“Put that out I can hear your baby coughing”: Exploring the stigma associated with women’s smoking during pregnancy

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BA (Hons)

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Abstract

Despite comprehensive tobacco control policies in Australia, smoking during pregnancy is still relatively common. Women who continue to smoke during pregnancy report significant guilt, shame, and embarrassment for smoking in the face of widespread messages about the risks to the developing foetus of smoking. Located within critical health psychology and working within a social constructionist framework, this thesis examines the social meanings attached to smoking and addresses their incompatibility with dominant constructions of motherhood, specifically, what it means to be a good mother. The aims of the thesis are twofold: to (1) explore experiences and perceptions of smoking during pregnancy in the Australian context (2) examine the ways in which the presumed stigma attached to smoking during pregnancy is discursively negotiated by both members of the public and women who engage in this practice. This thesis is based on three interconnected projects: 13 semi-structured, short interviews with women who smoked during their recent pregnancies (Study 1); a survey with 626 university students (Study 2); and an online survey with 47 women who smoked during their recent pregnancies (Study 3).

Chapter 1 outlines the theoretical framework that underpins this thesis, namely, critical health psychology and social constructionism. This is followed by a discussion of the relevance of reflexivity and a summary of the methodologies of the studies that make up the thesis. Chapter 2 provides a review of the literature relevant to the empirical chapters of this thesis. It covers the tobacco denormalisation movement and the stigmatisation of smokers, particularly in the Australian context, and critiques the limited consideration of gender and the need for a feminist perspective. It then discusses the ways in which the foetus remains a central part of tobacco control campaigns targeting women during pregnancy and the literature examining women’s smoking during pregnancy. Outlining the problems related to a foetal-centred approach to women’s smoking, this chapter explores how the good mother discourse contributes to the stigmatisation of women who smoke during pregnancy.

Relevant to the first aim of this thesis, Chapter 3 presents a thematic analysis of 11 interviews with women who smoked during their recent pregnancies (Study 1, excluding the two pilot interviews). It examines women’s experiences and constructions of stigma, with a particular focus on the material consequences of stigma. Building on these findings, Chapter 4 examines the extent to which university students expressed negative views towards women who smoke during pregnancy, drawing on quantitative data provided by 595 university students (Study 2, excluding 31 participants due to high levels of missing data). Together these chapters point to the need to explore alternative, more supportive, approaches to promoting smoking cessation during pregnancy.

Reflecting on this ‘evidence’ of stigma concerning women who smoke during pregnancy, Chapter 5 considers the role of the research design in university students’ views (Study 2). It
questions the extent to which this ‘evidence’ of stigma (namely, negative text responses provided by university students) was co-created by the research context. This chapter reflects a shift in the methodological approach to data analysis and also the explicitly social constructionist ontology of this thesis.

As a result of this reorientation, Chapters 6 and 7 examine the ways in which the presumed stigma attached to smoking during pregnancy is discursively negotiated by women who smoke during pregnancy. Chapter 6 analyses interview data from Study 1 (excluding the email interview) and focuses on how women accounted for their smoking and their identities in the context of a biomedical discourse, which constructs smoking during pregnancy as undoubtedly harmful to the foetus. Chapter 7 draws on three sources of data to examine the available ways for women who smoke during pregnancy to represent themselves: 13 interviews from Study 1; survey data from Study 3; and a media article written by an Australian television and radio host who smoked during pregnancy. This chapter highlights the lack of positive identities offered by anti-smoking and good mother discourses, and how the combination of these discourses works to discursively silence these women’s experiences and render them untellable.

In closing, Chapter 8 brings together the empirical, methodological, theoretical and practical contributions of this thesis. This chapter revisits the material and discursive perspectives I have taken in exploring stigma, and how this uniquely impacts women who smoke during pregnancy, to offer a feminist voice in the debate regarding the ethics and effectiveness of stigmatising smokers. Further, I consider future empirical and theoretical directions for work in this area, and discuss the role of reflexivity in shaping the dissemination of this work.
Declaration by author

This thesis is composed of my original work, and contains no material previously published or written by another person except where due reference has been made in the text. I have clearly stated the contribution by others to jointly-authored works that I have included in my thesis.

I have clearly stated the contribution of others to my thesis as a whole, including statistical assistance, survey design, data analysis, significant technical procedures, professional editorial advice, and any other original research work used or reported in my thesis. The content of my thesis is the result of work I have carried out since the commencement of my research higher degree candidature and does not include a substantial part of work that has been submitted to qualify for the award of any other degree or diploma in any university or other tertiary institution. I have clearly stated which parts of my thesis, if any, have been submitted to qualify for another award.

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Contributions by others to the thesis

Contribution was made by Professor Christina Lee to Chapters 3, 4 and 5, as outlined above. Professor Christina Lee also contributed to the overall design of this program of work, the revisions of Chapters 1 and 2, and revisions of Chapters 3, 4 and 5 in preparation for publication. Dr Ingrid Rowlands contributed to the final revisions of Chapters 1-8. Alexandra Gibson contributed to the data analysis (specifically, coding) presented in Chapter 3. The concept behind Chapter 5 emerged from theoretical discussions with Alexandra Gibson and Claire Moran. Professor Michelle Lafrance contributed to Chapters 6 and 7, as outlined above. Professor Michelle Lafrance also contributed to revising these two chapters in preparation for publication. Paul Jackson designed the website for Study 3, which forms part of data set for Chapter 7. BubHub Pregnancy Forum were instrumental in advertising for Studies 1 and 3, which forms part of the data presented in Chapters 3, 6 and 7.

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Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title Page</td>
<td>i</td>
</tr>
<tr>
<td>Abstract</td>
<td>ii</td>
</tr>
<tr>
<td>Declaration by Author</td>
<td>iv</td>
</tr>
<tr>
<td>Publications during Candidature</td>
<td>v</td>
</tr>
<tr>
<td>Publications Included in this Thesis</td>
<td>vi</td>
</tr>
<tr>
<td>Contributions by Others in this Thesis</td>
<td>ix</td>
</tr>
<tr>
<td>Statement of Parts of the Thesis Submitted to Qualify for the Award of another Degree</td>
<td>ix</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>x</td>
</tr>
<tr>
<td>Keywords</td>
<td>xi</td>
</tr>
<tr>
<td>Australian and New Zealand Standard Research Classifications (ANZSRC)</td>
<td>xi</td>
</tr>
<tr>
<td>Fields of Research (FoR) Classification</td>
<td>xi</td>
</tr>
<tr>
<td>Table of Contents</td>
<td>xii</td>
</tr>
<tr>
<td>List of Figures</td>
<td>xv</td>
</tr>
<tr>
<td>List of Tables</td>
<td>xvi</td>
</tr>
</tbody>
</table>

Chapter 1. Theoretical framework..........................................................1

Perspectives in health psychology..........................................................1
  Mainstream health psychology.................................................................1
  Critical health psychology.........................................................................2
Social constructionism..................................................................................5
Stigma as a social construct..........................................................................9
Reflexivity......................................................................................................13
Structure of the thesis....................................................................................15

Chapter 2. Good mothers do not smoke: The role of gendered discourses in stigmatising women’s smoking during pregnancy.................................21

Tobacco denormalisation and stigma ...........................................................21
  The Australian context.................................................................................23
  What about class, gender and ethnicity?...................................................24
The relevance of a feminist perspective in tobacco control..........................25
A feminist perspective in tobacco control: Still a minority?........................29
Appendix B2..............................................................................................................172
Appendix B3.............................................................................................................194
Appendix C1..............................................................................................................216
Appendix C2..............................................................................................................217
Appendix C3..............................................................................................................222
Appendix D..................................................................................................................228
List of Figures

Chapter 3

Figure 1. Visual representation of themes.................................................................47
List of Tables

Chapter 3
Table 1. Demographics of sample........................................................................................................45

Chapter 4
Table 1. Semantic differential responses: comparisons between smoking and non-smoking
conditions (N = 595)..........................................................................................................................67
Table 2. Semantic differential responses: six out of 12 items showed an interaction between
smoking and pregnancy conditions (N = 595)................................................................................69
Table 3. Semantic differential responses: seven out of 12 items showed an interaction between
smoking and elaboration conditions (N = 595). ...............................................................................70
Table 4. Semantic differential responses: two out of 12 items that showed an interaction between
elaboration and pregnancy conditions (N = 595)...........................................................................70
Chapter 1: Theoretical framework

This thesis investigates the stigma assumed to be associated with smoking during pregnancy and with women who partake in this practice. The thesis aims to explore experiences, perceptions and discursive negotiations of smoking during pregnancy amongst a sample of Australian women (who smoked during pregnancy) and to explore a related set of experiences, perceptions and discursive negotiations amongst a sample of university students considering their own views about (other) women who smoked during pregnancy. Located within critical health psychology and working within a social constructionist framework, the thesis examines the social meanings attached to smoking and addresses their incompatibility with dominant constructions of motherhood, specifically what it means to be a good mother.

Using both quantitative and qualitative methods, I explore the stigmatisation of women who smoke during pregnancy and the consequences of this presumed stigma. I also address the experiences of women who smoke during pregnancy, exploring the meanings and identities available to them in representing themselves and their smoking. Thus, the aims of the thesis are twofold: to (1) explore experiences and perceptions of smoking during pregnancy in the Australian context (2) examine the ways in which the presumed stigma attached to smoking during pregnancy is discursively negotiated by both members of the public and women who engage in this practice.

In this chapter, I outline the theoretical perspectives which have shaped my PhD work, namely, critical health psychology, social constructionism and the conceptualisation of stigma. This will be followed by a discussion of reflexivity and a summary of the studies that make up this thesis.

Perspectives in health psychology

In this section, I discuss the emergence and nature of mainstream health psychology, and, in doing so, address some of the main critiques that critical health psychologists (and other critical scholars) have with the theory, methods and assumptions of (positivist) mainstream health psychology. This is followed by an introduction to critical health psychology.

Mainstream health psychology.

Mainstream health psychology emerged in the 1970s in reaction to the dominance of biomedicine, characterised as a biological, reductionist approach to the study of disease (Crossley, 2001). Mainstream health psychology (Hepworth, 2006) operates largely within a positivist ontology, and within what has been termed a discourse of scientific progress (Crossley, 2008). Positivism is based on the assumption that knowledge can be observed,
quantified, or derived mathematically from observations (Murray & Poland, 2006). When
mainstream health psychology operates within a positivist ontology the focus is often on
predicting, controlling, and changing individual behaviour (Stephens, 2008).

During its emergence, health psychology was heavily influenced by the
biopsychosocial model proposed by Engel (1977). At the time, the biopsychosocial model
was a highly influential critique of biomedicine because it offered a framework in which
knowledge about the biological, psychological and social factors could be incorporated to
understand individual health and illness. The biopsychosocial model relies on the
quantification of psychological and social constructs (e.g., individual beliefs or perceptions)
in a way that appears to make these factors comparable to biological factors (Crossley, 2001).
As a result, mainstream health psychologists celebrated the emergence of the biopsychosocial
model as a framework that prioritised psychological and social factors (Crossley, 2001),
allowing these variables to gain recognition within biomedical circles (Yardley, 1997).
However, critical scholars have expressed concerns regarding the taken-for-granted nature of
the biopsychosocial model within mainstream health psychology (e.g., Marks, 2002; Stam,
2000). These concerns focus on how this model, together with biomedicine, serves to
objectify and depersonalise health and illness by relying on quantitative methods that remove
the contextual, ambiguous and complex nature of people’s experiences (Crossley, 2001;
Crossley, 2008).

Mainstream health psychology has also relied heavily on social cognitive models
(Stephens, 2008), which focus on individual cognitions (e.g., attitudes towards smoking) in
efforts to explain health behaviour. Despite three decades of research, social cognitive
theories, which have been applied extensively in mainstream health psychology, “have not
been very successful at either predicting behaviour or changing it” (Lyons & Chamberlain,
2006, p. 82), and there have been recent debates about the practical usefulness and formal
validity of these theories even within mainstream health psychology (e.g., Sniehotta,

Critical health psychology.

Critical health psychology emerged in the 1990s in response to mainstream health
psychology (Hepworth, 2006). As a field, critical health psychology interrogates the
institutions and social structures that facilitate the production of power and knowledge.
Alongside other constructionist disciplines in the social sciences, critical health psychology
takes issue with the quantification of individual health and illness and health psychology’s
uncritical acceptance of models that serve to situate health at the level of the individual,
devoid of social context or cultural meaning. On this note, Marks (2008) has argued that in order for meaningful theoretical change to occur in health psychology there needs to be a shift from “the study of what is (description) to the study of what might be (explanation), from what individuals do and say (behaviour) to what that behaviour means (contextuality), from ‘social cognitions’ (box ticks) to personal subjectivities (mental experience), from the status quo (demographics) to social injustice (structures of power and inequality)” (p. 980). Part of this shift involves a more thorough investigation of the complex interactions between socio-economic, cultural, and political circumstances that account for individual health, an investigation that existing health psychology models cannot support.

Critical health psychologists, Horrocks and Johnson (2014), have argued that mainstream health psychology has considered health behaviour as an easily identifiable and unitary construct that is largely unaffected by (and therefore unrelated to) people’s social context – hence the practice of controlling experimentally or statistically for contextual factors such as education and gender in quantitative research. Taking up a similar position, the feminist psychologists Fine and Gordon (1989) argued that focusing on ‘gender differences’ at an individual level, produced through quantitative assessment and analysis, diverts attention from questions of power, context, meaning and subjectivity. Instead, such analyses serve to normalise and reify the “aspects of ‘personal’ experience which are ideologically constructed and born of inequality” (p. 152).

A critical health psychologist, Crossley (2008), has argued that “the assumption that experiences of health and illness are amenable to quantitative measurement, experimental manipulation and statistical analysis, may simply be wrong. Such attempts often result in simplistic, frequently banal representations of human experience which, in reality, are replete with complexity and ambiguity” (p. 25). Similar points have been made by feminist sociologists (e.g., Cook & Fonow, 1986; Leckenby & Hesse-Biber, 2007), who note the pitfalls of relying exclusively on quantitative methods, pointing to how such methods overlook the value of women’s subjective accounts and because of this may reproduce oppressive and narrow representations of women and their experiences.

While the reliance on quantitative methods is clearly an issue that requires careful consideration, using exclusively qualitative methods is not necessarily a complete answer. Some critical health psychologists have raised concern that a reliance on qualitative methods, with the assumption that they will be a guaranteed escape from mainstream health psychology approaches, is not a solution in itself (Stam, 2000), and that it is important that qualitative inquiry is guided by theory in order to move beyond descriptive analyses and
engage critically and reflexively with the topic at hand (Chamberlain, 2000). Similar discussions have been held within feminist research (DeVault, 1996), in that much attention has been directed to the quantitative-qualitative divide, including the misleading assumption that the use of qualitative methods means the research is necessarily feminist, when, in fact, quantitative methods can sometimes be better placed to make women’s experiences ‘visible’.

Critical health psychology is part of a broader movement towards a critical psychology, an approach that draws extensively on postmodern theories, in line with other disciplines such as sociology and anthropology, in an effort to challenge the persistence of a positivist ontology in psychology and provide more socially informed theory (Murray & Poland, 2006; Stam, 2000). Postmodernism rests on the assumption that one “cannot discover ‘objective facts’ because there are no such facts – no timeless, naturally occurring psychological phenomena (such as presumed ‘attitudes’ and ‘beliefs’) – to be ‘discovered’” (Stainton Rogers, 1996, p. 70). Rather, the emphasis is on foregrounding the socially constructed nature of reality and hence the knowledge systems (e.g., discourses) by and through which our realities are constituted (Stainton Rogers, 1996).

Postmodernism, then, rejects the notion that the world can be fully understood in relation to grand theories or what are termed metanarratives, emphasising instead that we live in a society where there are multiple self-contained knowledge systems available to us, which we can “dip in and out of as we please” in our efforts to make meaning of our experiences and selves (Burr, 2003, p. 12). Therefore, and in line with the values of a critical psychology, critical health psychology analyses the values and assumptions of a society in order to better understand the social and political nature of health and illness (Marks, 2002).

The prominence of biomedicine is of particular interest to critical psychologists who are interested in issues of power and knowledge. In response to the dominance of biomedicine, a critical psychologist might ask, how does biomedicine have the power to construct, disseminate and legitimate knowledge, for what purpose, and to whose detriment? In the context of smoking during pregnancy, biomedicine wields power over the construction of smoking as unquestionably risky and unhealthy for the developing foetus (Oakley, 1989). The reproduction of this discourse takes place through public health campaigns which rely on foetal imagery and government health warnings to deter pregnant women from smoking (Oaks, 2001). In this thesis, women’s negotiations of a biomedical discourse which positions smoking during pregnancy as not only harmful but also immoral are examined (Chapter 6), along with the relevance of this discourse in women’s constructions of stigma (Chapter 3).
From a critical psychology perspective, examining power is central to understanding the social determinants of health and illness (Hepworth, 2006; Prilleltensky & Prilleltensky, 2003). By focussing on power, critical health psychologists can work to re-locate health and illness within the social, cultural, political and economic context (Lyons & Chamberlain, 2006). This allows attention to be paid to external factors that constrain individuals’ capacity to experience health and well-being or to behave in accordance with recommendations (such as abstaining from smoking during pregnancy).

With reference to smoking during pregnancy, the mainstream approach to public health interventions has been to focus solely on women’s smoking cessation (e.g., Ingall & Cropley, 2010) and to accept as a moral imperative the position that all women can and should make a free and independent decision to stop smoking during pregnancy. An important aspect of this thesis, which will be covered in more detail in the next chapter, is that it contributes to an alternative literature grounded in the social sciences that seeks to re-position smoking as a contextualised, gendered and political topic in need of a feminist lens (Greaves et al., 2003; Greaves & Jategaonkar, 2006). The details of this feminist lens will be explicated in Chapter 2 of this thesis.

Therefore, in line with critical health psychology, and acknowledging the often more fully developed theories and approaches of other disciplines (e.g., sociology and anthropology), in this thesis I seek to explore the social meanings attached to smoking during pregnancy in order to create research that is relevant, effective and empowering (Prilleltensky & Prilleltensky, 2003). By situating smoking within the broader social context, researchers are able to develop strategies for social change, which usefully connect the individual with her social world and avoid individualising and de-politicising her health. Such an approach is consistent with a social constructionist framework of health.

**Social Constructionism**

In this thesis, I take a feminist perspective on women’s smoking to address the issues of gender and stigma, and draw on a social constructionist framework to acknowledge that tobacco use is situated within a broader social and political context. From a social constructionist perspective, individual experience is historically, culturally and linguistically mediated (Willig, 2008). Our ways of understanding the world and ourselves within it are cultural products sustained through social processes such as language (Burr, 2003; Parker, 1992). In line with postmodernism, social constructionism takes a critical stance towards taken-for-granted knowledge, considering all knowledges and ways of understanding as
constructed (Burr, 2003). Such an ontological perspective rejects the pursuit of a single truth, whether in experience, reality or knowledge, instead seeking plurality of meaning.

Berger and Luckman (1967) were some of the earliest, and most influential, writers on the social construction of reality. Situated within the discipline of sociology, their text sought to orient that discipline to the social processes behind the construction of ‘knowledge’ and how it comes to be socially understood (and taken for granted) as ‘reality’. Berger and Luckman offered a conceptualisation of reality that bridged the objective and subjective, the biological and the cultural, to highlight the ongoing dialectical process that occurs between an individual and society: “to be in society is to participate in its dialectic” (p. 149). Their redefinition of the sociology of knowledge inspired many other disciplines in the social sciences (including critical psychology) to take up distinctly constructionist perspectives and to engage with the historical and philosophical nature of knowledge.

A social constructionist approach implies that individuals construct and understand their experiences and identities by making use of available social meanings. These reflect a particular socio-cultural context, whereby the meanings ascribed to a practice, such as smoking, are largely shaped by the broader social context (Burr, 2003). Consequently, this thesis focuses not on the experience of smoking during pregnancy, but rather on how women construct their experiences and identities within a socio-cultural context that prioritises biomedical and gendered discourses that discourage smoking during pregnancy.

A social constructionist approach acknowledges that there may be many available ways of understanding and articulating a particular event, phenomenon or experience (Willig, 2008). These ways of understanding and articulating, however, are embedded in discourses, broad socially accepted understandings about the world, which in turn are shaped by, and themselves shape, power relations. Although I take a social constructionist perspective, I attend to the material realities of women’s lives in combination with focus on the patterns, function and effects of women’s talk (see the combination of a material and discursive perspective in Chapters 6 and 7). This perspective allows consideration of a material reality outside of discourse and texts (Burr, 2003).

Discourses shape and limit the available ways of representing one’s experiences and identities. Parker (1992) has defined discourses as culturally recognisable sets of statements, metaphors, understandings or meanings attached to a particular event or experience. For instance, in the context of this thesis, the good mother discourse calls for a particular approach to mothering, one that is child-centred (Hays, 1996). This discourse provides women with a well-recognised and legitimate framework from which to talk themselves and
their experiences of motherhood into being. A social constructionist approach acknowledges that the construction of identities (such as the good mother) and the negotiation of discourses are inherently contextual and transient (Willig, 2000). Discourses, then, are connected with the ways in which society is socially, politically and economically governed; dominant discourses reflect and reproduce the interests of privileged and powerful groups in society (Burr, 2003; Parker, 1997).

In this sense, discourses serve purposes of social control. However, their power is largely invisible. As Foucault (1977) argued, power is not recognised as social control; it tends to operate not through force but instead through knowledge (e.g., discourse), and is evident in the ways in which individuals internalise certain knowledge systems. Accordingly, power is produced and reproduced through discourse, in that discourses promote certain ways of living or behaving that are intimately tied to institutional social structures (Burr, 2003; Foucault, 1977).

From a critical health psychology perspective, it is essential to trace how discourses function from a top-down perspective, producing a political and cultural climate in which individuals negotiate their experiences of health and illness. Equally important is understanding the bottom-up processes of self-surveillance, as well as understanding bottom-up resistance: how individuals resist and reconstruct broader cultural discourse to better represent and reflect their experiences, identities and individual context. The internationalisation of certain knowledge systems and the effects of these systems for individual subjectivity is a particular interest to critical scholars invested in understanding the operation of systems and the privileging of certain knowledges.

For example, practices of self-surveillance, from Foucault’s (1977) perspective, are seen as disciplinary forms of power that operate through the internalisation of discourses. To give an example of relevance to this thesis, Sawicki (1999) applied Foucault’s concept of disciplinary power to the topic of women’s bodies, attending to the subtle and intimate ways in which knowledge systems are internalised by individuals, not through any form of coercion or violence, but rather through the inherently constitutive and productive nature of power.

