Maternal Smoking During Pregnancy. [Article]. *Obstetrics & Gynecology*, 101(1), 140-147.
- Pletsch, P., Morgan, S., & Pieper, A. (2003). Context and Beliefs About Smoking and Smoking Cessation. [Article]. *MCN, American Journal of Maternal Child Nursing*, 28(5), 320-325.
- Pletsch, P. K., & Kratz, A. T. (2004). Why do women stop smoking during pregnancy? Cigarettes taste and smell bad. [Article]. *Health Care for Women International*, 25(7), 671-679.
- Rubin, H., & Rubin, I. (2005). *Qualitative Interviewing The Art of Hearing Data* (2nd Edn ed.). Thousand Oaks: Sage Publications.
- Secker-Walker, R., & Vacek, P. (2003). Relationships between cigarette smoking during pregnancy, gestational age, maternal weight gain, and infant birthweight. *Addictive Behaviors*, 28(1), 55-66.

- Siahpush, M. (2004). Why is lone-motherhood so strongly associated with smoking? *Australian & New Zealand Journal of Public Health*, 28(1), 37-42.
- Siahpush, M., Borland, R., & Scollo, M. (2003b). Factors associated with smoking cessation in a national sample of Australians. *Nicotine & Tobacco Research*, 5(4), 597-602.
- Sondergaard, M., Henriksen, T., Obel, C., & Wisborg, K. (2001). Smoking during pregnancy and infantile colic. *Pediatrics*, 108(2), 342-346.
- Walsh, R., Redman, S., Byrne, J., Melmeth, A., & Brinsmead, M. (2000). Process measures in an antenatal smoking cessation trial: another part of the picture. *Health Education Research*, 15(4), 469-483.
- Westmaas, J., Wild, T., & Ferrence, R. (2002). Effects of gender in social control of smoking cessation. *Health Psychology*, 21(4), 368-376.
- WHO (2001). *WHO Evidenced Based Recommendations on the Treatment of Tobacco Dependence*. Europe.
- Wisborg, K., Henriksen, T., Obel, C., Skajaa, E., & Ostergaard, J. (1999). Smoking During Pregnancy and Hospitalization of the Child. *Pediatrics*, 104(4), 46-.