Sawicki (1999) applied the concept of the external (male) ‘gaze’ to examining the role of reproductive technologies (e.g., ultrasounds, foetal monitors and antenatal tests) in the surveillance and control of women’s bodies and their identities as mothers. In particular, she suggested that reproductive technologies can be understood as disciplinary technologies that serve to produce new objects and subjects of knowledge, normalise monitoring and
surveillance, and ultimately serve to control the (female) body by making it more useful, powerful and docile. These technologies, according to Sawicki, have enabled the creation of new subject groups of women and of mothers. By identifying specific problems that are constructed as residing within specific individuals, these technologies have enabled the identification of ‘problem women’: women who are infertile; women who are surrogates; biologically unfit mothers; psychologically unfit mothers; and neglectful mothers who avoid prenatal genetic testing. These technologies garner their power by creating “new norms of motherhood by attaching women to the identities of mothers, and by offering women specific kinds of solutions to the problems they face” (p. 194).

Using a social constructionist framework allows power to be foregrounded in understanding why certain practices, identities and knowledge systems are privileged over others. For instance, in the context of biomedical discourse, which is asserted as the one ‘true’ and acceptable explanation for health and illness (Stephens, 2008), top-down surveillance and bottom-up self-surveillance appear to reinforce each other in the view that smoking during pregnancy is self-evidently a sign of ‘badness’ (see Chapter 2 for a review of literature) and any alternative accounts or explanations for smoking during pregnancy are simply dismissed as foolish or misguided. Understanding how women legitimise their accounts of smoking during pregnancy in the face of biomedical discourse will be discussed in this thesis (Chapter 6).

Taking a social constructionist approach, I am interested in the ways in which dominant discourses shape women’s experiences of smoking during pregnancy. In the context of health, the discourse of neoliberalism is particularly salient (Crawford, 2006). In particular, neoliberalism rests on assumptions of individual responsibility, self-management and risk awareness, suggesting that all individuals can and should take responsibility for the effective management of their health. Neoliberal discourse saturates public health messages, which emphasise individual lifestyle and risk factors as indicators of one’s position as a healthy citizen (Bell, Salmon, & McNaughton, 2011; Petersen & Lupton, 1996). The morally charged pursuit of ‘good’ health in Western societies is based on middle-class values regarding what constitutes (and who defines) ‘healthy’ and ‘unhealthy’ behaviour and how healthiness should be practised (e.g., through self-surveillance and individual behaviour change) (Skrabaneck, 1994), as well as on the unexamined assumption that health should be prioritised over any other aspect of one’s life.

Recently, critical health psychologists have demonstrated how mainstream health psychology works alongside neoliberal discourse by approaching individual behaviour
through the same ontology of personhood (Horrocks & Johnson, 2014). That is, individuals are positioned as rational decision-makers who, with the ‘right’ cognitions, will make ‘healthy,’ and therefore correct and morally defensible, decisions. Critical scholars have interrogated widely accepted dichotomies such as ‘healthy’ versus ‘unhealthy’, by offering a critique of the moral and political undertones of these seemingly objective categories (Crawford, 1980; Skrabanek, 1994; Stephens, 2008). The highlighting of underlying discourses such as neoliberalism is one example of how critical health psychologists seek to raise awareness of the underlying political context and socially constructed nature of the ‘science’ of psychology.

In taking a social constructionist approach, I argue that the mainstream health psychology approach of locating behaviour within an individual cognitive framework fails to capture the specific (and sometimes transient) meanings attached to health and the ways in which these reflect a political and moral agenda. This thesis focuses specifically on the ways in which stigma may serve to control and oppress women who fail to act in accordance with the gendered scripts (sometimes referred to as “pregnancy rules”: Oaks, 2001, p. 19) that define good (pregnant) mothers. In what follows, I provide a broad contextualisation of the concept of stigma, before I explore the social and political context surrounding smoking, stigma and motherhood in Chapter 2.

**Stigma as a social construct**

Stigma, as originally articulated by Goffman (1963), arises when an individual bears an attribute or ‘mark’ of social disgrace or difference. This has the effect of positioning the individual as tainted or spoiled, an object of social devaluation and deviance. According to Goffman, there are three different types of stigma. First, stigma may refer to an abomination of the body, which can include various physical deformities such as blindness. Second, stigma may arise from blemishes of individual character, which Goffman described as perceptions of “weak will, domineering or unnatural passions, treacherous and rigid beliefs, and dishonesty, these being inferred from a known record of, for example, mental disorder, imprisonment, addiction, alcoholism, homosexuality, unemployment, suicidal attempts, and radical political behaviour” (p. 4). Last, stigma may result from tribal identities, which include racial, national, or religious associations. Of the three main types of stigma, Goffman argued that those signifying blemishes of character are seen to be more socially debilitating because they have connotations of individual responsibility.

Goffman emphasised the socially constructed nature of stigma: it is not inherent in an individual but is produced through social interactions (for instance, with non-stigmatised or
‘normal’ people). Therefore, depending on the visibility of an individual’s discrediting characteristic, he or she may be able to pass as ‘normal’ by concealing information about this characteristic in interactions with others. This allows a person temporarily to avoid prejudice or discrimination that would result from the disclosure (or knowledge) of his or her discrediting characteristic.

Goffman’s work has been taken up extensively in the social sciences to investigate topics such as HIV/AIDS, mental illness, disability, addiction, sexuality, disease, and more recently smoking. However, the ways in which the concept of stigma has been applied has varied substantially, and as a result there is much debate over the use of the term, including its definition and broad application (Campbell & Deacon, 2006; Parker & Aggleton, 2003; Weiss & Ramakrishna 2006). In addition, Goffman’s work has been criticised for lacking a discussion of more profound questions surrounding the origin and nature of stigma (e.g., Hannem & Bruckert, 2012) and a consideration of the broader context in which stigmatisation occurs (e.g., Campbell & Deacon, 2006; Kleinman & Hall-Clifford, 2009; Parker & Aggleton, 2003).

In response to the extensive uptake of the concept of stigma in the social sciences, particularly within psychology, Link and Phelan (2001) proposed a return to studying stigma from a distinctly sociological perspective. In doing so, Link and Phelan (2001) reviewed critiques of Goffman’s (1963) definition, which addressed perceptions of it as both too vague and too individually focussed. They put forward a renewed sociological conceptualisation that could be applied across disciplines to contemporary social and health problems. Specifically, they argued that five components need to co-occur in order for stigma to be identified: distinguishing and labelling differences; associating differences with negative attributes; separating ‘us’ from ‘them’; status loss and discrimination; and the dependence of stigma on power. This re-conceptualisation sought to move the study of stigma away from the individual and his or her cognitions (as is typical in mainstream psychology) to highlight the broader social processes that perpetuate the production of stigma.

In what follows, I discuss three examples of writing on the topic of stigma. All of these examples share a postmodern perspective and illustrate the importance of moving away from individualist analyses to incorporate the role of broader social processes (as per Link & Phelan’s (2001) framework). While some these authors have coined their own terms to describe the links between stigma and inequalities, my point here is to highlight the ways in which scholars from various disciplines have approached stigma as a product of complex social processes linked to broader macro-inequalities.
Link and Phelan’s (2001) criticisms of the conceptualisation of stigma were shared by Parker and Aggleton (2003) in their writing on the topic of HIV/AIDS stigma. Parker and Aggleton (2003) argued that research and intervention on the topic of HIV/AIDS and the associated stigma has lacked any significant development, in part as a result of inadequate conceptualisation and theorisation of the concept of stigma. Parker and Aggleton observed that many researchers drawing on Goffman’s definition of stigma had produced individualist analyses in which stigma was mapped onto people who were understood to possess undesirable (and static) characteristics or differences. Such an approach is not consistent with a social-constructionist conception of stigma as a function of dynamic social processes, best understood in relation to broader Foucauldian concepts of domination and power. In Parker and Aggleton’s view, stigma, stigmatisation and discrimination are structured by broader social, cultural, political and economic forces that serve to maintain social order and social inequalities. Therefore, analysing stigma as a ‘thing’ that individuals impose on other individuals disguises the inherently political nature of stigma, and the ways in which stigma is socially and culturally constituted.

A similar argument has been put forward regarding abortion-related stigma. In particular, Kumar, Hessini and Mitchell (2009) argued that stigma in this area has been poorly theorised, relying on positivist assumptions that abortion stigma exists universally, and is often devoid of any cultural reference. The authors drew on cross-cultural and geographically diverse literature to demonstrate that abortion stigma is a social phenomenon, constructed and reproduced through local pathways of knowledge and practices which position women who seek to terminate pregnancy as ‘inferior’ women. Applying Link and Phelan’s (2001) framework, they argued that the root causes of abortion stigma were complex, but resulted largely from systems that disallow women equal access to power and resources, and that maintain the hegemony of narrow gender roles in an effort to control female sexuality. Again drawing on Foucault (1973), they argued that these ideological power struggles are shaped by larger medical, economic and political forces. The authors conceptualised abortion stigma as a “compound stigma” (p. 634) produced by existing forms of discrimination and structural inequalities.

Similarly aware of the need to examine power and discrimination within the broader context, Hannem and Bruckert (2012) turned to Foucault’s work to discuss the influence of cultural and institutional forces in the production of stigma. Building on commonalities in Goffman’s and Foucault’s work (specifically, the rejection of concepts of objective truth), the authors argued that Foucault’s interest in the institutions and practices that serve to
marginalise or ‘other’ individuals may provide a structural lens to complement Goffman’s study of stigma at an interactional level. They proposed the concept of “structural stigma” (p. 5) to describe a situation in which stigmatic assumptions embed themselves into social policies and practices. They argued that, in contemporary society, this often occurs under the guise of ‘risk management’, in that risk language is used both to stigmatise a group of people and to frame them as ‘dangerous’ or ‘risky’ and hence requiring increased surveillance and intervention to manage them.

Building on this multidisciplinary work, in which stigma is understood in distinctly postmodern terms as a social construct which relies on, and is expressed through, culturally available meanings, I approach stigma in this thesis as a product of complex social processes (such as discourses) linked to broader macro-inequalities (Campbell & Deacon, 2006). Stigma, then, is produced and reproduced through language and in interactions. I conceptualise stigma in postmodern terms as an expression of negative views, perceptions or stereotypes towards women who smoke during pregnancy – these terms are used interchangeably to refer to the expression of statements that position women who smoke during pregnancy negatively (see Chapters 3, 4 and 5). These expressions of stigma play a central role in reproducing power relations. In particular, consistent with Foucault’s (1977) work on systems of knowledge and power, in this thesis I approach the production of stigma and stigmatisation to involve the marking of difference among categories of people, complicit with the constitution of social order (Parker & Aggleton, 2003). Terms such as compound stigma (Kumar et al., 2009) or structural stigma (Hannem & Bruckert, 2012) orient to the explicit and implicit ways in which stigma has been linked with broader forms of injustice and inequalities. This perspective on stigma clearly departs from individualist or cognitive explanations that would suggest that stigma resides within a person, and rather seeks to explore the knowledge systems through which stigma is reproduced and social control is exercised.

In Chapter 2, I explore the social and political context surrounding both smoking and motherhood and, in doing so, make the contributions of my thesis explicit. In this chapter, I argue that motherhood as a system, or an institution of knowledge, serves to stigmatise women who fail to comply with its ideology. However, before doing so, a critical perspective means that it is pertinent that my position as the researcher is made transparent, including my own values and interests and their role in shaping how I have undertaken my PhD work.
Reflexivity

There is strong agreement among critical health psychologists (Chamberlain, 2000; Lee, 2006; Murray & Poland, 2006) and feminist scholars across disciplines (Cook & Fonow, 1986; DeVault, 1996; Gringeri, Wahab & Anderson-Nathe, 2010) that it is just as important to critique one’s own social location (class, ethnicity, gender) as it is that of others. Reflexivity must occupy a central place in the development and practice of critical health psychology research and practice (Bolam & Chamberlain, 2003). This involves questioning the aims, values, assumptions, power relations and theoretical positions of the research and the researchers. In addition, it means considering whose interests are being met, who benefits from research and research outputs, and how participants are being considered during different stages of the research.

Willig (2008) described two types of reflexivity: personal reflexivity and epistemological reflexivity. Personal reflexivity involves “reflecting upon the ways in which our own values, experiences, interests, beliefs, political commitments, wider aims in life and social identities have shaped the research” (p. 10). Willig described epistemological reflexivity as questioning how the research is defined and limited: the roles of study design and method of analysis in co-producing the data and findings, and how the same research question could be investigated differently. Both types of reflexivity are important to this thesis, as to all critical psychology research.

Personally, I enrolled in a PhD with an interest in how people make sense of occupying mutually contradictory social positions, or engaging in mutually contradictory behaviour. Having never been pregnant or smoked cigarettes, my interest in smoking during pregnancy was largely reflective of my assumption that there was a contradiction associated with smoking during pregnancy, and my further assumption that this contradiction might produce stigma. Accordingly, my interest was not stigma per se, as a theoretical construct, but rather the sources, explanations, and justifications of the presumed social phenomenon of stigma concerning women who smoke during pregnancy.

As a young, white, educated, heterosexual, able-bodied and cisgendered woman, I started this project having to question the basis of my own anti-smoking views. Having a mother who has smoked on and off during my life (including through my pregnancy) and living in a country where anti-smoking views are widely accepted meant that negotiating my own views (and those of people who are important to me) about smoking was an ongoing task while conducting this research. This negotiation was particularly relevant in responding to others’ largely negative and judgemental responses to smoking during pregnancy, a
position I attempted to resist in the communication of the research, but a position I felt that others (including pregnancy forum moderators and medical centres whom I approached to recruit for my research) uncritically accepted. I assume that this lack of empathy or shared understanding of the rationale of my projects came from the fact that my research was not directly focussed on smoking cessation during pregnancy, and because I took a somewhat sympathetic approach to these women. As a result, I felt that I needed to balance a position that was neither pro- nor anti-smoking in absolute terms on a topic that is so often polarised. In the process of communicating and writing about this topic I found this task was made easier by focussing on the ethics of stigmatising women who smoke during pregnancy, and on the practical question of whether this stigmatisation actually made it harder for those women to stop smoking.

Starting this project as an outsider to women’s experiences of smoking during pregnancy was a clear challenge in conducting this research in an ethical and sensitive manner. Accordingly, the decision to begin my PhD by interviewing women who smoked during their recent pregnancies (Study 1) was an important step in understanding their perspectives and challenging my own views. The extent to which women’s interviews were saturated with moral language (e.g., descriptions of shame, embarrassment, hiding and secrecy) prompted a level of feminist solidarity that set the tone for a more political exploration of stigmatising women who smoke during pregnancy. Reading in the area of women’s smoking (including the work of Greaves, 1996, and Oakley, 1989) guided my own reflexive journey and served to remind me of the importance of a political agenda on the topic.

The reflexive discussions present throughout my thesis are consistent with the feminist perspective I adopt in my work. In particular, feminist researchers “position themselves, through political perspective within the research process, engaging and interacting with their epistemological perspective, the methodologies employed, and the methods at hand” (Leckenby & Hesse-Biber, 2007, p. 277). For instance, epistemological reflexivity played an important role in the later chapters of my thesis. In Chapter 5, I discuss the ways in which epistemological reflexivity became a central tool through which I developed a particular ontological position to inform my work. In that chapter, I discuss the importance of reflexivity in my decision to use discourse analytic approaches within an explicitly social constructionist framework. Chapter 5 reflects a deliberate ontological shift in my approach to research and analysis and therefore is presented as the joining piece between the earlier (Chapters 3-4) and the later parts of this thesis (Chapters 6-7).
Throughout this thesis, I attempt to demonstrate how attention to epistemological 
reflexivity has not only helped me define my theoretical and methodological approach, but 
also guided research-related decisions and dissemination (Chapter 8). In particular, the 
politics of representing smoking during pregnancy and women who engage in this practice 
was an ongoing responsibility for me as the researcher. In Chapter 8, I discuss how my 
dissemination strategies and ongoing negotiations regarding the representation of this topic 
and these women evolved over my PhD.

**Structure of the thesis**

My thesis is based on two main research themes: (1) exploring experiences and 
perceptions of smoking during pregnancy in the Australian context, and (2) examining the 
ways in which the presumed stigma attached to smoking during pregnancy is discursively 
negotiated by both members of the public and women who engage in this practice. Chapter 2 
provides a review of the literature that informed my thinking throughout the thesis. 
Specifically, it covers debates regarding tobacco denormalisation and the stigmatisation of 
smokers, and critiques the limited consideration of gender and the need for a feminist 
approach to studying women’s smoking. It then provides a discussion of the centrality of the 
foetus in anti-smoking efforts directed towards women who smoke during pregnancy, and 
shows the implications of such an approach. Finally, Chapter 2 considers how women who 
smoke during pregnancy may face increased stigma for their failure to adhere to social 
constructions of what it means to be a good mother, thus returning to the importance of a 
gendered perspective in examining smoking-related stigma. Together, these discussions 
provide a platform on which to situate the subsequent chapters of my PhD.

The rest of the thesis is based on three separate but interconnected projects. All three 
projects received ethical clearance from The School of Psychology (at The University of 
Queensland, St Lucia).

Study 1 involved 13 semi-structured, short interviews with women who smoked 
during their recent pregnancies. The aim of these interviews was to gain an understanding of 
women’s experiences of smoking during pregnancy, specifically whether, and in what ways, 
they experienced and responded to stigma. Two pilot interviews were conducted face-to-face 
with women whom I knew personally, with the aim of checking the appropriateness of the 
questions. This was followed by 11 interviews (10 via telephone, one via email) with women 
who were recruited from a range of online and offline channels, between April and August 
2011. Interviewing continued until I and my primary advisor decided that no new information 
was emerging from the interviews. On average, each interview lasted between 10 and 20
minutes in length, with the email interview taking place over three consecutive days. Interviews were semi-structured: all started with a general question about the interviewee’s experience of smoking during pregnancy; included follow-up questions around times and places of smoking, and others’ responses to their smoking; and ended with a question about their intentions to smoke during any future pregnancy. All interviews were anonymised and transcribed verbatim. (See Appendix A for study materials).

Study 2 was an online survey of a convenience sample of 626 university students, focusing on their views of women who smoke during pregnancy and using both quantitative and qualitative methods. The quantitative component used a three-way between-participants design. A hypothetical vignette was manipulated to explore participants’ perceptions of stigma towards a mother based on her smoking status (smoker, non-smoker), pregnancy status (pregnant, non-pregnant), and level of individuating information (simple, elaborated). The aim of this experimental manipulation was to explore whether reported stigma towards the target woman in the vignette was affected by any or a combination of these factors. Particularly, the interest was in the inclusion of individuating information and whether there was potential to reduce stigma by providing contextual information (elaborated condition) about the woman’s smoking, in order to underpin the development of public health strategies for promoting cessation in non-stigmatising ways.

The remainder of the survey included Likert scale items and open-ended questions exploring participants’ views of women who smoke during pregnancy. This included, for instance, personal reactions to smoking during pregnancy, views of the harms of smoking during pregnancy, and whether they would confront a woman who was smoking during pregnancy.

Originally the survey was designed exclusively to examine students’ views towards mothers who smoke during pregnancy (Appendix B2). However, we subsequently included the same survey with questions (and vignettes) examining students’ views towards mothers who smoke when not pregnant (Appendix B3). This latter survey allowed us to distinguish experimental effects between a pregnant and a non-pregnant smoking mother (See Appendix B for study materials).

Study 3 was an online survey with 47 women who had smoked during their recent pregnancies. The aim of this survey was to explore women’s experiences of seeking information and support about smoking during pregnancy in both online (pregnancy forums) and offline contexts. Advertising for this study took place online via prominent Australian online pregnancy forums, and participant responses were accepted between March 2013 and
March 2014. The survey consisted of open-ended questions related to whether (and why) women went online for information and support regarding their smoking during pregnancy, whether (and why) women disclosed to others online and offline about their smoking during pregnancy, and more generally how their experiences of support and interactions about smoking during pregnancy online compare with offline (See Appendix C for study materials).

Survey responses to the open-ended questions varied according to length, ranging from a sentence to a paragraph. The nature of this survey meant that women’s responses were often very specific to the question being asked – this could explain why some women provided responses only a sentence long. Although there are mixed views on the utility of qualitative analysis of open-ended survey questions (e.g., Garcia, Evans & Redshaw, 2004), many have posited that data should be judged according to the significance and quality of the interpretation, rather than according to the specific details of data collection (Beckett & Clegg; Peel, 2012; Rich, Chojenta & Loxton, 2013).

Orienting women to particular and often very sensitive topics in the course of this survey allowed me the opportunity to examine women’s perspectives on a range of issues relating to support (or lack of) in the context of smoking during pregnancy. Because of this sensitivity, my view is that the medium in which these data were collected was particularly important. An online survey offered women maximum anonymity and privacy from which to respond to these questions. The extent of descriptions of hiding and non-disclosure in the data alerted me to the possibility that women’s willingness to participate in this online survey depended on their being able to maintain a level of secrecy.

Together these three projects broadly address the representation of smoking during pregnancy and women who partake in this practice. However, they do so from different vantage points: the woman’s perspective (Studies 1 and 3) and the observer’s perspective (Study 2). These two perspectives are maintained throughout this thesis in an attempt to provide multiple perspectives on the topic through the use of multiple methods.

Employing both quantitative and qualitative methods in this thesis allows me to answer a range of questions and provide a holistic account (Leckenby & Hesse-Biber, 2007) of the topic of women’s smoking during pregnancy and the presumed stigma. This mixed-methods approach is positioned within a postmodern perspective, which embraces multiple versions of truth and reality (DeVault, 1996). This thesis, then, approaches the notions of ‘perceptions’, ‘attitudes’, ‘beliefs’, ‘experiences’, and ‘identities’, in relation to the topic of smoking during pregnancy, as social constructs which can be analysed and understood within a postmodern context.
This thesis is presented chronologically, to reflect (and narrate) my own intellectual journey in conducting this research. In particular, the thesis examines Australian women’s experiences of smoking during pregnancy and the presumed stigma attached to this experience (Chapter 3); and the public’s perceptions of smoking during pregnancy and women who partake in this practice (Chapter 4).

In particular, these first two empirical chapters ask the following questions:

a. Do Australian women who smoke during pregnancy experience stigma and, if so, how is stigma constructed and with what material consequences?

b. Do Australian university students express negative perceptions of women who smoke during pregnancy?

Chapter 3 presents a thematic analysis of 11 interviews with women who smoked during their recent pregnancies (Study 1, excluding the two pilot interviews). Specifically, this chapter examines women’s experiences and constructions of stigma, with a particular focus on the material consequences of stigma. The chapter has been published in *Critical Public Health* and was written for a public health audience. This chapter highlights the counterproductive material consequences of stigma, including how stigma may actually serve to reduce women’s capacity to stop smoking.

Building on a concern about the stigmatisation of women who smoke during pregnancy, Chapter 4 analyses data provided by 595 university students in Study 2 (note that the total sample was 626, but thirty-one participants were excluded due to high levels of missing data). Chapter 4 presents a quantitative analysis of closed-item responses, which has been published in *Psychology and Health* (the open-ended responses are analysed in Chapter 5) and examines university students’ perceptions of women who smoke during pregnancy. Chapter 4 also presents the results of the experimental manipulation from Study 2 that was designed to explore whether negative views were affected by the inclusion of individuating information – that is, contextual information about the woman’s smoking. This chapter builds on the findings from Chapter 3 to highlight the importance of attending to the consequences of stigmatising smoking during pregnancy and exploring alternative, more supportive, approaches to promoting smoking cessation during pregnancy.

These two chapters set the scene for the remainder of the thesis, which moves beyond ‘experiences’ and ‘perceptions’ to examine discursive negotiations of the presumed stigma attached to smoking during pregnancy. The next three chapters explore the ways in which members of the public (Chapter 5) and women who have smoked during pregnancy (Chapters
6 and 7) discursively negotiate stigma. These three chapters represent a step change in the development of my own critical thinking around this topic.

After the publication of Chapters 3 and 4, I began to read and analyse the open-ended text responses provided by the students who had participated in the online survey in Study 2. In particular, I was interested in the overwhelmingly negative tone of their responses. From a reflexive point of view, this observation led me to consider the role of the research design in producing this ‘evidence’ of stigma and to question the extent to which these data were co-created by the research context. Chapter 5, which has been published in *Qualitative Research in Psychology*, analyses textual data from Study 2 and discusses my reflexive realisation of the role of the research design in co-producing stigma. This chapter also discusses the usefulness of discourse analysis within a social constructionist framework in analysing these qualitative data. This chapter reflects a shift in my methodological approach to data analysis, and also my explicitly social constructionist ontology, and as a result my subsequent interest in discursive negotiations of stigma (Chapters 6 and 7).

Although this shift (methodologically) and realignment (ontologically) is not traditional for a doctoral thesis, this was largely the result of working in a department and discipline that encourage publication during candidature, and of entering my PhD candidature still attempting to understand and disentangle the implicit assumptions of my positivist training in psychology. As a result, I only began extensive reading in the area of critical health psychology, discourse analysis, reflexivity, and social constructionism, after I had finished and published Chapters 3 and 4. Chapter 5, then, serves an important middle-ground or bridge for this thesis, as it details my explicit social constructionist understanding of Study 2 and an acknowledgement of how my social position and the research context shaped the ways in which I collected and analysed data.

The point of Chapter 5 is to provide context to the subsequent empirical chapters (6 and 7) and to demonstrate the usefulness of moving towards a discursive approach. This chapter is written in such a way that it walks the reader through my intellectual journey and provides a level of transparency and honesty that might call into question the usefulness of Study 2. However, the point of this chapter (and its publication in *Qualitative Research in Psychology*) is not to undermine Study 2, nor the published article based on it that comprises Chapter 4, but rather to narrate my ontological and methodological shift in the hope that it will be useful to others, particularly in disciplines like psychology that rarely practise reflexive dialogue, who are making similar journeys towards engaging more critically with the research process and the influence of their own social positions.
In response to this reorientation, Chapters 6 and 7 examine the available discourses and identities for Australian women who smoke during pregnancy, and therefore provides a discursive perspective on women’s negotiation of stigma. These chapters focus on the discourses that make it easy and acceptable to judge women negatively for smoking during pregnancy. Chapter 6 focuses on one particular discourse that enables and normalises stigma concerning women who smoke during pregnancy and which women oriented to in their interviews (Study 1). This chapter presents a re-analysis of the 12 interviews conducted in Study 1 (excluding the email interview – as a reviewer requested we remove this from the sample). The point of re-analysing the interviews was to use discourse analysis to explore the discursive underpinnings of stigma and to illustrate the rhetorical difficulty of formulating positive accounts of smoking during pregnancy. Therefore, Chapter 6 focuses on how women accounted for their smoking and their identities, in the context of a biomedical discourse which constructs smoking during pregnancy as undoubtedly harmful to the baby.

The final empirical chapter, Chapter 7, draws on three sources of data to consider the ways women who smoke during pregnancy represent themselves in different discursive contexts: the 13 interviews from Study 1 (including both the two pilot interviews and the email interview); online survey data from Study 3; and a media article written by an Australian television and radio host who was ‘caught’ smoking during pregnancy (see Appendix D). This analysis highlights the lack of positive identities offered by anti-smoking and good mother discourses, and how the combination of these discourses works to discursively silence these women’s experiences and render them untellable.

In closing, Chapter 8 brings together the empirical, methodological and theoretical contributions of the previous chapters. In this chapter I re-visit the main aims, findings and practical implications of my work. Specifically drawing on the material and discursive perspectives I have taken in exploring stigma, I re-address the debate regarding the ethics and effectiveness of stigmatising smokers. Bringing together the main messages of this thesis, including the move from a material to a discursive perspective on stigma, this final chapter considers future empirical and theoretical directions for work in this area. In addition, I discuss the ways in which reflexivity has allowed me the space to reflect on the ethical nature and practical usefulness of my PhD work.
Chapter 2. Good mothers do not smoke: The role of gendered discourses in stigmatising women's smoking during pregnancy

This chapter starts with a brief review of how tobacco denormalisation policies have resulted in the stigmatisation of smoking and smokers, noting that a feminist perspective in tobacco control is lacking. It develops the argument that a feminist perspective is important for three reasons: the role of smoking in (gendered) identity expression and performance; the role of gendered discourses in stigmatising smoking; and the significance of social context and gendered meanings attached to smoking. It demonstrates that tobacco control policy and intervention lacks a feminist perspective that could engage with women’s smoking in ways that do not reinstate sexist assumptions, particularly in the context of women’s smoking during pregnancy – in which the foetus’ health is foregrounded. It discusses the persistence of, and problems related to, a foetal-centred approach to women’s smoking during pregnancy, and then discusses how this focus stems from the meanings attached to the construction of a good mother and in turn serves to stigmatise women who smoke during pregnancy.

Tobacco denormalisation and stigma

Internationally, the tobacco control movement accelerated in the 1960s and 1970s after the release of two major health reports documenting the harms of smoking. The US Surgeon General’s report in 1964 represented the first major health warning about the significant health effects of smoking (U.S. Department of Health, Education, and Welfare, 1964) and the US Surgeon General’s report in 1972 was the first warning to specify the significant harm of second-hand smoke to non-smokers, including children and babies (U.S. Department of Health, 1972).

In their analysis of government documents, public polls and marketing reports, Markle and Troyer (1979) tracked the changing positioning of smoking in its re-marketing by tobacco control advocates as a deviant behaviour. They stated that “attacks on smoking and tobacco have continued, but with different emphasis, during the mid and late 1970s. [...] New regulations, which treat the smoker more as enemy than friend, focus on the protection of minors, air and food pollution and fire prevention” (p. 612). This exemplifies the way in which, since the release of major health warnings regarding smoking, the meanings attached to smoking have dramatically shifted: this shift is consistent both with a social and political landscape that prioritises biomedical knowledge, particularly about the harms of smoking and second-hand smoke (Bayer & Colgrove, 2002), and with a hegemonic neoliberal discourse, which positions the health-conscious citizen as someone who should act responsibly to avoid such harms (Petersen & Lupton, 1996).
A central aim of the modern tobacco control movement is still to denormalise tobacco use. In broad terms, denormalisation has been defined as “all programs and actions undertaken to reinforce the fact that tobacco use is not a mainstream or normal activity in our society” (Lavack, 1999, p. 82). Tobacco denormalisation has significantly shaped social norms surrounding tobacco use, including the legislation of smoking limitation in public places (Poland, 2000). In addition, scholars have argued that tobacco denormalisation has also contributed to the active stigmatisation of smoking and smokers (Poland, 1998).

Stigma, as described in the previous chapter, arises when an individual is perceived as bearing an attribute or mark of social disgrace. This ‘mark’ has the effect of positioning the individual as tainted or spoiled, an object of social devaluation (Goffman, 1963). Using Link and Phelan’s (2001) comprehensive conceptualisation of stigma, I will show how this framework offers a useful platform for the topic of smoking.

Bell et al. (2010) were the first to apply Link & Phelan’s (2001) framework to the topic of smoking. They conducted an analysis of interviews with 25 Canadian current and ex-smokers to examine how participants interpreted and responded to tobacco denormalisation policies. Bell and colleagues identified the stigmatised identity of a smoker, an identity to which participants oriented in their interviews. Bell and colleagues described the ways in which smokers’ experiences of being stereotyped and labelled, and their perceived loss of social status fit within Link and Phelan’s framework of stigma. With respect to the final component of Link and Phelan’s framework, power, Bell and colleagues (2010) argued that “given the class composition of smoking and the growing concentration of smoking amongst the poor and disenfranchised, stigma is clearly dependent upon social, cultural, economic and political power differences between smokers and non-smokers” (p. 922). They argued that smokers are susceptible to dual forms of stigmatisation, in that smoking stigma becomes connected with the stigma associated with material deprivation to the extent that smoking becomes concentrated among the socio-economically disadvantaged.

The validity of smoking-related stigma as a concept has been questioned by some tobacco control scholars. In particular, the relationship between the tobacco denormalisation movement and stigmatisation has been the subject of some debate (Burris, 2008). The purpose of tobacco denormalisation has been summarised as “depicting smoking as a negative behaviour” and this is arguably distinct from stigmatisation (Burgess, Steven, & van Ryn, 2009, p. 155), which has been described as “an arbitrary and cruel form of social control” characterised by shaming, blaming and discrediting smokers and smoking (Burris, 2008, p. 475). Some have argued that stigma is an unintended negative consequence of
tobacco denormalisation policies (Burgess et al., 2009; Stuber, Galea, & Link, 2009). However, others have unproblematically linked the stigmatisation of smokers directly to denormalisation policies, specifically examining the role of smoke-free legislation (Poland, 1998). This thesis takes the position that stigma is a consequence of tobacco denormalisation policies, whether deliberate or not.

**The Australian context**

Smoking is a leading cause of death and disease in Australia, responsible for 15,000 deaths annually (Collins & Lapsley, 2008). This is despite the fact that smoking rates have steadily declined over the past few decades in response to comprehensive national tobacco control strategies (Chapman & Freeman, 2008; Scollo & Winstanley, 2012). Most recent estimates suggest that 16% of adults in Australia smoke (Australian Bureau of Statistics, 2012). While prevalence is declining across all socio-economic groups, there are disproportionately higher rates of smoking among individuals occupying lower socio-economic positions (Scollo & Winstanley, 2012). For instance, Indigenous Australians are more than twice as likely to be current smokers as non-Indigenous Australians (Scollo & Winstanley, 2012). As in many other parts of the Western world, smoking is strongly tied to social class in Australia (Graham, 2012; Siahpush, 2004a).

Australia is one of the leading countries in the tobacco control movement, which aims to denormalise and reduce tobacco use through various population and individual level interventions. This movement is driven by the indisputable social and health costs associated with tobacco-related illness and death (Commonwealth of Australia, 2012). Australia’s tobacco control strategies are comprehensive. Policy-level measures include taxation, media campaigns, packaging warnings, mandated smoke-free areas, government funding for cessation programs, and electronic resources for cessation. Individual-level cessation measures funded by government include cognitive behaviour therapy services, telephone support, and other group and individual support classes and counselling (Scollo & Winstanley, 2012).

The impact of denormalisation policies, including the stigmatisation of smokers, is an area of research that has received significant attention in the social sciences. Within the Australian context, Chapman and Freeman (2008) conducted an analysis of various markers of the cultural positioning of smoking; these markers included movies, news reports, laws, dating websites, accommodation advertising, airport smoking policies, and health insurance. In their descriptive analysis, they identified a pervasive anti-smoking culture in Australia, in which smoking is represented as a ‘disgusting’, ‘unhealthy’ and ‘selfish’ practice of the
‘addicted’ ‘low-class’. This article provided the first documentation of the diverse ways in which the positive image of smoking has been eroded, and replaced with a mark of stigma, in a country with extensive tobacco denormalisation policies (Chapman & Freeman, 2008).

As another example of the eroded image of smoking, Gilbert (2008) conducted a discourse analysis of anti-smoking television advertising in Australia between 1997 and 2008. She identified an overt emphasis on self-governance and on individual responsibility for conforming to a healthy lifestyle (including the absence of smoking), through the deployment of graphic imagery and medical language about the harms of smoking on the body. Gilbert argued that, in these campaigns, smoking was positioned as a deviant and unhealthy behaviour and smokers as blameworthy for any smoking-related illness.

These two analyses provide strong evidence of the ways in which the meanings attached to smoking in Australian culture reflect distinctly neoliberal and classist values and serve to ‘mark’ smokers as deviant, unhealthy and inferior citizens who knowingly put themselves at risk of illness and disease. To reiterate Link and Phelan’s (2001) framework, smoking-related stigma then refers to the labelling and ‘othering’ of smokers, the emphasis of their negative attributes (deviant, unhealthy, inferior citizens), and their low status as evident by their socio-economic deprivation (Thompson, Pearce, & Barnett, 2007).

What about class, gender and ethnicity?

Although there is some literature describing the ways in which denormalisation policies differentially affect specific groups of smokers, for instance low-income and high-income smokers (e.g., Frohlich, Poland, Mykhalovskiy, Alexander, & Maule, 2010), policy discussions tend to minimise the discursive positioning of smoking and the intersectionality of class, gender and ethnicity (Graham, 2012; Siahpush, 2004b) – three salient social locations of smokers.

Underpinning this lack of attention seems to be an assumption that current tobacco denormalisation policies effectively (and equally) target all segments of the population. This assumption is especially concerning in the context of significantly higher rates of smoking among socio-economically disadvantaged groups (Siahpush, 2004a) and, relevant to this thesis, evidence that disadvantaged women smokers, in particular, face social-structural and psychosocial circumstances that reduce their capacity to stop smoking (Greaves & Hemsing, 2009). This assumption also fails to take into account the material conditions which contribute to higher smoking rates among particular segments of the population, the social meanings and functions served by smoking, and the differential effects of denormalisation policies (including stigmatisation) on various ‘groups’ of smokers, including women.
In this thesis, I focus on women’s smoking during pregnancy, taking a critical perspective on the ways in which the meanings attached to the construction of a good mother serve to stigmatise women’s smoking during pregnancy. In the next section, I develop an argument that a feminist approach that engages directly with women’s smoking is important for the three reasons outlined earlier in this chapter: the role of smoking in (gendered) identity expression and performance; the role of gendered discourses in stigmatising smoking; and the significance of social context and gendered meanings attached to smoking.

The relevance of a feminist perspective in tobacco control

In this thesis, and consistent with others (Greaves et al., 2003), I take a feminist perspective on women’s smoking to address the issue of gender and stigma, and draw on a social constructionist framework to acknowledge that tobacco use is situated within a broader social and political context. Drawing on a social constructionist perspective, gender is understood as a “multidimensional, social construct that refers to the processes by which we enact our belonging to various categories of being a woman, man, or transgendered person” (Bottorff et al., 2014, p. 4).

Acknowledging that there is no one feminist methodology, a feminist perspective in this thesis advocates woman-specific, context-sensitive and woman-positive interventions, research and campaigns, which take an ethical and empathetic position on women’s smoking, and importantly avoid blaming or shaming women. Central to feminist research is continuous and reflexive engagement with the significance of gender and (asymmetrical) gender relations as a fundamental part of reality and therefore of the research process (Cook & Fenow, 1986). Thus, the common aim of much feminist research (including this thesis) is to foreground women’s experiences, and examine the diversity of their lives and the ways in which dominant ideology works to silence and oppress so many women (DeVault, 1996).

Feminist research on the topic of women’s smoking has typically employed social constructionist approaches to situate and understand the meanings and context surrounding women’s smoking (e.g., Greaves & Jategaonkar, 2006; Greaves, Kalaw & Bottorff, 2007; Holdsworth & Robinson, 2008; Oaks, 2001), opening up the opportunity to take an ethical and empathetic stance on the topic. In this thesis, I take the view that a feminist perspective involves ongoing efforts to embed women’s experiences within their social context (using a social constructionist lens) and to interrogate the consequences of dominant ideology (e.g., good mother discourse) for women’s lives and storytelling.

Twenty years ago, it was argued that the tobacco control movement generally ignored gender (Greaves, 1995). The gender gap in smoking has been closing over the past few
decades, with recent Australian estimates suggesting similar smoking rates among men and women (Scollo & Winstanley, 2012: 22% men, 18% women). However, there has historically been a greater and steadier decline amongst men, which is largely due to the greater numbers of men who had ever smoked and who stopped smoking in the mid-late 1980s (Scollo & Winstanley, 2012). It has been argued that changes in the gender demographic of smokers has resulted to a large degree from the tobacco industry taking advantage of sociocultural shifts in the status of women to promote smoking directly to women (Amos & Haglund, 2000; Hunt, Hannah, & West, 2004).

Social scientists have argued that women’s smoking over the 20th Century has shifted from being a symbol of being bought by men (prostitute), to being like men (lesbian), to being able to attract men (glamorous/heterosexual) (Greaves, 1996), to being equal to men (feminism) and your own woman (freedom) (Amos & Haglund, 2000). A comprehensive analysis of internal tobacco industry documents, released publicly in 1998 but spanning back to the 1970s, revealed the tobacco industry’s deliberate efforts to target women by designing cigarettes that appealed to women’s presumed concerns (e.g., femininity and thinness), taste preferences (e.g., alternative flavours), smoking motivations (e.g., confidence and social acceptance) and design preferences (e.g., longer, thinner cigarettes) (Carpenter, Wayne, & Connolly, 2005). With this history of distinctly gendered tobacco marketing, it is crucial that research considers the relevance of gender with respect to people’s continued smoking, the effects of denormalisation efforts (including stigma), and developing gender-sensitive tobacco control policies and programs.

A feminist perspective on women’s smoking is important for several reasons. First, a number of social scientists (Gilbert, 2007; Grogan, Fry, Gough, & Conner, 2009; Haines, Poland, & Johnson, 2009; Wearing, Wearing, & Kelly, 1994) have pointed to the ways in which smoking holds significant meaning for women’s identity expression and performance. For instance, using grounded theory to analyse interviews with 20 young Australian women, Gilbert (2007) identified young women’s preference for buying feminine-branded cigarettes and for smoking in ‘feminine’ ways.

On the basis of a Foucauldian discourse analysis of interviews with young Norwegian adult smokers, Scheffels (2009) argued that smoking was central to young smokers’ constructions of their self-image. Smoking represented pleasure, acceptability and fashion to these young adults, yet at the same time, smoking was also positioned as stigmatised, immoral and undistinguished. Young women, in particular, emphasised the need to smoke the
“right way”, which the author described as “purposeful, controlled and clean” (p. 480). Failing to smoke this way threatened their social status and their femininity.

Second, a feminist perspective is necessary because several studies (Alexander, Frohlich, Poland, Haines, & Maule, 2010; Greaves, Oliffe, Ponic, Kelly, & Bottorff, 2010; Scheffels, 2009) have highlighted the role of gendered discourses in shaping the acceptability of smoking among men and women. For instance, Alexander et al. (2010) analysed interviews with 23 Canadian adult smokers to explore how gender shaped men’s and women’s smoking practices. They concluded that women expressed dissonance about their smoking; for example, several women cited their roles as mothers or caregivers in describing the conflict and contradiction associated with their smoking. In comparison, men did not report any dissonance regarding their smoking and gendered roles; rather, smoking enhanced the construction of their masculine identity.

Research on other people’s perspectives on women smokers offers a third rationale for a feminist perspective. Farrimond and Joffe (2006) interviewed British smokers and non-smokers, about their representations and experiences of smokers, concluding that women smokers were rarely described in a positive light. In another interview study, which focussed on smoking legislation in Scotland, Ritchie, Amos, and Martin (2010) described the ways in which both men and women smokers constructed smoking as “unladylike” (p. 626) and reported heightened levels of disapproval towards women smokers. The term “unladylike” implies that smoking is not consistent with a particular type of feminine identity, a view that has been identifiable at least since the 1980s (Elkind, 1985).

From these multidisciplinary studies, it appears that gender (and gendered discourse) plays a role in shaping the acceptability of smoking among men and women. In particular, gender seems to shape how women and men can appropriately express their identities – which, for some (for example, mothers and caregivers), may mean avoiding smoking altogether (Alexander et al., 2010).

Fourth, a feminist perspective is important given the social context and gendered meanings attached to smoking. Graham’s social policy work has been instrumental in advocating for a structural lens through which to understand women’s smoking (Graham, 2009). In particular, her work with British women highlighted how smoking is embedded into women’s daily routines of coping with stress, caring and material disadvantage (Graham, 1976, 1987, 2012). For instance, in a cross-sectional survey with 905 British women whose primary responsibility was caring for their families, Graham (1994) found that working class mothers who smoked tended to be those who faced greater demands regarding their caring
responsibilities and material circumstances. Specifically, heavy smokers were more likely to have more children (and children with poor health) than never smokers; mothers without partners were more likely to be smokers than mothers with partners; and heavy smokers were more likely to be dependent on benefit income than never smokers.

In her earlier work, with 57 women from low-income families who participated in interviews and kept daily diaries, Graham (1987) suggested that women who smoked (and smoked heavily) often did so in the context of poverty, caring responsibilities, a lack of emotional and physical energy, and feelings of isolation. Some women spoke of the ways in which smoking was tied to their breaks from caring for their children, when they “rested and refuelled” (p. 52). Based on these women’s daily routines of care giving, Graham (1987) concluded that for more than 60% of the sample, smoking was a helpful strategy for coping with their caring demands. Further, the women who were caring for their children full-time, and in the context of poverty, described smoking as their only luxury and source of leisure (Graham, 1987). Examining the intersection of gender and class, Graham’s (1987) multiple-methods study provides compelling evidence of the need to understand women’s smoking with reference to the specific and transient meanings women attach to smoking, and how smoking is embedded in their daily routines and roles as mothers.

Another study of Graham’s was based on a survey of 920 British women smokers aged 16-49, which examined the patterns and predictors of their smoking (Graham & Der, 1999). Using population data, collected as part of the British Household Panel Survey, Graham and Der (1999) examined the role of socio-economic position, psychological health and partner’s smoking status in women’s smoking rates. Of relevance here, they found that higher cigarette consumption was linked to greater socio-economic disadvantage and poorer psychological health. Graham and Der argued that their findings confirm the assumption that women smokers experience greater disadvantage than do women in general, as indicated by their socio-economic conditions and psychological health.

Also taking a feminist perspective, and seeking to examine the intersections of gender and class, Greaves (1996) interviewed Canadian and Australian women who smoked and examined the meanings and experiences of smoking for women living in poverty and with unequal domestic responsibilities. In her sociological analysis, Greaves (1996) argued that smoking was a strategy for exerting control, which allowed women to deal with the stress and emotions of their everyday lives. She conceptualised smoking as a socially accepted form of self-medication that assisted women in carrying out their unequal and often unsatisfying social roles.
Together, these studies by Graham (e.g., 1987, 1994) and Greaves (1996) suggest that women’s smoking is linked in both direct and systemic ways to the material circumstances of their everyday lives. In the next section, I examine how existing tobacco control efforts overlook the extent to which smoking is a gendered practice that is embedded in people’s social context. Specifically, I will discuss how a feminist perspective that engages with women’s smoking, in ways that do not reinstate sexist assumptions, is still a minority approach – particularly in the case of smoking during pregnancy.

**A feminist perspective in tobacco control: Still a minority?**

Despite a significant push for gender to be considered in tobacco control in Canada, the US and the UK (e.g., Amos, Greaves, Nichter, & Bloch, 2012; Greaves & Jategaonkar, 2006), there is little evidence of gender-sensitive (and gender-positive) tobacco control in Australia. This absence was previously noted by Ebert and Fahy (2007) in their review of qualitative research examining women’s experiences of smoking during pregnancy. They discussed the lack of funding, strategies or programs in the Australian National Tobacco Control Strategy that were tailored to women who smoke during pregnancy. The current National Tobacco Control Strategy (2012-2018), which details the national framework for tobacco control in Australia, continues to pay little attention to gender; the only mention of gender focuses on smoking cessation programs, services and marketing for pregnant women, particularly pregnant Indigenous women (Commonwealth of Australia, 2012).

Recent debates about the ethics of deliberately stigmatising smoking and smokers through public policy (Bayer, 2008; Guttman & Salmon, 2004; Stuber et al., 2009) also lack a feminist perspective. Although tobacco use is legal, it has been argued that stigma is being used as a tool to replace the prohibition of tobacco use (Bell, Salmon, Bowers, Bell, & McCullough, 2010). That is, stigma is being used as a form of social control, coercing people to adopt ‘healthier’ behaviours (Burris, 2008) and instilling middle-class values as the yardstick of ‘acceptable’ behaviour (Poland, 1998). These debates, then, tend to focus on the intersections of class and smoking, at the expense of examining the discursive positioning of smoking and its intersectionality with class, gender and ethnicity, in order to ask whether and how particular groups of smokers (e.g., low-income mothers) may be subject to increased stigma and with what consequences.

The relative absence of gender in tobacco control policy and intervention is evident in a number of ways. For instance, the woman-specific health effects of smoking on menstruation, fertility, menopause, and the risk of cervical cancer and breast cancer (Scollo &
Winstanley, 2012) continue to be overlooked in the construction of smoking as a gender-neutral issue (other than during pregnancy). In addition, there has been recent concern that gender-specific disparities in smoking are often masked by national trend data, which do not capture or respond to tobacco use within specific at-risk populations (Greaves & Hemsing, 2009). A tobacco control movement that is largely gender blind is particularly worrying given recent discussions about the vulnerability of women from developing countries, which are starting to witness higher rates of smoking among women (Greaves, Hemsing, Poole, Bialystok, & O’Leary, 2014).

Until the 1980s, the only two aspects of smoking that were focused on women were the effects of smoking on women’s appearance and on pregnancy complications (Greaves, 1995). This focus is an indication of the sexist assumptions underpinning smoking campaigns targeting women. And remarkably little has changed in anti-smoking campaigns that target women today. For instance, the most recent campaign in Queensland, Australia, is entitled, “If you smoke your future’s not pretty”, and focuses on young women’s appearance in an attempt to discourage women from smoking (Queensland Department of Health, 2014). A recent Australian campaign targeting pregnant women states “When you smoke, she [the baby] gets less oxygen” and uses a 3D ultrasound image of a developing foetus (Quit Now, 2012). These campaigns continue to be based on the assumption that women will respond most strongly to concerns about their appearance or the health of their unborn babies, rather than their own health and wellbeing. Both campaigns thus reinstate sexist assumptions by emphasising women’s appearance, suggesting that ideal feminine appearance is synonymous with youth (Grogan et al., 2009), and identifying women with their reproductive functions (Greaves & Poole, 2005).

In the context of smoking during pregnancy, foetal-centred campaigns and interventions targeting pregnant women rest on the assumption that the presence of a foetus should be sufficient for any woman to stop smoking (Greaves et al., 2003). This focus reinstates women’s positioning as reproductive vessels who should comply with public health and biomedical discourse regarding what is considered ‘healthy’ and ‘appropriate’ behaviour during pregnancy, thereby prioritising women for their reproductive capabilities rather than as autonomous individuals (Greaves & Poole, 2005). Further, such an approach overlooks any broader influences on women’s smoking (e.g., partner smoking, economic deprivation), including the potentially limited extent to which women have control over their smoking and smoking environments (Burgess et al., 2009; Hemsing, Greaves, Poole, & Bottorff, 2012; Nichter et al., 2007).
Although there have been important feminist contributions to understanding women’s smoking and advocating gender-sensitive and positive tobacco control efforts from a range of fields (e.g., Amos et al., 2012; Greaves & Jategaonkar, 2006), attention to (or at least sensitive engagement with) the discursive intersection of smokers’ social identities is still in the minority. In particular, very few studies have considered age, gender, ethnicity and income-specific effects of tobacco policy and the potential unintended negative consequences of such policies for women and girls (Greaves & Jategaonkar, 2006). With this absence in mind, Greaves and Jategaonkar argued that “it is essential to recognise that tobacco use is both a response to, and a feature of, social and economic inequality and marginalisation and may bring solace and pleasure to lives where there may be little” (2006, p. 63).

Burgess et al. (2009), in their review article, have shown that there is remarkably little research on the consequences of tobacco denormalisation policies targeting socially disadvantaged mothers who smoke. Similarly, policies aiming to reduce children’s exposure to second-hand smoke were absent. Drawing largely on the broader stigma literature, Burgess et al. argued that denormalisation strategies are likely to produce unintended consequences for socially disadvantaged mothers, including withdrawal from stigmatising situations, experiences of poorer psychological and physical health, and experiences of bias from health professionals.

This thesis aims to fill a gap in knowledge by focusing on a particular group of women who occupy a highly gendered position: women who smoke during pregnancy. Since the 1970s, women who smoke during pregnancy have been the target of significant public health attention and have faced unique (and arguably increasing) stigmatisation for their smoking. In the next section, I will discuss how the dominant approach to smoking during pregnancy does not sensitively or positively engage with women’s smoking (in line with a feminist perspective), but rather persistently (and problematically) focuses on the foetus’ health.

**Smoking during pregnancy and the ever-present foetus**

Smoking during pregnancy, despite ongoing public health intervention, is still relatively common. A study of 262 women (mostly young with low education levels) accessing antenatal clinics in one Queensland health service district found that 37% were smoking prior to pregnancy and more than 25% smoked during pregnancy (Wilkinson, Miller, & Watson, 2009). A Queensland-wide estimate suggested that 18.7% of women, both Indigenous and non-Indigenous, were smoking after 20 weeks of gestation (Queensland Health, 2009), whilst national Australian data suggests that 17.4% of Australian women
smoke during pregnancy (Laws, Abeywardana, Walker, & Sullivan, 2007). This is remarkably similar to prevalence data from Canada (15%; Al-Sahab, Saqib, Hauser, & Tamim, 2010) and the UK (17%; NHS Information Centre, 2007). However, a potential issue in collecting prevalence data of smoking during pregnancy is women’s underreporting or non-disclosure to health care professionals. This presumed underreporting has been attributed directly to the stigma attached to smoking during pregnancy (Bull, Burke, Walsh, & Whitehead, 2008).

In Australia, rates of smoking during pregnancy follow the same gradient across socio-economic groups as do rates of smoking more generally: women facing socio-economic disadvantage are estimated to be four times more likely than women from socio-economic advantaged positions to smoke during pregnancy (Scollo & Winstanley, 2012). This offers further evidence of the striking relationship between smoking and socio-economic disadvantage (Siahpush, 2004a). Rates of smoking during pregnancy in Indigenous Australian communities have been estimated to be as high as 50-65% (Australian Institute of Health and Welfare (AIHW), 2011; Eades, Read, & Bibbulung Gnarneep Team, 1999). According to New South Wales antenatal data collected between 1994-2007, from all births in both public and private hospitals across the state, rates of smoking during pregnancy have declined overall, but the rates among rural, low income, and Indigenous women have increased (Mohsin, Bauman, & Forero, 2010). Consistent with a feminist perspective, these data highlight the importance of locating smoking within women’s social context and acknowledging the intersections of class, gender and ethnicity in contributing to women’s smoking during pregnancy.

Smoking during pregnancy has been the target of aggressive public health campaigns. Since the release fifty years ago of the first major medical reports noting the risk of smoking during pregnancy to the developing foetus (U.S. Department of Health, Education, and Welfare, 1964), anti-smoking messages have consistently focussed on the foetus in attempts to motivate women to stop smoking as soon as they find out they are pregnant (or even sooner).

Foetal-centred campaigns are not unique to the Australian context (for example: Southampton Quitters, 2014), rather they reflect a broader cultural approach to women’s bodies. In particular, this approach stems in part from the positioning of pregnancy as a “window of opportunity” (DiClemente, Dolan-Mullen, & Windsor, 2000, p. iii16) for health-related change. Pregnancy is often constructed as period that involves a significant focus on health, during which women presumably welcome advice and information from others about
how to do the best for their babies (Lupton, 2011). In the context of increased medical and public surveillance (Lupton, 2012) and risk-consciousness during pregnancy (Lupton, 1999), there is an imperative for women to avoid harmful or otherwise ‘unhealthy’ behaviour during pregnancy, especially smoking (Oaks, 2001).

A focus on foetal health has been identified in women’s interview accounts. Interview data across a range of contexts suggest that women who continued to smoke during pregnancy were aware of the potential harms of their smoking (Abrahamsson, Springett, Karlsson, & Ottosson, 2005; Graham, Flemming, Fox, Heirs, & Sowden, 2014), particularly concerning the health of their developing foetuses (Edwards & Sims-Jones, 1998; Gamble, Grant, & Tsourtos, 2014; Lendahls, Öhman, Liljestrand, & Håkansson, 2002). Awareness of foetal health can be a significant motivator for some women’s smoking cessation. For instance, research with Canadian women who stopped smoking during pregnancy suggested that women described stopping for the baby (rather than for themselves), which then provided a rationale for why they returned to smoking after the baby was born (Bottorff, Johnson, Irwin, & Ratner, 2000).

An awareness of foetal health may also have negative consequences for women. For instance, a review of qualitative literature (Flemming, Graham, Heirs, Fox, & Sowden, 2013) examining women’s experiences of smoking during pregnancy (26 studies: a total of 640 participants) identified women’s attention to foetal health, and the risks their smoking posed to the developing foetus, as a trigger of heightened anxiety and guilt. Reports of guilt were also identified in a qualitative study of 57 young low-income women who smoked during their recent pregnancies (Dunn, Pirie, & Lando, 1998), in that these women described significant guilt and moral concern about their smoking, and for some women this guilt led to smoking at higher rates.

These and similar findings raise a concern that foetal-centred approaches overlook the woman’s health and can lead to cessation that is only short-term (Greaves et al., 2003) or indeed to increased smoking (Dunn et al., 1998). Data from North America indicate high rates of smoking relapse post-partum: 70 to 90% of women who were able to stop smoking during pregnancy had resumed smoking within one year after their babies were born (Klesges, Johnson, Ward, & Barnard, 2001). A recent Cochrane review of interventions targeting smoking during pregnancy, several of which provided feedback to women on foetal health, found that interventions produced significant reductions in smoking during the later stages of pregnancy and early postpartum; however, overall there was no evidence of cessation beyond 6 months postpartum (Lumley et al., 2009).
Women’s short-term cessation is also evident in an analysis of longitudinal quantitative data that examined women’s smoking over various life transitions (McDermott, Dobson, & Russell, 2004). Based on an analysis of a cohort of 9683 Australian women aged 18-23 years who participated in general health surveys in both 1996 and 2000, McDermott et al. (2004) found that those ex-smokers who were pregnant at the first survey, and were not pregnant at the time of the second survey, were 3.2 times as likely to have returned to smoking as were ex-smokers who were not pregnant at either survey.

This pattern of women stopping smoking for pregnancy and resuming within years after the birth was also identified in accounts of Canadian women who were interviewed about their smoking relapses during pregnancy or postpartum (Edwards & Sims-Jones, 1998). An analysis of these interviews concluded that the women who stopped smoking during pregnancy described doing so out of concern for their babies’ health. These women’s narratives of relapse following the birth of the baby were centred around returning to their non-pregnant selves, for which smoking was a central part of dealing with daily stressors and socialising with friends. This highlights the importance of woman-centred (not foetal-centred) approaches in producing sustained changes in smoking.

A foetal-centred approach has also shaped a significant body of literature examining women’s smoking during pregnancy. A large body of research has focused on women’s perceptions of the barriers to smoking cessation during pregnancy (e.g., Abrahamsson et al., 2005; Ingall & Cropley, 2010; Tod, 2003; Wood, France, Hunt, Eades, & Slack-Smith, 2008), reasons for smoking during pregnancy (Ebert & Fahy, 2007; Maclaine & Clark, 1991), and attitudes to smoking during pregnancy (Dowsett, 1985; Dunn et al., 1998; Ortendahl, 2004; Walsh, Redman, Brinsmead, & Fryer, 1997). The focus of this research, problematising women’s difficulties in stopping smoking during pregnancy, suggests an implicit view that there is something particularly remiss about women who do not stop smoking during pregnancy. While there is clearly merit in understanding why many women find it difficult to stop smoking during pregnancy, my concern is that individual-focused approaches to understanding women’s smoking during pregnancy tend to disregard the role of contextual and socio-political constraints. As a result, women’s smoking during pregnancy is viewed as the product of individual choice with little reference to social context.

Although no research has yet (directly) focused on women’s experiences of stigma in the context of smoking during pregnancy, reports of guilt and anxiety are common, and are often combined with descriptions of social disapproval from others. These reports draw parallels with several qualitative studies (Bell, McCullough, Salmon, & Bell, 2010;
Farrimond & Joffe, 2006; Ritchie et al., 2010) that have examined (non-pregnant) smokers’ accounts of stigmatisation in the face of tobacco denormalisation policies. For instance, an exploration of the nature and process of stigma in light of increasing smoke-free legislation was undertaken using longitudinal qualitative data with 40 smokers in Scotland (Ritchie et al., 2010). The authors argued that smokers experienced a loss of social status in public spaces, self-stigmatised their own smoking behaviour, coped with stigma by smoking in less visible places, and smoked less when out socialising.

Several qualitative studies with women who smoked during pregnancy (Abrahamsson et al., 2005; Bull, Burke, Walsh, & Whitehead, 2007; Edwards & Sims-Jones, 1998; Gamble et al., 2014) have described the heightened levels of judgement and disapproval that women perceived from health professionals, the public and their close networks for continuing to smoke during pregnancy. For instance, Bull et al. (2007) observed that women who had smoked during pregnancy reported criticism from health professionals and community members; these women also described instances of non-disclosure and hiding their smoking. At the centre of women’s accounts of judgement and guilt is an awareness of their presumed failure to prioritise and protect their babies’ health (Abrahamsson et al., 2005). In the next section, I will show how the good mother discourse shapes the (un)acceptability of smoking during pregnancy and serves to stigmatise women who smoke during pregnancy.

**Good mothers do not smoke**

This thesis is written from the perspective that motherhood is a social phenomenon, “it is an institution that presents itself as [...] a natural manifestation of an innate female characteristic, namely maternal instinct” (Smart, 1996, p. 37). Motherhood, although synonymous with natural womanhood and femininity (Arendell, 2000), is an institution which governs women, designated as mothers, according to strict and often unattainable expectations.

It was Rich (1976) who first made the distinction between two intertwined meanings of motherhood: motherhood as an institution, and motherhood as an experience. In her view, the institution of motherhood refers to the ways in which women’s potential is degraded and restricted by a narrow definition of appropriate behaviour for mothers, and indeed for all women (as actual, potential, or failed mothers), ensuring that such potential (and therefore all women) remain under men’s control. The other meaning refers to the potential relationship that any woman might have with children or with her reproductive capabilities. Separating these two meanings is important, particularly for feminist scholars (e.g., Green, 2009), in
order to acknowledge that it is the patriarchal narratives of motherhood that are harmful and restrictive to women, not the experience of mothering.

Motherhood, as an institution, gained legal recognition in the mid-19th century after significant struggle for women’s rights to retain custody of children following separation or divorce (Smart, 1996). It was middle and upper-class mothers who shaped the ideology of motherhood, for these legal purposes, portraying mothers as “caring, vital, central actors in the domestic sphere, as well as persons with an identity and source of special knowledge that was essential to the good rearing of a child” (p. 45). The framing of these characteristics as ‘natural’ to all mothers coincided with distinct class-specific ideals of what makes a (good) mother.

Today, ideal motherhood takes the form of ‘intensive mothering’, a distinctly gendered and middle-class model to childrearing that is “child-centred, expert guided, emotionally absorbing, labour intensive, and financially expensive” (Hays, 1996, p.15). The ideal mother, then, willingly prioritises the needs and wants of her child over and above her own, and expends significant time, energy and resources in developing her child as a productive member of society.

Problematically, this approach to mothering conforms to neoliberal, patriarchal, capitalist values that serve to oppress and control women, such that women (and not men) are expected to provide limitless care and energy in fulfilling their children’s needs and desires (Hays, 1996; Smart, 1996). These discourses serve the foundation from which to judge and define ‘good’ and ‘ideal’ mothers (Hays, 1996; Smart, 1996). It is not a coincidence that ideal motherhood is difficult or even impossible to attain, and even socio-economically privileged women struggle to meet the mark of the ‘good mother’ (Hays, 1996). Those who are particularly oppressed and vilified by this ideology (because of their lack of the resources required to perform ‘intensive’ motherhood) include working class, single, poor, divorced or disabled women (Phoenix & Woollett, 1991; Smart, 1996) – highlighting the classist undertones of ideal motherhood.

As an example of an empirical analysis of mothers’ negotiations of idealised motherhood, Spowart, Hughson and Shaw (2008) analysed interviews with New Zealand mothers who snowboard – a practice that challenges hegemonic constructions of femininity and motherhood. Informed by Foucauldian theory, the authors conceptualised motherhood as a “set of effects produced by the technologies of power, of representation, and of the self” (p. 191). In particular, the authors understood the regulation of the institution of motherhood to operate through discourses (including the good mother discourse), which can be adhered to.
and resisted in mothers’ daily lives and behaviour. Based on their analysis, the authors argued that mothers exercised resistance to the all-encompassing and self-sacrificing nature of motherhood by participating in snowboarding – a practice that allowed them to nurture their identity and freedom outside of mothering.

It is worth noting that, although Spowart and colleagues (2008) did not attend to the pivotal role of social class, resources and social support, these were implicit in women’s narratives of upholding their position as ‘good’ mothers while still maintaining a leisure activity that defined them, and provided them with meaning, outside of motherhood. In fact, the centrality of class and gender cannot be underestimated in contextualising the institution of motherhood and the ways in which it works to exclude, stigmatise, and marginalise women who fail to meet criteria of the good mother. This is particularly the case given that this is an institution that has historically served the interests of white, middle-class, heterosexual women and their biological children (e.g., Smart, 1996).

To track the survival and strength of the institution of motherhood, and of idealised motherhood, it is important to focus on those who fall outside its boundaries. In doing so, many scholars have examined the institution of motherhood from a Foucauldian perspective. For instance, Wilson and Huntington (2005) traced the role of scientific discourse (as a regime of truth) in the positioning of teenage motherhood as problematic for society and public health. They showed how such positioning serves to exclude and vilify teenage mothers via the privileging of ‘scientific evidence’ that links teenage motherhood to welfare dependency and social exclusion.

Similarly, Smart (1996) applied Foucault’s concept of normalising discourse to show how, as ideals of good motherhood gained status (e.g., through legal policies), the content of these ‘rules’ of ideal motherhood gradually changed. The ever-changing nature of these rules highlight the constructedness of motherhood, while at the same time their normalisation emphasises the view that, in Foucauldian terms, adherence to these rules is “secured by the stigma and impositions placed upon those who disregard them” (p. 47). The threat of being marked as a ‘bad’ mother carries with it such negative connotations that it keeps women behaving in accordance with the (ever-changing) rules of motherhood.

Today, good mothers adhere to neoliberal notions of individual responsibility and risk management when it comes to their children’s health (Romagnoli & Wall, 2012; Warin, Zivkovic, Moore, & Davies, 2012), a view that is consistent with foetal-centred campaigns targeting women who smoke during pregnancy. This approach to mothering upholds
discourses of femininity by asserting that women’s moral and social worth is based on their capacity to produce and raise ‘good’, ‘healthy’, ‘productive’ future citizens.

Within the good mother discourse, women’s failure to care for, protect and promote their children’s health, which includes protecting the developing foetus from cigarette smoke, is constructed as socially and morally unacceptable and deserving of social commentary and criticism. The extent to which women are responsibilized, and blamed for child outcomes completely outside their control, is demonstrated by research which has shown the extent to which women who fail to produce a ‘healthy’ child experience stigma, including investigations with women whose children have disabilities (Craig & Scambler, 2006), or attention hyperactivity disorder (Norvilitis, Scime, & Lee, 2002), and research with women who have experienced stillbirth (Murphy, 2012).

This thesis addresses how constructions of good mothers are incompatible with practices deemed ‘unhealthy’, ‘selfish’, and ‘risky’. Women who use drugs during pregnancy are commonly positioned as self-serving, and thus as violating cultural constructions of good mothers (Murphy & Rosenbaum, 1999). It has been argued that this is one reason why women’s drug use has historically been (and continues to be) more stigmatised than men’s drug use (Ettorre, 2004; Radcliffe, 2011). The increased stigma women face for drug use during pregnancy was recently described as the result of women’s failure to act in gender-appropriate ways (Stengel, 2013). However, to date, we know little about whether, in what ways, and how women who smoke during pregnancy experience stigma.

A few qualitative studies examining women’s smoking have found that women mention pregnancy (and motherhood) as a reason to stop smoking. For instance, Abrahamsson et al. (2005) interviewed 17 pregnant and postpartum women about smoking during pregnancy. The authors described women’s views of smoking during pregnancy as a conflict, a source of their guilty conscience, and of smoking cessation during pregnancy as natural, “you just did it” (Abrahamsson et al., 2005, p. 372). An analysis of 80 interviews with young Australian women with a range of smoking histories (never smoker, continuing smoker, recent adopter, and quitter), many of whom were mothers, showed that these women identified pregnancy as a pre-determined cut-off point to smoking, a reason that would motivate future cessation (McDermott, Dobson, & Owen, 2006). Similarly, Holdsworth and Robinson (2008) conducted a thematic analysis of interviews with 12 British mothers who smoked, examining mothers’ smoking practices within the home and the negotiation of these practices. Their analysis focused on mothers’ accounts of protecting their children from
second-hand smoke and maintaining their position as a ‘good’ smoker, and the difficulties of negotiating the “seemingly incompatible positions as mothers who smoke” (p. 1097).

Collectively these studies point to pregnancy and motherhood as a life stage or identity in which women view their smoking as no longer permissible and as a source of significant guilt. However, these studies do little to contribute to theorising why and how smoking is incompatible with pregnancy (or motherhood) and how this relates to women’s experiences of stigma.

Two interview studies with mothers who smoke have considered the role of the good mother discourse in women’s experiences of stigma (Bottorff et al., 2000; Irwin, Johnson, & Bottorff, 2005). Women who relapsed postpartum described “never really having quit for themselves” but for their babies (Bottorff et al., 2000, p. 132). Underlying women’s narratives of relapse was an internal conflict in relation to their smoking, that as smokers they could not live up to idealised constructions of the ‘good’, ‘self-sacrificing’, and ‘protective’ mother. This often resulted in significant guilt and concerted efforts to avoid potential judgement and embarrassment. Irwin et al. (2005) similarly identified stories of guilt, shame and moral transgressions, as mothers made sense of their smoking in the face of idealised motherhood. Irwin et al. (2005) noted that the women they interviewed went to great lengths to describe their efforts to separate their children from their smoking, while still providing sufficient care and supervision.

In the context of smoking during pregnancy, where physical separation from the harms of smoking is not possible, and the visibility of the pregnant belly may be an indicator of a woman’s transgressions, we know little about how women construct, negotiate and respond to stigma in light of the cultural message that “good mothers do not smoke” (Bottorff et al., 2000, p. 132). Taking a feminist perspective, this thesis focuses on understanding whether and in what ways women are impacted by stigma, how they manage and respond to stigma, and with what material and discursive consequences. From a social constructionist perspective, this thesis generally conceptualises stigma as a product of complex social processes (such as discourses) linked to broader macro-inequalities (Campbell & Deacon, 2006). This thesis focuses specifically on the ways in which stigma may serve to control and oppress women who fail to act in accordance with the gendered scripts (sometimes referred to as “pregnancy rules”: Oaks, 2001, p. 19; or motherhood ideology) that define good (pregnant) mothers. The following chapter analyses interviews with women who smoked during their recent pregnancies to ask women about their experiences of smoking during pregnancy,
whether they experience stigma and, if so, to analyse how stigma is constructed and with what material consequences.
Chapter 3. A story of stigma: Australian women’s accounts of smoking during pregnancy

Without denying the importance of tobacco control, scholars have argued that there are a number of unintended consequences of tobacco control efforts that focus on the individual, including the stigmatisation of smokers (e.g., Stuber et al., 2009). However, we know little about if and how various subgroups of women smokers are affected by stigma and with what consequences (Burgess et al., 2009). The next two chapters of this thesis aim to contribute to discussions regarding the stigmatisation of smokers by considering pregnant women as a group who may experience stigma because of their smoking. These chapters explore the experiences and perceptions of smoking during pregnancy, from two perspectives: women who smoked during pregnancy and university students.

Chapter 3 presents the findings from Study 1 (excluding the pilot interviews), a thematic analysis of 11 interviews with women who smoked during their recent pregnancies (see Appendix A3 for interview guide). The aim of this study was to explore whether, and in what ways, these women described experiencing stigma associated with smoking during pregnancy. To date, there are few interview studies that focus explicitly on experiences of smoking-related stigma. These studies consider stigma in the context of fatherhood (Greaves et al., 2010), motherhood (Hemsing et al., 2012; Irwin et al., 2005), and being a smoker in an anti-smoking climate (Bell, McCullough, et al., 2010; Ritchie et al., 2010; Thompson et al., 2007). However, there is a lack of consideration of the ways in which stigma is conceptualised and experienced by women who smoke during pregnancy – a group of smokers who presumably face unique pressures to stop smoking. Therefore, the purpose of Study 1 was to understand whether such women experience stigma, and if so how is it constructed and with what material consequences. These findings are discussed in relation to existing public health literature, and I offer suggestions for more effective and ethical interventions with women who smoke during pregnancy. This chapter is in the form of a paper which was published in Critical Public Health in 2013.

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A story of stigma: Australian women’s accounts of smoking during pregnancy
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A story of stigma: Australian women’s accounts of smoking during pregnancy

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A substantial minority of Western women smoke during pregnancy. Understanding smoking from these women’s point of view may provide a richer understanding of experiences that are very often silenced, and provide some explanation for why pregnant women smoke despite widely disseminated public health campaigns urging them to stop. Strong social pressures directed at women to stop, justified mainly by arguments of protecting the foetus, are reinforced through the policing of women’s bodies, which is particularly powerful during pregnancy. This emerges in the form of criticism, confrontation and judgement, irrespective of individual women’s contexts and social backgrounds. Interviews with 11 Australian women who had smoked during recent pregnancies were conducted to explore their smoking-related experience of stigma. Thematic analysis examined their perceptions of stigma and surveillance, in the strong anti-smoking climate of Australia. Women’s talk constructed medical and social pressures as two separate dimensions of stigma, which they accepted or resisted, or – at times – did both. They also used discursive strategies to negotiate their position as ‘good mothers’ despite stigma, and spoke about the need to manage the contexts in which they smoked. The women’s talk suggests that directive, critical public health campaigns, and the associated social stigma, may actually make it harder for some to stop smoking. More supportive approaches that move away from a focus on individual responsibility, and from the assumption that pregnant women need to be coerced into healthy decision-making, might better assist some pregnant smokers to seek cessation support.

Keywords: smoking; pregnancy; stigma; Australia; tobacco control; qualitative

Australia is at the forefront of comprehensive tobacco control strategies worldwide, aiming to de-normalise and reduce tobacco use through population-level and targeted interventions. Despite the overt anti-smoking climate in Australia (Chapman and Freeman 2008), prevalence remains substantial, particularly amongst disadvantaged groups. Across Australia, 18% of women report smoking (Scollo and Winstanley 2008), and although pregnancy has long been viewed as a window of opportunity for intervening in women’s smoking (e.g. Lowe, Balanda, and Clare 1998), around 17% of Australian women report smoking while pregnant (Laws et al. 2007). The rate is much higher amongst Indigenous women (60–65%: Eades, Read, and Bibbulung Gnarneep Team

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1999), a socially disadvantaged group (Australian Bureau of Statistics 2009) whose experiences of colonisation, discrimination and institutionalised inequity have led to high levels of disadvantage, poor health and substance abuse (Briggs, Lindorff, and Ivers 2003).

Pregnant women who smoke experience confrontation, negative judgement and negative talk from family, friends, care providers and even strangers in public (Edwards and Sims-Jones 1998; Tod 2003; Bull et al. 2007). Our perspective is in line with the recent critique of the ‘new public health’ by Bell, Salmon, and McNaughton (2011), who pointed to the neoliberal discourses underlying the contemporary public-health focus on personal responsibility and choice, and on lifestyle risk factors, leading to a punitive blaming of the individual, to the neglect of broader social inequities. The discursive conflation of ‘healthy’ and ‘virtuous’, the downplaying of any motivation or influence other than those associated with physical health, and the related but more specific issue of the social policing of pregnant women’s bodies (Oaks 2001), we argue, combine to affect the experiences of women who smoke while pregnant, in ways which may actually inhibit their ability to stop.

Entrenched in the new public health is ‘healthism’, a pervasive social discourse based on the assumption that all behaviour can be categorised unproblematically and absolutely as healthy or unhealthy (Skrabanek 1994), and that the responsible citizen’s highest moral duty is to adopt healthy behaviours and avoid unhealthy ones. Discourses of risk are exacerbated in pregnancy: the good pregnant woman should be vigilant in policing her own behaviour (Lupton 1999), but social assumptions and – increasingly – legal frameworks encourage third parties to engage in surveillance, control and coercion, for example, through laws requiring the display of reproductive health risk warnings (Kukla 2010). The pervasiveness of such information perpetuates discourses of ‘reproductive citizenship’, the idea that a ‘good’ mother is self-sacrificing in order to protect the foetus (Salmon 2011; Lupton 2012).

This pregnancy policing is a manifestation of a discourse that endorses public ownership and control over pregnant women’s bodies. At the heart of pregnancy policing is the assumption of maternal-foetal conflict: that a woman’s needs and desires will inevitably be in opposition to those of her foetus and that women require continual monitoring and coercion during pregnancy, because they would otherwise choose to act in ways that harmed the foetus (Oaks 2001; Lupton 2012). In fact, the vast majority of pregnant women strive to achieve healthy pregnancies (Ruhl 1999), but an understanding of what constitutes ‘healthy’ differs across social, economic and cultural groups.

These discourses are situated in the neoliberal assumption that all individuals have equal control over their behaviours, regardless of social, cultural and economic factors. This reductionist discourse ignores contextual restrictions on choice, but also neglects the social and personal meaning of behaviours, which may at times be more important to the individual than is their potential long-term effect on health. The implications for pregnant women who smoke include disapproval, discrimination and in some countries criminalisation, and other strategies that focus on punishment rather than treatment (Young 1994; Murphy and Rosenbaum 1999).

Although Australia has no specific legal framework concerning substance use during pregnancy, and Australian drug strategy in general focuses on harm minimisation (Australian Government 2010), smoking in pregnancy is still the subject of zero-tolerance, coercive, moralising intervention. A recent campaign, ‘When you smoke, she [the baby] gets less oxygen’, depicts a 3D ultrasound image of a foetus (Quit Now 2012), clearly
illustrating the dominant foetal-centred approach that disempowers and sidelines the women themselves (Greaves and Poole 2005).

Regardless of the legal situation, women experience marked social disapproval of smoking: across several interview studies from different countries, pregnant women who smoke have consistently described an awareness of stigma (Abrahamsson et al. 2005; McDermott, Dobson, and Owen 2006; Bull et al. 2007). In both Australia and Britain, smokers in disadvantaged communities, where smoking rates are high, have described more tolerance (Bull et al. 2007; Wood et al. 2008). Previous qualitative work investigating the smoking experiences of pregnant women or mothers has mentioned stigma and public surveillance in passing, but has mostly focused on women who have reduced, or stopped, smoking and ignored those who continue to smoke. Across a range of contexts and social backgrounds, however, pregnant women describe feelings of guilt, embarrassment or shame for continuing smoking (Dunn, Pirie, and Lando 1998; Edwards and Sims-Jones 1998; Tod 2003; Abrahamsson et al. 2005; Irwin, Johnson, and Bottorff 2005; Nichter et al. 2008; Wood et al. 2008). Previous qualitative work investigating the smoking experiences of pregnant women or mothers has mentioned stigma and public surveillance in passing, but has mostly focused on women who have reduced, or stopped, smoking and ignored those who continue to smoke. Across a range of contexts and social backgrounds, however, pregnant women describe feelings of guilt, embarrassment or shame for continuing smoking (Dunn, Pirie, and Lando 1998; Edwards and Sims-Jones 1998; Tod 2003; Abrahamsson et al. 2005; Irwin, Johnson, and Bottorff 2005; Nichter et al. 2008; Wood et al. 2008). Research which does focus on stigma has tended to consider it as a problem for health professionals, for example, in leading to patients’ under-reporting of smoking (McDermott, Dobson, and Russell 2004; Bull et al. 2007).

The ethics of deliberately stigmatising smokers as a strategy to encourage cessation have been questioned, including women’s limited control over smoking and smoking environments (Burgess, Steven, and van Ryn 2009; Greaves and Hemsing 2009; Hemsing et al. 2012). This paper focuses on the experiences of Australian women who continued to smoke while pregnant, in order to examine their experiences of stigma and any unintended consequences for their smoking.

Method

Participants

Individual, semi-structured interviews were conducted with 11 Australian women who had smoked while pregnant in the previous two years; one of these women was again pregnant, and smoking, at the time of the interview. Table 1 lists the women’s chosen pseudonyms, with age, educational level and occupation. Although ethnicity was not systematically recorded, one woman identified as Indigenous Australian.

Table 1. Demographics of sample.

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>Current occupation</th>
<th>Highest level of education</th>
<th>Child born</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sally</td>
<td>35</td>
<td>Senior project manager</td>
<td>University</td>
<td>May 2010</td>
</tr>
<tr>
<td>Shelly</td>
<td>27</td>
<td>Hairdresser</td>
<td>Technical</td>
<td>June 2009</td>
</tr>
<tr>
<td>Kate</td>
<td>29</td>
<td>Youth worker</td>
<td>Technical</td>
<td>July 2010</td>
</tr>
<tr>
<td>Sarah</td>
<td>28</td>
<td>Stay at home mum</td>
<td>High school</td>
<td>March 2010</td>
</tr>
<tr>
<td>Jade</td>
<td>22</td>
<td>Appointment advisor</td>
<td>Technical</td>
<td>July 2009</td>
</tr>
<tr>
<td>Donna</td>
<td>26</td>
<td>Personal finance representative</td>
<td>High school</td>
<td>May 2010, Pregnant</td>
</tr>
<tr>
<td>Jessica</td>
<td>23</td>
<td>Student and home-maker</td>
<td>High school</td>
<td>July 2010</td>
</tr>
<tr>
<td>Caroline</td>
<td>33</td>
<td>Receptionist</td>
<td>Technical</td>
<td>April 2010</td>
</tr>
<tr>
<td>Lisa</td>
<td>30</td>
<td>Full-time mum</td>
<td>University</td>
<td>May 2011</td>
</tr>
<tr>
<td>Tracey</td>
<td>23</td>
<td>Stay at home mum</td>
<td>High school</td>
<td>July 2010</td>
</tr>
</tbody>
</table>
Recruitment and interviews
Posters, inviting women who had smoked during a recent pregnancy to participate in an interview, were displayed at community health centres, medical centres and a university campus in Brisbane, Australia. The study was also advertised through an email news update for university staff, and through online Australian pregnancy forums. All participants responded to the advertisement, and lived in the states of Queensland, Victoria and New South Wales.

The posters included an attractive photograph of a pregnant woman, a statistic indicating the prevalence of smoking while pregnant – with the aim of conveying a non-judgemental approach – and information about inclusion criteria, the nature of the interview and ethics clearance. Women who responded to the advertisements received detailed information and were asked for consent. Two respondents were not eligible (pregnant more than two years ago), and another four did not reply to an email follow-up. Those who consented were asked to select the most convenient medium for the interview; 10 chose telephone and one an email exchange. All telephone interviews were audio-recorded, and field notes were taken during and after each. Interviews lasted between 10 and 20 min, while the email interview was carried out intermittently over three days. No incentives or rewards for participation were offered.

Interview protocols
A series of questions was developed, and revised on the basis of two face-to-face pilot interviews. An initial open-ended question about the experience of being pregnant and smoking was followed, as necessary, by a series of prompts covering pregnancy and smoking history; times and places they smoked during their most recent pregnancy; changes in smoking patterns during pregnancy; and reactions of public, partner, family and health care professionals to smoking. All interviews ended with a question about intentions to smoke in any future pregnancy. Interviews were conducted between May and August 2011.

Interviewer
The interviewer (first author) was aware of the potential impact of her social position as a young postgraduate student and as a never-smoker who has never been pregnant, both on the interviewees and on her interpretation of the data. Although the fact that the interviews were not face to face may have reduced the influence of this social position, it would still have been apparent. One interviewee in particular seemed defensive and abrupt, perhaps because of a felt need to defend her position against a younger and more privileged woman. The interviewer attempted to convey a sense of curiosity rather than judgement during the interviews.

Analysis
All interviews were conducted and transcribed verbatim by the first author. Recruitment continued until saturation was reached, determined by both authors agreeing that no new information was emerging from the interviews.

The transcripts were subjected to thematic analysis, following the guidelines of Braun and Clarke (2006). The first author read the transcripts several times and made notes of possible themes and points of difference. After this, both authors and an
independent coder individually coded one randomly selected interview, and discussed and refined the codes. There was broad agreement at this stage, so the first author proceeded to code all the interviews, with assistance and discussion with the second author. Next, the first author identified common meanings or patterns around the codes, and after several iterative revisions the final themes emerged.

Consistent with feminist research perspectives on the use of triangulation to examine the veracity of researchers’ interpretations of participants’ voices (Hesse-Biber 2012), all women were sent a transcript of their interview and a summary outlining the themes. They were invited to provide feedback, but none did so.

Results

Overview of themes

Thematic analysis suggested three overarching, interrelated themes labelled construction of stigma, responses to stigma and mechanisms for coping. Figure 1 is a visual representation of themes and sub-themes. In their talk, the respondents constructed stigma as having two separate – but sometimes congruent – dimensions, medical (the understanding that smoking while pregnant harms mother and baby) and social (the understanding of the practice as socially unacceptable and morally wrong). They responded to these

![Figure 1. Visual representation of themes.](image-url)
forms of stigma in ways which were often complex and conflicting, but which could be classified as involving acceptance, resistance or both. Women’s talk often drew on the discourse of the maternal–foetal conflict (the understanding that the woman’s needs and wants are in opposition to the foetus). In doing this, women constructed three mechanisms for coping with stigma and maintaining their position as ‘good mothers’: justifying their smoking, passing as a non-smoker and using smokers as a safe haven.

We discuss the themes and sub-themes separately, but – as will be shown – women’s talk tended at times to separate, and at times to conflate, medical and social stigma, and acceptance and resistance, so that extracts and discussions inevitably address more than one theme.

Construction of stigma

Medical stigma: smoking during pregnancy harms mother and baby

Most women drew on a medical discourse to reference their awareness of the health dangers of smoking while pregnant: words such as ‘risks’, ‘consequences’ and ‘harm’ were used to position themselves as knowledgeable and responsible. This language is in line with the broader medicalisation of smoking underpinning many current anti-smoking campaigns (Chapman and Freeman 2008). It also aligns with healthism and discourses of reproductive citizenship, highlighting the woman’s responsibility for regulating her smoking to avoid harming her baby.

Whilst acknowledging medical harm, some women undercut this: for instance, Jessica referenced the maternal–foetal conflict and simultaneously drew on the medical concept of addiction to justify her smoking.

Jessica: I know, like, it is bad and stuff to smoke, like they say the tobacco is not good for them and that. But at the same time, like smoking is extremely addictive, and I’ve been smoking since I was 14. So it was really hard.

Women’s talk constructed influential others – including family, friends, colleagues and health care professionals – as communicating an expectation to be smoke-free, justified by medical stigma. This expectation is in line with anti-smoking messages that foreground medical evidence to justify social disapproval of smoking. The following extract illustrates a sense of powerlessness, accepting the medical stigma, but ill-equipped to take action, suggesting that medical stigma does not always have the intended effect:

Donna: Well, [sigh] with the first pregnancy my mum wanted me to stop um so, you know I had everyone pushing to stop – ‘you gotta stop, you gotta stop’ – so I tried. And then the second time round, and now mum’s saying ‘yes, you do need to stop but I’m not going force you to do it, but you know, for your health and for this baby’s health’. And for my son’s health I really do need to stop. So they’re, they’re still wanting me to stop, and trust me I really want to but I just I don’t know how to do it.

Medical stigma was referenced negatively, with health care professionals described as paternalistic and over-reliant on ‘pamphlets’ and ‘lectures’. These extracts highlight the lack of encouragement and support some women seemed to receive for harm-reduction attempts that did not involve complete cessation. In these extracts, Kate’s description of health professionals’ communications about smoking constructed them as directive and unsupportive, while Jessica illustrated the interwoven nature of medical and social stigma.
Kate: The midwife who I’d seen [...] you get all the big bag of information at your 12 week midwife appointment. And that was all part of it, to give the whole lecture of quitting smoking and you know not smoking, so not smoking there and not smoking here, and doing this and doing that.

Jessica: Some of them were all right, but I found that some of them were just, you know, a bit like I dunno like, kind of disappointed in a way that like they didn’t pressure it too much. I had one or two who were just like, ‘you know you should quit, you understand that you should’, like you know pressuring and stuff. But I knew there wasn’t any point lying to them and saying I’m going to quit when I’m not.

**Social stigma: smoking during pregnancy is morally wrong**

Consistent with qualitative work with new fathers who smoked (Greaves et al. 2010), 10 women spoke of disapproval grounded in a moral, rather than medical, discourse, from strangers, friends, family, colleagues and health care professionals: this dimension of stigma was less about smoking being ‘unhealthy’ and more about it being ‘wrong’. Most explicitly acknowledged pervasive social sanctions against smoking while pregnant, including the willingness of perfect strangers to express their disapproval. The prevalence of social stigma in women’s talk highlights the implications of a strong anti-smoking climate within Australia, where women reference their ‘baby bump’ as a source of vulnerability to heightened stigma.

Jessica: […] it wasn’t a problem really. But I guess towards the end, I kind of did feel like when I really was showing when I was pregnant I kind of felt like people looked at me and thought, you know, ‘how could you be smoking’. Like I did feel like, I did feel uncomfortable smoking whilst being heavily pregnant and people’s opinions. But no one really said much. But um I know a lot of people just don’t like people who smoke and are pregnant, especially when you are showing and pregnant.

**Responses to the stigma: medical and social**

**Acceptance**

Some women accepted stigma wholeheartedly, while others rejected it, and some expressed internally contradictory stances. Five women seemed to have accepted the medical stigma and drew on the discourse of maternal–foetal conflict, to construct a variety of positions which prioritised the foetus and highlighted their own role in putting the unborn child at risk. This resonates with reports from Swedish mothers, who expressed guilt and fear that their smoking while pregnant might harm the baby (Abrahamsson et al. 2005). In the following extracts, the women drew on maternal–foetal conflict to accept the medical stigma that they were harming their vulnerable babies, and resigned themselves to accepting responsibility for failing to protect the ‘at risk’ foetus (Lupton 2012):

Sally: Because I do believe that it’s your personal choice to smoke, but it’s obviously you shouldn’t put that on to your baby. I do actually believe that, so I was guilty that I was smoking because I thought ‘why can’t I just give up for the sake of my baby’s health,’ you know, I love this child and yet I’m harming it, but unfortunately I couldn’t.

The recurrent acceptance of maternal–foetal conflict and medical stigma reflects the current approach of anti-smoking campaigns directed at pregnant women who smoke. The focus on the foetus casts the mother – particularly if she is single or working-class –
as irresponsible, neglectful and individually to blame for any ill-health (Bell, McNaughton, and Salmon 2009). These foetal-centred messages resonate with broader approaches to drug use during pregnancy, including alcohol and illicit drugs. Medical and policy approaches, as well as the mass media, position substance use as an individual, rational and deliberate choice that harms the baby, thus defining women as deliberately ‘bad’ and justifying a disempowering, paternalistic and coercive approach (Greaves and Poole 2005).

Seven women explicitly accepted social stigma by describing a guilty conscience, constructing their smoking as ‘upsetting’, ‘embarrassing’, ‘horrible’ and ‘heart wrenching’. These responses are similar to the experiences of Canadian mothers who relapsed postpartum, and expressed an internal conflict because ‘good mothers don’t smoke’ (Botchorff et al. 2000). The moral tone was also implicit in the women’s use of terms such as ‘shouldn’t’, ‘wrong’ and ‘guilty’, which reiterate the understanding that they are behaving in ways that are in sharp contrast to hegemonic constructions of ‘good mothers’.

Tracey referenced the classist construction of this stigma by pointing out that she had experienced less of it in a disadvantaged community populated by what she calls ‘ferals’ (Australian slang for welfare-dependent social dropouts), who are constructed as likely to smoke because of their disadvantaged social position and assumed inferiority. Her differential experiences of stigma are consistent with findings that stigma is lowest, and smoking rates highest, amongst socially disadvantaged groups (Stuber, Galea, and Link 2008):

Tracey: We were living in a different town when I was pregnant with my second daughter and it was, oh, it’s a bit of a hole. So you know, there’s a lot of ferals so no one really gives it a second thought, for them to see someone smoking who is heavily pregnant. And there were a few, like the older people, they’d give you looks and make little comments as they were walking past. But it wasn’t as … I didn’t find it as bad as when I was pregnant with my first daughter, and I didn’t let it get to me at all.

The only woman who wholly accepted both the social and medical stigma was Donna. She had stopped smoking in her previous pregnancy, but relapsed with a single cigarette and lost the pregnancy the following day. She described her condition as a blighted ovum (a non-viable pregnancy-like condition involving implantation of an unfertilised ovum, which could not possibly have progressed) and associated her smoking with the loss of a baby. Donna’s experience could be interpreted as an instance where resistance – to any dimension of stigma – was not an option given the severe outcome that she believed resulted from her smoking. Donna’s experience also speaks to notions of blame and responsibility associated with adverse health outcomes, and the entrenched, but misinformed, idea that pregnant women are able to prevent pregnancy loss (Ruhl 1999).

Donna: I did actually cut down the smoking. I was embarrassed about smoking while I was pregnant but I didn’t … In my first pregnancy I actually tried to quit and I went 3 days without, and my, I ended up in bed crying and my husband threw a packet of smokes at me and told me to ‘go have a smoke’ and ‘I want you to go have a smoke’. And it was actually the next day that I lost the baby. So I kind of, mentally I couldn’t quit because I was scared that if I quit I was going to get to that 3 day stage, and I was going to stress myself out again that I was going to lose my son that I had. So it was a mental thing for me. I was, I was so embarrassed to smoke, but I didn’t want to lose the baby again and I know it probably had nothing to do with it the first time, but I did try and quit smoking. But um, you know just trying to get over that mental state was a bit hard.
Resistance

Resistance to medical stigma was often grounded in references to the good health of their babies. Phrases such as ‘no complications whatsoever’, ‘healthy children’ and ‘no problems’ were used to construct their personal experiences in opposition to broader medical understanding and, at times, to challenge the view that smoking was genuinely harmful.

Jade: They say there’s so many effects on the unborn child […] the midwife actually said that my placenta um, was probably the most healthiest she’s ever seen even for a non-smoking woman […] So I don’t entirely believe that smoking affects the unborn child.

Six women described resisting strangers’ expressions of social stigma; this was described positively as resisting interference and asserting one’s right to self-determination. This resistance suggests that policing women’s behaviour may not always have the intended effect, and may further stigmatise these women by reinforcing classist values, rather than supporting their cessation efforts:

Tracey: I did have a lady sort of have a pretty nasty go at me at the shopping centre about smoking. But I think I was just that used to people making comments and feeling they can judge me that I just … it was water off a duck’s back.

Accepting and resisting stigma

Seven women took up conflicting positions in which they both resisted and accepted stigma. This was particularly the case with medical stigma, which enabled women to downplay their vulnerability to risk, an unintended consequence of the medicalisation of smoking. This is similar to responses of Australian Indigenous women who drew on personal experiences of good health to discount the impact of smoking (Wood et al. 2008), suggesting that lay interpretations of, and meanings attached to, health are often prioritised over expert medical knowledge.

Sally: With this baby it was born smaller than the others as well, but for the whole pregnancy I did stress out then, whether I’d smoke so much that he was gonna be born with problems. But thankfully he wasn’t, but actually he is my healthiest. But not that I’ll [laughs] I encourage people to smoke while they are pregnant. The other two kids I didn’t smoke with at all and they were born bigger babies but both ended up having asthma at, you know, a very young age and this one has been the healthiest of them all, I think he is immune to all the smoke I gave him.

The next extracts illustrate simultaneous acceptance and resistance of both dimensions of stigma, illustrating the complex and at times contradictory nature of perceptions of stigma which can actually lead to increased smoking. In these extracts, women referenced the blurred boundaries of the ‘interembodied maternal/foetal subject’ (Lupton 2011), and how they negotiated their position of subjecting the foetal body to risk:

Jenny [email interview]: I found that I was judged as a disgusting, uneducated, gutter rat. I found this by the way people would look/stare, question my motives, make comments on my parental ability etc. I found it quite horrible, my body, my baby, my choice.

Sarah: Yeah I would say that the biggest sort of feeling is absolute guilt of smoking. Like, knowing there’s a baby growing inside of you and how bad it is for you, you know not
being pregnant, but being pregnant is even worse. And basically, like the guilt sort of con-
tinues, sort of like making you want to smoke, if that makes sense. Like, it’s, you basically,
you’re feeling really bad about it but as opposed to just sort of like throwing cigarettes in
the bin and getting rid of them you’re just even more drawn to um to doing it, basically.

**Mechanisms for coping**

**Justifying smoking**

Several women justified their smoking by constructing it as an informed decision,
supported by health care professionals, and – drawing on the medical discourse – as
actually better for the foetus than would be the stress of stopping. Their justifications
often focused on attaining balance between the stress of quitting and the harm of
continued smoking, creating a space for them to negotiate risk and stigma by using
‘expert’ opinions to legitimise smoking.

Jenny [email interview]: Anyway, with my daughter I had already been smoking for 6 years
except when pregnant earlier. I was 19, turned 20 before birth. It was all I craved, I tried
cut down to quit, no good. I spoke to my ob [obstetrician] and he said that the baby
would already be used to it and he really didn’t believe that it caused all that much
damage.

Tracey: Yeah it was oh, she was, she was the best doctor and you know I’d say she did
the whole doctor thing and tried to get me to quit and everything. And then yeah, she saw
me on a day when I hadn’t had a cigarette and she’s gone ‘no, no just continue to cut
down, cut down as much as you can’ and you know when I was able to actually take
something to help me quit then she would put me onto it, so, right after I’d had the baby.
But I never actually ended up doing it, so. But no, she was really good, she um, yeah she
was really supportive.

The women frequently positioned themselves, regardless of their actual smoking
rate, as actively engaging in harm reduction to manage the risks and stigma associated
with smoking in pregnancy. Nichter (2003) has suggested that individuals often use
harm reduction strategies to reclaim a sense of control. In particular, women’s descrip-
tions of their harm-reduction strategies allowed them to reposition themselves in a posi-
tive light and manage their ‘spoiled’ identities as pregnant smokers (Goffman 1963;
Chapman and Freeman 2008). By constructing a sense of themselves as managing the
risk, they were able to construct themselves as ‘good mothers’.

Sarah: The urge to smoke and to feel normal again because it was quite, like an anxiety as
well. Just to, sort of feel normal by smoking again, I actually thought that would be in
some way better for my health than sort of like feeling sick and hungry and stressed out
all the time. So, I decided like, I started smoking again but I decided then that as opposed
to sort of smoking 30 a day – because that’s what I was doing – I decided not to go over
10 a day and that’s like, I pretty much did that for the entire pregnancy with, with him.

Only one woman described re-starting smoking when pregnant, after years as an
ex-smoker, and in doing so justified her smoking by describing a social environment
that promoted smoking. Caroline did not describe returning to the ‘smoker’ identity she
had previously inhabited (As far as I was concerned I was a non-smoker), but instead
described smoking as a deliberate and occasional act, chosen to help her cope with the
stress of motherhood. This conflict between the non-smoker identity and the act of
smoking has also been described by socially advantaged smokers in Canada, who rejected a ‘smoker’ identity as inconsistent with their lifestyles, yet still smoked (Frohlich et al. 2010).

Caroline: I was a smoker about ahh, 6 years ago and I quit and I had my first baby, and didn’t pick up smoking again until I was pregnant with my second one. And I’d have a cigarette probably once a month or so, mainly because the people that I was with at the time in a social situation were smokers. I knew it wasn’t a good idea, I knew it was it could harm the baby but unfortunately um being around other people that were smoking – and my excuse was um a little bit of stress from already having [laughs] a child – um I’d have the occasional um cigarette.

Using smokers as a safe haven
Several women referenced other people’s smoking status as an explanation for how they did or should react, based on the expectation that smokers would not judge pregnant smokers. This assumption aligns with comments that stigmatisation has strengthened the ‘in-group’ identity of smokers (Burgess, Steven, and van Ryn 2009). These women used an ‘us versus them’ model for identifying and negotiating stigma, assuming that judgement by friends and family would depend entirely on their smoking status. However, this was not always the case and women described receiving judgement from other smokers, contradicting their expectations of a safe haven.

Kate: Yes some of them were a bit you know um, oh not disgusted, but they weren’t happy. [...] But they couldn’t say much because they’d all done exactly the same thing. Yeah, so they were like ‘oh you know you shouldn’t be smoking na na na na naa’ and I’d be like ‘yeah I know but you can’t talk so you know.’ So I just used to um, so if we were at a family gathering I would just go around the other side of the house to smoke.

This construction of smokers as a safe haven illustrates the way in which social environments enabled or hindered smoking. This may be an unintended counterproductive effect of smoking-related stigma, by increasing social withdrawal from non-smokers (Stuber, Galea, and Link 2008) and at times other smokers. Women, at times, explicitly described moderating their own smoking as a function of this, highlighting the advantages of a concealable stigmatised status:

Lisa: Yeah around certain people as well I suppose, like it’s ah, certain people that you know are more against it than others. And um, but then there’s other people that I would feel more comfortable with as well. So like one of my sisters who has also smoked through her pregnancies, you know every one of her pregnancies, I feel comfortable having a cigarette with her, compared to one on one with my elder sister who would say things like, you know ‘put that out I can hear your baby coughing’.

Passing as a non-smoker
Several women described concealing their smoking in order to pass as non-smokers and avoid stigma, another unintended consequence of stigma (Stuber, Galea, and Link 2009). This, too, marginalises smokers, creating a perceived need to present themselves dishonestly to others, and may result in their avoiding contexts in which they might be offered support for cessation. This resonates with the reluctance of substance-using mothers and pregnant women to seek treatment, due to shame and fear of prejudice.
(Poole and Isaac 2001), suggesting that stigma is a barrier to disclosure and hence treatment for a range of addictive behaviours in pregnancy.

Some women only told certain people, usually smokers, and kept their smoking in pregnancy a secret from people from whom they expected judgement or differential treatment:

Caroline: Ah I don’t think I mentioned it to them [health care professionals].
BW: because it was so, such a small amount?
Caroline: Yeah because it was a small amount and I knew the consequences and I knew what they were going to say, basically I knew they would tell me it’s not a good idea, and it can harm your baby. [...] As far as I was concerned I was a non-smoker, in my eyes [sigh] I knew I was a smoker but having one so rarely or not, you know, I wasn’t having one every day and I wasn’t having, or a packet at least every day, I was having one a month. I thought oh well maybe I’m not classed as a smoker.

Other women spoke of avoiding smoking in public, in order to avoid implicit, or at times explicit, stigma. This is similar to the ways in which Scottish smokers negotiated the stigma associated with smoke-free policies, in particular smoking in places which are less visible to others (Richie, Amos, and Martin 2010). However, many women were strongly of the view that one should not smoke in public while visibly pregnant. This suggests that smoke-free policies and social stigma serve to marginalise smokers, who may seek out places where smoking is permitted (smoking islands: Thompson, Pearce, and Barnett 2007), and thus avoid non-smokers and the increasingly large areas where smoking is not permitted.

Donna: No, I generally didn’t do it in public um, um sorry there was, um, I didn’t do it [muffled sob] um, I would go to the shops and I would wait till I got home and I would smoke out the back at home so no one could see me. I wouldn’t do it in public because I didn’t want to [sighs], um I had people – I had a lady look at me funny and I felt really bad. So I didn’t do it in public like, because I didn’t have to, because – I dunno – I could just switch off in my head while I was out.

Lisa: Just also out in general public like, I wouldn’t just have one wherever I would normally have one when I was not pregnant, like I would find somewhere where no one would really see me, even to the extent of – like what I did with this pregnancy, my latest one – is like um, like when you get out of the car or whatever I would kind of lean on the car a bit so no one could see my belly.

Discussion
This analysis explores the experiences of women who smoked during pregnancy from the perspective of stigma arising from ‘new public health’ requirements that individuals take responsibility for, and manage, risk behaviours. All the women described perceived smoking-related stigma. Their talk constructed two distinct but connected sources of stigma, one related to the medical evidence against smoking (medical stigma) and the other concerning moral evaluations of smoking (social stigma). Women’s perceptions of, and reactions to, stigma offer insight into its paradoxical implications, and suggest that it effectively prevents them from disclosing their smoking status or seeking help with cessation.

Over the past several decades, the cultural meaning of smoking has been deliberately shifted from ‘attractive’ to ‘dirty’ (Chapman and Freeman 2008), and legislative and policy changes have led to the stigmatisation of smoking and smokers (Bayer and
Stuber 2006). These women both accepted and resisted these social dimensions of stigma. However, they seemed more likely to resist medical stigma, often by reference to the good health of their babies or the belief that stopping smoking would ‘stress’ their unborn babies, making it safer to continue. These arguments, focusing as they do on the health of the foetus, are situated in a patriarchal approach to the female body as primarily a vessel for reproduction rather than an aspect of an autonomous individual (Greaves and Poole 2005). Women spoke of ways in which they managed or avoided stigma, including justifying continued smoking, relying on the support of other smokers, and concealing their smoking in a range of contexts.

The findings contribute to the debate about the ethics and effectiveness of using stigma as a tool for reducing smoking rates (Chapman and Freeman 2008; Stuber, Galea, and Link 2008). The stigma experienced by these women did not appear to help them stop: for some, continuing to smoke was associated with emotional distress and self-blame; for others, stigma seemed to produce resistance to the very idea of stopping. For most, it encouraged them to conceal their smoking and thus to reduce the likelihood of receiving appropriate treatment.

This suggests that the current punitive, zero-tolerance approach to pregnant women who smoke is at best ineffective, and at worst counterproductive, for at least some Australian pregnant women. An alternative might be a more empathetic approach, which acknowledges that pregnant women who smoke do want to avoid harm to themselves and their babies, but need support rather than censure in order to stop smoking. Moving away from individual-blaming messages to recognise sociocultural factors that hinder cessation efforts (e.g. high levels of smoking within family or social group) and promoting cessation amongst the family and friends of pregnant women, might serve to mobilise a sense of a joint endeavour to create a smoke-free environment, thus offering support and shared effort in place of blame.

The findings suggest that it is unhelpful to pregnant women who smoke to assume that they are ignorant or do not care about the health of the foetus, and to acknowledge that pregnant women find smoking cessation just as hard as anybody else, and that encouragement and support are more effective than stigma. A social environment in which pregnant women feel more able to make positive decisions to stop smoking would involve fewer negative and coercive responses from the public, care providers, family and friends. Within this framework, we suggest more endorsement of harm-reduction efforts, consistent with current Australian policies for the use of other addictive and harmful drugs (Australian Government 2010).

Of course, qualitative interviews with a small sample of women provide evidence of their perceptions, not necessarily of social realities. However, it is notable that we experienced considerable gatekeeper resistance to recruitment for this study. We were refused permission to place recruitment posters in three local community and medical centres, while another two requested that we apply for a second round of ethics approval. Two online forums also refused to carry our advertisement. We formed the impression that gatekeepers felt that acknowledging the existence of pregnant women who smoke would suggest a level of acceptance of the practice, with which they were uncomfortable. These barriers to research on smoking during pregnancy support our conclusion that pregnant women who smoke may find it difficult to access sympathetic assistance to stop. The fact that no interviewee was willing to speak face to face may also be a reflection of this climate of shame.

In conclusion, we suggest that public health campaigns that focus on creating a social discourse that labels particular actions as shameful does not promote good health,
but rather entrenches a classist culture of blame that makes it less likely that individuals will be able to find the support they need.

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Chapter 4. Stigma and hostility towards pregnant smokers: Does individuating information reduce the effect?

The previous chapter provided an inductive thematic analysis of how women constructed, responded to, and coped with the stigma associated with smoking during pregnancy. We found that women’s reports of stigma involved descriptions of stigmatising behaviour, both from health professionals and from family, friends, and strangers. Stigma was understood as taking two forms: social stigma and medical stigma. Social stigma reflected the cultural representation of smoking during pregnancy as (socially) unacceptable, while medical stigma referred to smoking during pregnancy as (medically) harmful. We found that some women reported the greatest judgement from people who did not know them, suggesting that strangers may be a source of significant disapproval.

This analysis had similarities to a previous analysis (Bell et al., 2010) of Canadian smokers’ accounts of their experiences of denormalisation policies. In particular, Bell and colleagues (2010) applied Link and Phelan’s (2001) definition of stigma, showing the ways in which smokers experienced being stereotyped and labelled, and described a loss of social status, and a perception that smoking was a marker of lower class. Our analysis similarly revealed negative stereotyping and labelling with classist undertones, which implied a loss of social status (e.g., "disgusting, uneducated, gutter rat"), and provided evidence of an ‘us’ versus ‘them’ model which women used to identify and negotiate potential judgement. In addition, we found that women’s harm reduction efforts allowed them to manage their ‘spoiled’ identity (Goffman, 1963) and reclaim their position as ‘good’ mothers.

In summary, the previous chapter provided the first analysis of women’s experiences of the presumed stigma associated with smoking during pregnancy. In this analysis, we showed the (negative) role of members of society in women’s accounts, often positioned as the source of negative views. It was this finding that led me to consider the importance of the perspectives of community members in producing negative views concerning women who smoke during pregnancy.

To broaden the view, in the next chapter the focus shifts to members of the community to examine their role in producing stigma. Previous studies have examined how smoking-related stigma is perceived by both smokers and non-smokers (Farrimond & Joffe, 2006; Stuber, Galea, & Link, 2008), including the influence of legislative restrictions on the negotiation (and stigmatisation) of smoking in public spaces (Poland, 2000; Poland et al., 2000). While these studies have provided insight into the ways in which smokers are stigmatised by other smokers and non-smokers, there is little consideration of specific groups
of smokers, such as women who smoke during pregnancy, who may face increased stigma for smoking. Further, these studies do not attempt to examine avenues to reduce stigma towards smokers.

To date, there has been little consideration of the ways in which community members might display negative views towards smokers (specifically, pregnant smokers) and to what extent information about a smoker’s personal circumstances might reduce those negative views. In this chapter, stigma is conceptualised as an expression of negative views, attitudes or stereotypes towards women who smoke during pregnancy – these terms are used interchangeably to refer to the expression of statements that position women who smoke during pregnancy negatively. This can best be understood within Link and Phelan’s (2001) framework, as one of the components of stigma, in which stigma is defined as the association of an identifying difference, such as smoking, with negative attributes. The concept of stereotypes offer a lens through which to examine the production of stigma at an individual level (Frost, 2011).

Building on the previous chapter, we consider whether information about a woman’s personal circumstances may reduce community members’ negative views of a hypothetical pregnant smoker. We draw on experimental social psychology literature to examine the role of stereotyping and individuating information in influencing university students’ views of women who smoke during pregnancy.

Stereotypes are conceptualised as characteristics assumed to be common to a particular social group; researchers have argued that stereotypes are more likely to be activated when people do not have the opportunity to consider individuating information, such as trait or behavioural information about a particular person (Hamilton, Sherman, & Ruvolo, 1990; Pratto & Bargh, 1991). We apply the concept of individuating information in a controlled experimental setting, to examine whether manipulating the level of contextual information about a hypothetical woman smoker reduces students’ negative views.

The concept of individuating information offers a useful lens through which to examine representations of women who smoke during pregnancy, in an experimental setting. Consistent with a postmodern perspective, we use this concept to examine whether language use (information about the person, or only about her membership of the social group of women who smoke during pregnancy) can promote or inhibit expressions of stigma (conceptualised in this chapter as negative views). In particular, whether providing individuating information about a hypothetical woman smoker offers the space for participants to construct positive views about this hypothetical woman.
In particular, Chapter 4 examines the perspectives of a convenience sample of university students (see Appendix B1 for information sheet). The findings presented in this chapter are based on a quantitative analysis of data collected as part of Study 2 (see Appendix B2 and B3 for survey). Although the sample of first-year university students is not representative of the general population (our sample was mainly young, white, non-smoking women, from relatively privileged backgrounds), their perspectives may be similar to other groups in society who are similarly made up of a majority of white, non-smoking, educated women. These might include health professionals who may have contact with women who smoke during pregnancy. The aim of this chapter is to examine whether, and to what extent, a sample of university students express negative views, and whether altering information about a hypothetical smoker affects their views about that smoker. This paper is in the form of a paper published in *Psychology and Health* in January 2013.

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Stigma and hostility towards pregnant smokers: Does individuating information reduce the effect?
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Stigma and hostility towards pregnant smokers: Does individuating information reduce the effect?

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Australia is at the forefront of tobacco control, yet 17% of Australian women smoke during pregnancy. Negative attitudes to smoking are intensified when the smoker is pregnant, consistent with a discourse that encourages surveillance of pregnant women. Such overt anti-smoking attitudes create a context which may make it difficult for pregnant smokers to seek assistance to stop. However, there is little evidence on the extent to which pregnant smokers are stigmatised by community members. We used vignettes to examine the degree of smoking-related stigma expressed by 595 Australian university students who rated a woman, described as a mother who was smoking or not, and pregnant or not. Further, we examined whether provision of individuating information reduced the degree of stigma. Mothers described as smokers were rated more negatively than those not, particularly if they were pregnant: smokers were perceived as unhealthy, and also as bad mothers. Provision of individuating information slightly reduced these effects. These findings support the view that smokers – particularly if pregnant – are subject to negative moral judgement. Our findings contribute to the ethical debate about stigma-inducing tobacco control efforts, and suggest that anti-smoking campaigns that contextualise smoking in pregnancy might reduce stigma and assist cessation.

Keywords: smoking; pregnancy; tobacco control; stigma; attitudes

In developed countries such as Australia, social attitudes towards smoking have undergone a dramatic shift in recent decades, as a result of concerted campaigns aimed to de-normalise and stigmatise tobacco use (Bayer & Stuber, 2006; Bell, Salmon, Bowers, Bell, & McCullough, 2010; Chapman & Freeman, 2008). What was once considered a high-status, sexy practice is now generally regarded as unhealthy, unclean and an indication of low social status (Chapman & Freeman, 2008).

Australia is widely regarded as an international leader in many aspects of comprehensive tobacco control, and in the past few decades it has seen large decreases in smoking rates (Scollo & Winstanley, 2008). However, as in other countries, tobacco control strategies have been least effective amongst the most disadvantaged, to the extent that tobacco consumption is a strong indicator of level of social disadvantage (Siahpush, 2004). As Graham (2012) has noted, smoking has come to have a particular, negative, social meaning; not only has it become a marker of low social status, but it

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has also become highly stigmatised, within a discourse which equates smoking with fecklessness, poverty and ignorance.

There is emerging consensus that smoking can be understood as a ‘spoiled identity’ (Chapman & Freeman, 2008; Stuber, Galea, & Link, 2009). The framework of stigmatisation as posited by Link and Phelan (2001) may usefully be applied to contemporary attitudes to smoking: negative stereotyping is identified as one of five elements that contribute to the process of stigmatisation (Stuber et al., 2009). Thus, throughout this paper, we refer to ‘negative attitudes’ in discussing research participants’ specific responses to smokers, and ‘stigma’ to refer to the broader, shared, cultural discourse that enables people to criticise those who smoke. In Australia, the discourse that creates the stigmatised, spoiled identity of the smoker is entrenched (Chapman & Freeman, 2008), but only recently has research started to explore the unintended negative effects of this stigma, for instance showing how increased social isolation and public criticism of smokers serves to undermine cessation efforts (e.g. Stuber et al., 2009).

Without denying the importance of tobacco control, a number of authors (e.g. Bayer & Stuber, 2006; Bell et al., 2010; Burgess, Steven, & van Ryn, 2009) have argued that the deliberate creation of social stigma associated with smoking may be particularly counterproductive amongst marginalised and disadvantaged groups. This paper addresses one particular group that has been extensively targeted by health promotion campaigns, namely pregnant women. Despite widespread awareness of the health risks, a significant proportion of women continue to smoke when pregnant. In Australia, approximately 17% of women report smoking when pregnant (Laws, Abeywardana, Walker, & Sullivan, 2007), but the figure is as high as 60–65% amongst Indigenous women (Eades, Read, & Bibbulung Gnarneep Team, 1999).

Oaks (2001) has argued that a social discourse of ‘pregnancy policing’ endorses a sense of public ownership over pregnant women’s bodies, and serves to justify overt commentary about, and criticism of, pregnant women’s behaviours in ways which would be considered socially inappropriate if directed to other people. Pregnant women who smoke have consistently described experiences of social stigma (Abrahamsson, Springett, Karlsson, & Ottosson, 2005; Bull, Burke, Walsh, & Whitehead, 2007; McDermott, Dobson, & Owen, 2006), and a range of qualitative studies has highlighted pregnant women’s internalisation of stigma as guilt, embarrassment and shame (Abrahamsson et al., 2005; Dunn, Pirie, & Lando, 1998; Edwards & Sims-Jones, 1998; Irwin, Johnson, & Bottorff, 2005; Lendahls, Öhman, Liljestrand, & Håkansson, 2002; Nichter et al., 2008; Tod, 2003; Wood, France, Hunt, Eades, & Slack-Smith, 2008). In addition, for their health and that of their babies, pregnant women describe reactions that actually serve to make it less likely that they can access assistance to stop, such as hiding their smoking from family or the public (Bottorff, Johnson, Irwin, & Ratner, 2000; Edwards & Sims-Jones, 1998; Wigginton & Lee, 2012) and avoiding disclosure to health care professionals (Bull et al., 2007; Wigginton & Lee, 2012).

Although the above suggests that women who smoke during pregnancy experience social stigma and that this may reduce their ability to access support for cessation, there is no evidence as to whether community members actually have stronger, or different, attitudes to pregnant smokers than they do to other smokers. This paper aims to explore this question, and to contribute to the ongoing debate about the ethics of deliberately engendering stigma, by examining the extent of social stigma towards pregnant smokers.
amongst university students, using a series of vignettes describing a woman, the mother of a two-year-old, who is described as pregnant or not and as a smoker or not. Our research is informed by a concern that a high level of stigma would be counterproductive for pregnant women who smoke (Wigginton & Lee, 2012). This research occurs in a country with a pervasive anti-smoking public culture, and explores the extent of smoking-related stigma in the context of comprehensive tobacco control, amongst a relatively advantaged group of university students.

Stereotypes about a particular group—such as pregnant smokers—are based on assumptions about characteristics shared by members of that social group (Hamilton, Sherman, & Ruvolo, 1990). Stereotypes are most likely to be activated when people do not have the opportunity to consider individuating information, which could include trait or behavioural information about the target that is relevant to the observer (Pratto & Bargh, 1991). Thus, to explore the extent to which stigmatising responses are related to stereotyping, and to examine whether stereotyping and negative attitudes may be reduced by provision of individuating information, we provide descriptions of targets with (elaborated) or without (simple) individuating information.

We make three main predictions: that those rating the smoker will have more negative attitudes than those rating the non-smoker; that this effect will be stronger for those rating the pregnant woman than those rating the non-pregnant woman; and that both these effects will be moderated by the provision of elaborated (vs. simple) information.

**Method**

*Participants*

Five hundred and ninety-five students enrolled in first year psychology courses at the University of Queensland, Australia, participated for course credit (a further 31 participants were excluded from this set of analyses because of high levels of missing data). Participants were mainly women (83%), with a median age of 18 ($M=20.52$, range 16–48), and 94% were studying full-time. Overall, 58% also had paid work, mostly working 1–15 h per week (38%). Most were born in Australia (64%), single (61%), and childless (95%). We categorised 10% as smokers ($N=62$: 10 daily smokers, 52 social or occasional smokers) and 88% as non-smokers ($N=526$), with seven not stated. Overall, 83% of participants had at least one smoker amongst their parents ($N=92$), friends ($N=368$), partner ($N=31$), siblings ($N=71$), or other family members ($N=298$). This included all current smokers and 72% of non-smokers.

*Design*

A three-way factorial between-participants design was employed, in which the smoking (non-smoker, smoker) and pregnancy status (pregnant, non-pregnant) of the target woman, and the level of individuating information (simple, elaborated) were manipulated. Each participant read one of the eight vignettes before rating the woman described in the vignette on a series of 12 semantic differential items derived from a review of qualitative literature of women’s descriptions of being stigmatised as pregnant smokers.
Measures

Vignettes

All vignettes described Marge as the mother of a two-year-old (in order to distinguish any effects of pregnancy from general effects of motherhood). Depending on the condition, the following information was present or absent: Marge was described as pregnant with her second child, or not (pregnancy status); as smoking half a pack of cigarettes a day, or not (smoking status); and with or without individuating information about her personal circumstances, which was designed to provide possible explanations (recent major life event, busy lifestyle and emotional distress) for why she might find it difficult to stop smoking (elaborated/simple). For example, the pregnant, smoker, elaborated condition was:

Marge is due in early September with her second baby [pregnancy status]. Early on in her pregnancy her fiancé left her and since then she has been busy looking after her two-year-old, working full-time, and preparing for the new arrival [individuating information]. She looks forward to the arrival of her new baby. Marge has been smoking half a pack of cigarettes a day throughout her pregnancy [smoking status]. She has been cutting down her smoking as much as she can and plans to continue this throughout the pregnancy. She says the cigarettes are the only thing keeping her from breaking down at this point [individuating information].

The non-pregnant, smoker, elaborated condition was:

Recently, Marge’s fiancé left her and since then she has been busy looking after her two-year-old and working full time [individuating information]. Marge has been smoking half a pack of cigarettes a day [smoking status]. She has been cutting down her smoking as much as she can and plans to continue this. She says the cigarettes are the only thing keeping her from breaking down at this point [individuating information].

The pregnant, smoker, simple condition was:

Marge is due in early September with her second baby [pregnancy status]. She looks forward to the arrival of her new baby. Marge has been smoking half a pack of cigarettes a day throughout her pregnancy [smoking status].

The non-pregnant, non-smoker, simple condition was:

Marge is the mother of a two-year-old.

Semantic differential

The participants read one of the vignettes and then rated the extent to which they felt Marge was described by 12 semantic differential items, derived from a reading of qualitative work on pregnant women’s experiences of smoking-related stigma (e.g. Bull et al., 2007; Edwards & Sim-Jones, 1998; Wood et al., 2008). We identified common themes in the descriptions given by pregnant women who smoked, and selected an adjective pair to create a semantic differential item for each theme (see Table 1).
Demographics

Participants specified their age, gender, country of birth, relationship status, smoking status, parenthood status, employment status, smoking status of family and friends, and enrolment status at university.

Questionnaire

The vignettes, semantic differential and demographics were presented in the context of an online questionnaire. Responses to other questions, pertaining to attitudes to pregnant smokers more generally, are reported elsewhere (Wigginton & Lee, In preparation).

Procedure

Data were collected across two enrolment periods in order to generate an appropriate sample size. The four conditions involving the pregnant target were collected between August and November 2011, and the four involving the non-pregnant target between December 2011 and May 2012. After ethics approval had been obtained, students were recruited through an online database which provided a choice of potential research projects for course credit. Participants met with the first author and were provided with written information about the study and directed to the online survey. Assignment to condition was on the basis of a unique code provided on each information sheet, which mapped on to one of the eight conditions.

Results

Because data were collected across two periods, demographic variables were compared across the ‘pregnant’ and ‘non-pregnant’ conditions. The participants in the ‘pregnant’ conditions were more likely to be Australian-born, partnered, employed, smokers, and with smokers in their social networks. Analysis was conducted both with and without

<table>
<thead>
<tr>
<th>Dependent variables</th>
<th>Smoking mean</th>
<th>Non-smoking mean</th>
<th>F (df=1,593)</th>
<th>eta-squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy–unhealthy</td>
<td>4.43</td>
<td>2.47</td>
<td>879.81*</td>
<td>.600</td>
</tr>
<tr>
<td>Good mother–bad mother</td>
<td>3.61</td>
<td>2.00</td>
<td>502.92*</td>
<td>.461</td>
</tr>
<tr>
<td>Empowered–passive</td>
<td>3.59</td>
<td>2.51</td>
<td>183.05*</td>
<td>.238</td>
</tr>
<tr>
<td>Aware–ignorant</td>
<td>3.52</td>
<td>2.10</td>
<td>304.23*</td>
<td>.341</td>
</tr>
<tr>
<td>Accepting–dismissive</td>
<td>3.45</td>
<td>2.13</td>
<td>340.79*</td>
<td>.367</td>
</tr>
<tr>
<td>Proud–embarrassed</td>
<td>3.19</td>
<td>2.25</td>
<td>205.20*</td>
<td>.259</td>
</tr>
<tr>
<td>Sceptical–believing</td>
<td>2.78</td>
<td>3.38</td>
<td>82.26*</td>
<td>.123</td>
</tr>
<tr>
<td>Dependent–independent</td>
<td>2.68</td>
<td>3.66</td>
<td>93.66*</td>
<td>.138</td>
</tr>
<tr>
<td>Guilty–innocent</td>
<td>2.42</td>
<td>3.60</td>
<td>263.04*</td>
<td>.309</td>
</tr>
<tr>
<td>Controlled–in control</td>
<td>2.35</td>
<td>3.51</td>
<td>189.28*</td>
<td>.244</td>
</tr>
<tr>
<td>Selfish–selfless</td>
<td>2.14</td>
<td>3.89</td>
<td>611.19*</td>
<td>.510</td>
</tr>
<tr>
<td>Stressed–relaxed</td>
<td>1.92</td>
<td>2.39</td>
<td>39.62*</td>
<td>.063</td>
</tr>
</tbody>
</table>

Notes: *p<.001.
Response options 1–5, with a lower score indicating stronger endorsement of the first item in each pair.
these variables as covariates, and the pattern of results was identical. Analysis was also conducted with and without the inclusion of smokers, and the pattern of results was again unaffected. Results presented are with the full data set, and without covariates.

**Semantic differential**

A three-way (smoker–non-smoker; pregnant–non-pregnant; and simple–elaborated) between-participants multivariate analysis of variance was performed on 12 semantic differential scores. All three main effects were significant: smoking status, multivariate $F(12, 576) = 110.30, p < .001$, partial $\eta^2 = .70$; pregnancy status, multivariate $F(12, 576) = 9.87, p < .001$, partial $\eta^2 = .17$; and level of information, multivariate $F(12, 576) = 33.96, p < .001$, partial $\eta^2 = .41$. The three two-way interactions were also significant: pregnancy and smoking status, multivariate $F(12, 576) = 5.14, p < .001$, partial $\eta^2 = .10$; smoking status and level of information, multivariate $F(12, 576) = 8.80, p < .001$, partial $\eta^2 = .15$; and pregnancy status and level of information, multivariate $F(12, 576) = 3.51, p < .001$, partial $\eta^2 = .07$. The three-way interaction was not significant, multivariate $F(12, 576) = .83, p = .616$, partial $\eta^2 = .02$.

**Smoking status**

Univariate analyses with Bonferroni adjustments (alpha = .004) showed statistically significant main effects for smoking status on all 12 dependent variables, with ratings of the smoking woman being significantly more negative than those of the non-smoking woman (see Table 1). The largest mean differences were for ‘healthy–unhealthy’ and ‘good mother–bad mother’, while the largest effects as indicated by $F$ ratio and partial eta-squared were for ‘healthy–unhealthy’ and ‘selfish–selfless’.

**Smoking and pregnancy**

Univariate analysis with Bonferroni adjustments (alpha = .004) of the main effect of pregnancy status showed that six variables were statistically significant. The pregnant woman was rated as more healthy, empowered, accepting, proud, believing, and relaxed than the non-pregnant woman. However, this main effect combined smoking and non-smoking conditions. Looking only at the interaction between smoking status and pregnancy status, a total of six variables were significant ($p = .004$).

Table 2 presents cell means, univariate tests, and pairwise comparisons for this interaction. Comparison of means shows that for each of these variables, the difference in ratings between smoker and non-smoker was greater for the pregnant than the non-pregnant target. Four of the six variables showed a consistent pattern of differences, where the pregnant smoker and non-pregnant smoker were rated equally and most negatively, followed by the non-smoking non-pregnant woman, with the non-smoking pregnant woman rated most positively. This included the following variables: ‘healthy–unhealthy’; ‘good mother–bad mother’; ‘accepting–dismissive’; and ‘guilty–innocent’. For ‘aware–ignorant’, all four targets were significantly different from each other: the pregnant smoker was considered most ignorant, then the non-pregnant smoker, the non-pregnant non-smoker and the pregnant non-smoker. For ‘selfish–selfless’, the pregnant smoker was rated most selfish, then the non-pregnant smoker, with the two
non-smokers rated equally and as least selfish. In summary, these effects suggest that the effect of smoking information was greater when the target was also described as pregnant, and that the pregnant smoker tended to receive the most negative ratings and the pregnant non-smoker the most positive ratings.

Individuating information, smoking and pregnancy

Univariate analyses of the main effect of information elaboration showed that nine of the variables were statistically significant using a Bonferroni-adjusted alpha level of \( p = .004 \). The woman described simply was rated as more dependent, controlled, a bad mother, guilty, ignorant, relaxed, proud, dismissive, and selfish, than the woman in the elaborated conditions. Of more interest were the two-way interactions of individuating information with smoking and with pregnancy, which are detailed in Tables 3 and 4.

For the interaction between individuating information with smoking status, Table 3 shows that seven of the twelve semantic differentials showed significant effects. For six of these variables, the difference in ratings between smoker and non-smoker was greater in the simple than in the elaborated condition, except for ‘sceptical–believing,’ for which the post hoc tests showed a main effect of smoking condition only. The pairwise comparisons showed two patterns of interactions. For three of the semantic differentials – ‘healthy–unhealthy’, ‘good mother–bad mother’ and ‘selfish–selfless’ – ratings were significantly different across all four conditions, with the most negative ratings for the simple smoker, then the elaborated smoker, then the simple non-smoker, with the elaborated non-smoker receiving the most positive ratings. The other three – ‘aware–ignorant’, accepting–dismissive’ and ‘guilty–innocent’ – showed a second pattern. Again, the most negative ratings were for the simple smoker, then the elaborated smoker, with the two non-smokers being rated equally and most positively.

For the interaction with pregnancy status, Table 4 shows that univariate interactions were significant for only two of the twelve variables. For ‘aware–ignorant’, the woman in the non-pregnant simple condition was rated as more ignorant than in any other
condition. For ‘stressed–relaxed’, the woman described in the pregnant simple condition was rated as the most relaxed, followed by the non-pregnant simple condition, with the two elaborated conditions rated equally as the most stressed.

Discussion

We explored the extent to which Australian university students were likely to rate women negatively if they smoked, and particularly if they were pregnant, and examined whether individuating information would reduce the degree of negative attitudes. This was the first empirical investigation to document the extent to which pregnant women who smoke are stigmatised by community members, in a social and political context that endorses widespread anti-smoking initiatives.

As predicted, we found a very strong effect of the woman’s smoking status, which explained 70% of the variance in response to the semantic differentials. Australian
students rated the woman described as a smoker as having the undesirable and negative characteristics which have been shown elsewhere to be ascribed to smokers (Burgess et al., 2009). This included being rated as more unhealthy, a worse mother, and more passive, ignorant, dismissive, embarrassed, sceptical, dependent, guilty, controlled, selfish, and stressed than the non-smoking comparison.

We also found the expected interaction with pregnancy information, such that the level of stigma was greater for the pregnant smoker than for the non-pregnant smoker. This is consistent with the socially constructed view that pregnancy is a time when higher than normal standards of behaviour are expected of women, and that other people have a right or a duty to pass judgement on pregnant women (Oaks, 2001). However, the multivariate effect was small, accounting for only 10% of the variance, and at a univariate level, only six of the semantic differentials showed the expected effect. The overall pattern of means suggested that, in the absence of smoking information, the woman was rated more positively if she was described as pregnant, but with the information that she smoked, she was rated more negatively if described as pregnant. This polarisation of views about pregnant women’s bodies, serves to justify stronger value judgements than might otherwise be seen as appropriate (Oaks, 2001).

There was only partial support for the expectation that individuating information might lessen negative attitudes to the woman’s smoking. There was a strong main effect for the provision of individuating information, explaining 41% of the variance, which suggests that providing information about a target’s personal circumstances leads to more positive attitudes, regardless of smoking or pregnancy status. This finding is consistent with the view that stereotypes are activated when there is no opportunity to access or integrate individuating information (Pratto & Bargh, 1991). However, the interactions suggested a more complicated picture, whereby the individuating information served to reduce negative attitudes towards the smoker, but only slightly, with the smoking woman still being rated significantly more negatively than the non-smoker.

Thus, even individuating information that might be interpreted as providing an explanation for the woman’s continued smoking was not as powerful as the information that she smoked at all, suggesting that it was only somewhat effective in combating smoking-related stereotypes. We suggest future work might employ a more convincing technique to individuate the smoker, for instance the use of personal video stories from pregnant women who smoke, to examine the usefulness of this individuation technique in challenging stigma. Challenging formats have been suggested by a few authors (Burgess et al., 2009; Burgess, Widome, van Ryn, Phelan, & Fu, 2011; Smith, 2007), and to date have been largely overlooked in terms of their potential usefulness in anti-smoking campaigns to assist in delivering health information in a sensitive and non-judgmental way.

Taken together, the findings support the existence of an overt anti-smoking discourse in Australia, within which smokers are constructed in stereotypically negative ways. Further, the level of stigma was exacerbated in the case of the pregnant smoker because the act of smoking clashes not only with anti-smoking discourses but also with hegemonic constructions of pregnant women and ‘good mothering’ (Irwin et al., 2005).

We have argued elsewhere (Wigginton & Lee, 2012) that this double stigmatising has detrimental implications for cessation during pregnancy. Further, the focus on the
individual as solely responsible for her choice to smoke serves to downplay the social and material conditions that impact on individual capacity to choose (Bell, Salmon, & McNaughton, 2011). The established social inequalities associated with smoking (Siahpush, 2004) suggest that current stigma-inducing campaigns to reduce smoking are neither ethical nor effective, being situated in a neoliberal, ‘health-ist’ and coercive discourse of public health which denies the very existence of inequities (Skrabanek, 1994). Therefore, we recommend supportive and non-judgmental approaches to encouraging cessation rather than punitive action toward pregnant smokers.

Our university-student sample consisted mainly of young, relatively privileged, non-smoking women, whose responses conveyed strong negative attitudes that construct smokers not only as unhealthy but also as morally and socially unacceptable. Whilst these students are, of course, not representative of society at large, other groups who are likely to have regular contact with pregnant women who smoke, such as nurses, midwives, medical practitioners and sonographers, are similarly predominantly female, non-smoking, educated and socially advantaged. Thus, the views of this student group may be typical of those held by the health professionals with whom pregnant smokers are likely to have contact.

On the other hand, the attitudes of family, friends and other community members are also likely to affect pregnant women’s experiences and actions concerning smoking. Thus, it would be useful to extend this research question to other social groups, to capture the differential conceptualisations and responses to smoking-related stigma across smokers and non-smokers of varying demographics. This is particularly important as the findings of existing research with members of advantaged and disadvantaged groups has come to conflicting conclusions (e.g. Paul et al., 2010; Ritchie, Amos, & Martin, 2010; Stuber, Galea, & Link, 2008).

In conclusion, though, these findings support the view that smoking-related stigma is powerful in Australia, and is particularly strongly expressed against pregnant women who smoke. We have argued that a stigma-induced approach to encouraging cessation is likely to be ineffective or even counterproductive, and that there is a need to explore alternative strategies for promoting non-smoking amongst pregnant women.

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We would like to thank the editor and two anonymous reviewers for their helpful feedback during the revision process.

References


Chapter 5. Thematic and discursive approaches to university students’ responses to women who smoke while pregnant

The previous two chapters explored experiences and perceptions of smoking during pregnancy in the Australian context, by drawing on two perspectives: women who smoked during pregnancy and university students. In Chapter 3, a thematic analysis of interviews with women who smoked during recent pregnancies, we found that women described stigma as having medical and social dimensions, both of which they negotiated in their talk. Women also detailed strategies that they used to cope with stigma, including passing as a non-smoker, using smokers as a safe haven, and justifying their smoking. However, descriptions of stigma were often paired with outcomes counterproductive to cessation. That is, for some women, stigma produced resistance to cessation and, for many others, stigma led women to smoke more or hide their smoking, and limited their opportunities to gain support. These strategies for dealing with (or avoiding) stigma are consistent with other recent qualitative studies on smokers’ experiences of stigma (Bull et al., 2007; Burgess et al., 2009).

Chapter 4 described quantitative findings from Study 2, drawing on data from a sample of university students. This chapter focussed on the notion of stereotyping as an expression of stigma, in line with Link and Phelan’s (2001) framework. We found that participants viewed the hypothetical ‘pregnant smoking mother’ more negatively than the ‘smoking mother’. In addition, the use of individuating information, for the most part, did not reduce negative views of the hypothetical ‘pregnant smoking mother’. These findings highlight the pervasiveness of negative views towards smoking mothers, especially those who are pregnant, in a sample of Australian university students.

Taken together, these two chapters offer evidence of an anti-smoking discourse which positions smokers as tainted (Chapman & Freeman, 2008), particularly pregnant smokers. In the previous two chapters, we argued that the negative consequences of stigma mean that the induction of stigma is neither an effective nor an ethical approach to encouraging cessation among pregnant women, in line with previous research (Burgess et al., 2009; Greaves et al., 2003). In these chapters, stigma is experienced via judgement, disapproval, labelling, and a loss of status (Chapter 3), and expressed by others through negative views or stereotypes (Chapter 4). While Chapter 6 will continue to approach stigma as a social construct that is embedded within broader social processes, the current chapter focuses on a selection of open-ended responses from Study 2.

In particular, examining the open-ended responses provided by the university students who took part in Study 2, I was struck by participants’ lack of any positive or sympathetic
responses, and the frequency of strongly negative responses. This observation, in combination with my reading in the area of reflexivity, social constructionism, and critical and discursive psychology, led to a consideration of the role of the researcher in the pursuit for ‘evidence’, and thus to a question of the extent to which these comments may have been affected by the context in which they were sought.

The data analysed in Chapter 5 are drawn from the question ‘Imagine seeing a pregnant woman smoking in a public place (e.g. shopping centre). How would that make you feel? What might you think of her?’ The aim of this chapter is to explore the relative usefulness of two qualitative methods of analysis (thematic and discourse analysis) and the relevance of reflexivity and social constructionism in qualitative analysis.

Using a selection of comments from this question in Study 2, this chapter provides a reflexive and methodological exploration of the analysis of elicited comments. This chapter aims to explore the researcher’s role in co-producing qualitative data, specifically in co-producing negative views in the context of Study 2.

“But I Am Not One to Judge Her Actions”: Thematic and Discursive Approaches to University Students’ Responses to Women Who Smoke While Pregnant

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“But I Am Not One to Judge Her Actions”: Thematic and Discursive Approaches to University Students’ Responses to Women Who Smoke While Pregnant

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Qualitative methodologies offer various approaches to interpreting qualitative data. Here we consider how different approaches to interpreting the same data can be useful in learning about the scope and utility of qualitative methods and in exploring the role of reflexivity in analytic decision making and interpretation. We apply both thematic and discourse analyses to university students’ responses to an open-ended question about women who smoke while pregnant. We show how our interpretations differ when analytic attention is paid to the content (thematic analysis) versus the rhetorical function (discourse analysis) of participants’ responses. We also show how reflexivity, compatible with our discursive analysis, allowed us to identify the local discursive context in which the data were produced and therefore how participants oriented to this context. We use our learning experience as a way of showcasing the value of dynamic and reflexive approaches to qualitative data.

Keywords: discourse analysis; discursive psychology; positioning theory; qualitative; reflexivity; social constructionist; thematic analysis

Qualitative research in psychology generally rests on the assumption that social reality is constructed through language. This social constructionist approach (Willig 2008) enables critical psychologists to draw attention to the social, structural, and systemic factors implicit in language that serve to constrain individual behaviour and subjective realities, thus locating behaviour at a social level, rather than explaining it solely at the level of the individual (Lyons & Chamberlain 2006). From this perspective, critical psychology is concerned with the links among discourse, subjectivity, and material realities.

Whilst qualitative psychology is growing rapidly, there is little guidance for the researcher on which of the broad range of methods might be appropriate for any specific research question or set of data. In this article, we use text responses from university students on the topic of women who smoke while pregnant to explore thematic and discursive interpretations of the same set of qualitative data. We are both relatively inexperienced with qualitative methods—the first author is a PhD student and the second a senior academic with mainly quantitative research experience—and present these thoughts not as definitive guidance to others but rather as reflections on our own learning.

Broadly, our substantive interest is in the practice of smoking in pregnancy. In Australia, smoking is associated with significant material disadvantage (Siahpush 2004), particularly smoking during pregnancy (Laws et al. 2007). Using interviews with women...
who smoked during their most recent pregnancies, we have previously argued that these women simultaneously internalise and resist powerful social discourses that position them as “bad mothers,” and that they respond to these discourses, and their social expression, in ways that actually reduce their capacity to stop smoking (Wigginton & Lee 2013a). We have also used quantitative methods to demonstrate negative views amongst university students toward pregnant women who smoke (Wigginton & Lee 2013b). As an extension of our second article, which was based on an online survey completed by 626 university students, we now draw on unpublished material, open-ended text responses to the question: “Imagine seeing a pregnant woman smoking in a public place (e.g., shopping centre). How would that make you feel? What might you think about her?”

Although there is mixed opinion about the usefulness of open-ended questions at the end of surveys, with some viewing them as producing data that are “thin” and lacking the richness necessary for qualitative analysis (Garcia, Evans & Reshaw 2004), we agree with others (e.g., Beckett & Clegg 2007; Peel 2012) that such data can be entirely appropriate for qualitative analysis and that the usefulness of any set of data should be judged according to the interpretations that are made rather than their source.

After an initial thematic analysis, we considered the utility of a discourse analysis of these data, prompting a reflexive consideration of the source of the data. In the process, we realised that the specific discursive context in which the data were produced had a profound effect on what was, and could be, expressed. In this article, we explore our journey toward a discursive interpretation and the role of reflexivity in enabling this perspective on the data.

**Thematic Analysis and Its Scope for Interpretation**

Braun and Clarke (2006), in their influential article on thematic analysis, define a theme as capturing “something important about the data in relation to the research question, [. . .] some level of patterned response or meaning within the data set” (p. 82). The process of organising data into meaningful patterned responses, or themes, is a fundamental skill in qualitative research (Holloway & Todres 2003) and is arguably the starting point to most forms of text-based qualitative analysis, including discourse analysis.

Although there has been criticism of thematic analysis on the grounds that it cannot go beyond what is explicitly mentioned in the text (e.g., Parker 2005), Braun and Clarke (2006) have argued otherwise, distinguishing between semantic and latent themes. In their view, semantic themes are explicit in the text, whilst latent themes reflect underlying, implicit meanings or implications. In this sense, latent themes may not be immediately apparent to the analyst, but instead reflect underlying messages within the text, potentially offering a deeper interpretation of the data.

In our analysis, we were interested in how participants responded to a hypothetical situation of smoking in pregnancy, specifically, how they constructed women who smoke in pregnancy, the practice of smoking in pregnancy, and their personal responses. We were guided by Braun and Clarke (2006) in that our analysis involved initial explorations of the data to gain a sense of familiarity, which included descriptive coding of key words or phrases. The high volume of responses meant that saturation was reached relatively quickly, but the entire data set was coded to avoid favouring earlier responses, allowing the first author to attend to points of difference across the data set. The first author worked iteratively through descriptive codes in order to identify common patterns across and within responses, which were eventually labelled as themes.

From early on in the coding and analysis process, it became apparent that the most common response was embedded in a negative and judgemental theme that we labelled
Within this theme, participants expressed the view that women who smoke while pregnant are violating their natural role as mothers who (should) willingly make personal sacrifices to protect their innocent unborn children. The overwhelming presence of this theme in participants’ responses served to highlight those few responses that seemed to diverge from this dominant construction. In particular, it seemed that there was a minority of participants who were responding in a way that was less judgemental of the hypothetical woman and her smoking. Our purpose is to use these minority views within our data to illustrate the differing interpretations available via thematic and discursive approaches.

Through a thematic interpretation, we came to understand the minority of responses as negotiations of the *good mothers don’t smoke* theme, where participants drew on imagined contextual factors to construct more sympathetic responses to smoking in pregnancy. Here we offer a thematic interpretation of some of these responses:

I don’t like people smoking in areas where they shouldn’t due to the smell and effect it has on others, especially in areas such as a shopping centre when children are around. To smoke is the mother’s choice, it is affecting her child but I am not one to judge her actions. (Woman, 20 years)

It would make me feel upset. However, there are a lot of worse things that a mother can do to her child than smoking. Hence, I would think she is rather selfish, but would not judge her parenting skills based on smoking. (Woman, 17 years)

In the extracts above, both participants initially construct an emotional response to smoking in pregnancy (“don’t like” or “upset”), but then offer alternative reasons why they personally “don’t judge” smoking in pregnancy, either because it is “the mother’s choice” or because “parenting skills” are not influenced by one’s smoking, and there are many “worse” things a mother could do to her child. In this sense, both extracts are attending to the *good mothers don’t smoke* theme by referencing children’s vulnerability to smoking—and in the second extract the woman’s selfishness—but both manage their personal judgement of the woman on the basis of her smoking by emphasising autonomy or suggesting parenting is more complicated than that.

In the next three extracts, participants similarly describe emotional or moralistic responses to smoking in pregnancy (or smoking in general). However, all participants follow up with statements that downplay their initial visceral response:

I’ve seen it before and I judged her really harshly. She had quite a big bump and was obviously around 7 months pregnant. I remember saying “what an idiot.” I felt angry towards her. But I am not a smoker so I have not experienced what it is like to be addicted to smoking. In hindsight and after reading the previous story in this survey, I have realised that I did not know the full story and perhaps shouldn’t have judged her so harshly. (Woman, 18 years)

I think it would be very irresponsible and selfish for the unborn child, as smoking is shown to lower a baby’s birth weight which can have lasting negative impacts over their lifespan. It’d make me sad for the child, but I wouldn’t necessarily think that she was a bad person, as it is really hard to quit smoking, and
being pregnant can add stress to a person’s life, making it even harder to quit at the time. (Woman, 18 years)

I would feel disgusted (as smoking in general disgusts me) so being pregnant wouldn’t be the deciding factor, I have heard via research that quitting smoking while pregnant can be in some cases more detrimental to the baby than continuing to smoke hence not having a stronger opinion. (Woman, 27 years)

In the first extract, the participant draws on the realities of an addiction to smoking and her inability, as a nonsmoker, to “know the full story.” The second participant reconciles her strong articulation of the good mothers don’t smoke theme (“I think it would be very irresponsible and selfish for the unborn child”) by emphasising the difficulty of quitting and the stress of pregnancy on a person’s life.

Finally, the third participant constructs a justification for her “not having a stronger opinion” against smoking in pregnancy, and hence attempting to resist the good mothers don’t smoke theme, by referencing “research” that offers counter evidence. The participant constructs the notion that “quitting is more stressful to the baby” as a way of reversing the theme good mothers don’t smoke, to suggest that a “good mother” might continue to smoke for her baby’s health. It is notable, however, that she seems unable to resist a more general good mothers theme, with the implicit assumption that everything a pregnant woman does should be judged by its effect on her baby.

In all three cases, participants construct an initial negative reaction followed by references to “addiction,” “stress,” or “research” that allow them to negotiate the good mothers don’t smoke theme and construct a less negative attitude towards the particular woman. From a thematic social constructionist perspective, we are able to attend to the constructed nature of participants’ responses and how these are being produced within a specific socio-cultural context that devalues smoking and those identified as smokers (Chapman & Freeman 2008)—as expressed by participants’ visceral responses to smoking in pregnancy. However, participants’ follow-up statements provide context or justifications to explain that they do understand that smoking in pregnancy is complicated, allowing them to negotiate the good mothers don’t smoke theme and construct the practice, and the women involved, in more humanising ways.

These five extracts were from a small selection of our data, but the analysis did suggest that some participants were able to construct partially sympathetic accounts of women who smoke while pregnant. However, even these participants worked within the good mothers don’t smoke theme to offer a contextualised response to smoking in pregnancy.

From this thematic reading of the data we are, however, unable to describe how participants use language to construct themselves as simultaneously supportive of the good mothers don’t smoke theme and of the rights of individual women to make their own choices about smoking. It is these types of questions that require a discursive lens to understand the rhetorical effects of particular responses. This observation, together with a reflexive awareness of how our own role in the research process might have evoked such responses, drew us to discourse analysis.

**Discursive Approaches as an Alternative Platform for Interpretation**

There is no single widely accepted definition of discourse analysis. Rather, from a social constructionist perspective, discourse analysts view language (and, increasingly, images and objects) as a social activity that both constructs and reproduces social reality (Willig
Discourse analysis has been divided into two distinct approaches: a top-down approach that is interested in the social, ideological, and political consequences of discourses (Parker 1992) and a bottom-up approach that offers a fine-grained analysis with attention to the “action orientation” of people’s talk, and is located theoretically within conversation analysis and ethnomethodology (Edley & Wetherell 1997). We take a synthetic approach to discourse analysis, as proposed by Wetherell (1998), acknowledging that people’s talk reflects not only the local context but also broader culturally available discourses that circulate within particular contexts, and that speakers are active in taking up or resisting these levels of discourse. Therefore, we understand discourses as culturally specific sets of statements, meanings, or metaphors that construct an object or identity (Burr 2003; Parker 1992).

Before exploring a discursive interpretation of our data, we turn our attention to reflexivity and its role in helping us to identify the local context within which the participants constructed their responses.

Locating the Researcher in the Research: Reflexivity within Discourse Analysis

Social constructionists hold that it is neither possible nor desirable to separate the researcher from the research process (Wetherell, Taylor & Yates 2001), as the researcher is part of the context in which research questions are asked and answered (Burr 2003). From this perspective, regardless of the type of analysis, one acknowledges that there are multiple interpretations available from a data set and that each interpretation is located within a specific social, cultural, and political context.

It was our consideration of whether to take a discursive approach to the data that was the catalyst for us to consider how our own positions as “the researchers,” the research context in which the data were collected, and the nature of the survey and questions, all influenced the responses. In learning about discourse analysis, we were forced to consider how issues of power, language choice, and discourses evoked by the topic of smoking in pregnancy were embedded in our research. In particular, we found ourselves considering not only the broader culturally available discourses that position “women who smoke while pregnant” but also the immediate discursive context of the research itself.

What we provide here is an account of our “discursive reflections” (see Cooper & Burnett 2006), our version of the local discursive context of the research. We present these reflections as an integral part of a discursive interpretation of our data, because discourse analysis is usefully informed both by a reflexive awareness of the researcher’s standpoint and by a focus on implicit power relations between researcher and researched (Blanche, Durrheim & Painter 2006; Parker 1992).

First, survey participants were recruited from undergraduate psychology students—participating for course credit—as a “psychology experiment” about “women who smoke while pregnant.” This initial description of the study immediately evoked a particular discursive space that privileged certain responses and potentially silenced others. That is, we had constructed an invitation for participants to consider women who smoke while pregnant as a group with salient characteristics in common, as problematic, and as subjects worthy of psychological research attention. At the same time, we positioned the participants both as people who were not women who smoke while pregnant and as people who would have valuable and legitimate views on women who smoke while pregnant and who could therefore consider themselves superior to such women.
Our psychology experiment was presented to first-year psychology students as an opportunity for them to learn about research by participating in the production of “psychological knowledge,” positioned as a compulsory and valuable part of their introduction to the study of psychology. As the researchers, we had the power to decide what was worthy of research; the students, as participants, had only the power to decide whether to choose this particular project from a number of advertised projects. Further, we had the power to grant course credit, and held the status of university insiders. This broader social positioning of ourselves as experts and the participants as non-experts further served to entrench the apparent legitimacy of our positioning of women who smoke while pregnant. Thus, participants’ responses were embedded within a context in which we held the power and could dictate the terms of our interaction.

The way in which we positioned “women who smoke while pregnant”—as a uniform group, as necessarily problematic, and as “other”—had several effects on students’ responses. Specifically, we argue that our positioning evoked discourses of neoliberalism and gender differences, suggesting that women who smoke while pregnant were “choosing” to smoke and thus disrupting gendered expectations of how women should behave while pregnant. The open-ended question we discuss here was positioned at the end of a longer, quantitative survey which began with the presentation of vignettes (see Wigginton & Lee 2013b) and continued with questions about the extent to which women’s smoking was (inter alia) “responsible” and “motherly,” hence inviting participants to apply neoliberal and gendered discourses to the practice of smoking in pregnancy.

In summary, we realised that our construction of the topic, the women of interest, ourselves as researchers and our participants as receiving instruction, and our embedding the open-ended question within a specific set of items, together produced a context in which neoliberal, gendered, and scientific discourses were privileged. Whether or not participants were responding consciously to this construction is unimportant, but what is important is that this local discursive context needed to be taken into account. This perception led us to a decision to apply positioning theory in our discursive analysis.

**Positioning Theory as a Discursive Tool for Interpretation**

Positioning theory (Davies & Harré 1990) offers a dynamic approach to understanding the representation of individuals within discourse. It allows the researcher to acknowledge the power of culturally available discourses, which provide a framework for experience and subjectivity, while at the same time acknowledging the agency of the individual in taking up, resisting, or negotiating discourses in particular (micro) contexts (Burr 2003). In this sense, the individual speaker is not only positioned by discourse but also positions themself relative to discourse (Davies & Harré; Harré & Langenhove 1991).

Depending on the approach to discourse analysis, there are several ways of examining speakers’ orientation to identity within discourse. A top-down approach assumes that discourses allow a limited number of subject positions for individuals to construct their identity and experience. Subject positions offer ways of representing oneself within a particular discourse and in relation to a specific object, constraining what a person can say or do within that discourse (Harden & Willig 1998). In comparison, a bottom-up approach is interested in the ways in which individuals construct a social order, including their own identities, within conversations, in which utterances do certain things that are inter-subjectively understood and taken up within that particular interaction (Wetherell 1998). Here, identity positioning is highly specific to the particular conversational context and therefore cannot be taken out of this context to draw general conclusions about subjective
A synthetic approach considers identity positions as achieving particular social objectives within talk; that is, they are used strategically to do certain things (Willig 2000), but at the same time takes an interest in the effects of various identity positions. The emphasis is on the individual’s agency within the local discursive setting, the individual orientation to that discursive setting, and thus how participants position themselves relative to that discursive setting within talk (Wetherell 1998). This analytical approach fits with the unanswered questions following our thematic interpretation; that is, how are participants able to work within the broader view that women should not smoke while pregnant, but at the same time position themselves as nonjudgemental regarding smoking in pregnancy?

From this perspective, the same text is subject to a very different interpretation:

I don’t like people smoking in areas where they shouldn’t due to the smell and effect it has on others, especially in areas such as a shopping centre when children are around. To smoke is the mother’s choice, it is affecting her child but I am not one to judge her actions. (Woman, 20 years)

It would make me feel upset. However, there are a lot of worse things that a mother can do to her child than smoking. Hence, I would think she is rather selfish, but would not judge her parenting skills based on smoking. (Woman, 17 years)

Both participants initially refer to a moral response to smoking (“I don’t like people smoking”) or smoking in pregnancy (“It would make me feel upset”). This represents an initial orientation to the discursive context created by the research project, within which women who smoke in pregnancy are positioned as a problematic group. Both participants then seek to take up a broader cultural discourse that valorises respect for other people’s individual rights with the claim that they do “not judge her.” We argue that these participants’ comments create trouble for their identity positions because they reference two conflicting discourses. Thus, their use of the word ‘but’ signals an acknowledgement of the trouble, and the subsequent statement of not judging serves as identity repair work, in which they seek to distance themselves personally from the judgement implied within the research project and in their initial remarks.

In the first extract, the participant initially positions the woman as having a choice, while simultaneously constructing her smoking as undoubtedly harmful, with the assertion that her smoking “is affecting her child” (our emphasis). The participant initially uses the terms “her actions” and “choice” to account for the woman’s smoking through an individualist lens. The term “choice,” in the context of smoking, invokes a neoliberal ideology to suggest that individuals are in a position from which to make unconstrained choices and are ultimately responsible for the consequences of their actions. Drawing on neoliberal discourse also enables the participant to distance herself from the woman’s actions and maintain a positive identity position as someone who encourages autonomy and freedom of choice, by not judging the choices of others (“but I am not one to judge her actions”).

In the second extract, the participant positions herself within the discursive context of the research project by claiming that she would be upset and that the woman is “rather selfish” but also seeks to repair her identity position, in this case by minimising the severity of smoking in pregnancy (“however, there are a lot of worse things a mother can do”) and
positioning herself as nonjudgemental by changing the topic from smoking to parenting skills.

It is worth noting that in both extracts the positioning of “mother” is fully articulated, a positioning which has clear ideological implications. The position of mother confers certain responsibilities and expectations on a woman regarding her behaviour. In turn, this opens the space for participants to take up judgemental positions and make statements about her “selfish” behaviour, which does not have the child’s best interest at heart. However, both participants are able to negotiate this dominant construction to some extent, either by drawing on individualist rhetoric or by social comparison (for discussions on the limits of discourses of motherhood and femininity, see Lafrance 2009).

The next three extracts highlight other ways in which participants managed their positioning as nonjudgemental, and at the same time attended to broader discourses pertaining to smoking in pregnancy and to the micro-discursive context of our study.

I’ve seen it before and I judged her really harshly. She had quite a big bump and was obviously around 7 months pregnant. I remember saying “what an idiot.” I felt angry towards her. But I am not a smoker so I have not experienced what it is like to be addicted to smoking. In hindsight and after reading the previous story in this survey, I have realised that I did not know the full story and perhaps shouldn’t have judged her so harshly. (Woman, 18 years)

I think it would be very irresponsible and selfish for the unborn child, as smoking is shown to lower a baby’s birth weight which can have lasting negative impacts over their lifespan. It’d make me sad for the child, but I wouldn’t necessarily think that she was a bad person, as it is really hard to quit smoking, and being pregnant can add stress to a person’s life, making it even harder to quit at the time. (Woman, 18 years)

I would feel disgusted (as smoking in general disgusts me) so being pregnant wouldn’t be the deciding factor, I have heard via research that quitting smoking while pregnant can be in some cases more detrimental to the baby than continuing to smoke hence not having a stronger opinion. (Woman, 27 years)

In these extracts, all participants orient to the question in similar ways to those discussed above—offering moral responses to smoking in pregnancy while simultaneously asserting that judgement is inappropriate—but repair their identity in different ways. The first participant describes a prior experience where she “really harshly” judged a woman for smoking while heavily pregnant. In recounting the extent of her judgement, including verbal judgement (“I remember saying”) and “anger” towards the woman, the participant uses the contrasting conjunctive “but” to indicate a start to repairing her positioning as judgemental. In repairing her account of how she previously responded to a woman’s smoking in pregnancy, she asserts her position as a nonsmoker to indicate her inability to pass judgement, and orients to her prior ignorance about the context of smoking in pregnancy, referring to the vignette provided in the earlier part of the survey. In doing so, she creates a space to reposition herself positively (“I did not know the full story and perhaps shouldn’t have judged her so harshly”).

In the second extract, the participant similarly works to repair the incompatibility of her positioning of women who smoke while pregnant as “irresponsible” and “selfish” and smoking as harmful in the long-term to their unborn child with an identity position of herself as nonjudgemental. Again, the word “but” indicates the beginning of the participant’s
repair work. While the participant clearly articulates the “good mother” discourse, with reference to baby-centred outcomes, she subsequently steps out of a motherhood discourse by the repositioning the woman as not “necessarily a bad person.” Her hedged (indicated by “necessarily”) claim of the woman within a nongendered identity position (“person”) offers some discursive space from the mother identity allowing her to repair the woman’s identity. She goes on to position herself as knowledgeable and understanding of the context in which smoking in pregnancy occurs by referencing the difficulty and stress of quitting (“it is really hard to quit smoking, and being pregnant can add stress [. . .] making it even harder to quit at the time”). This allows her to reposition the woman as a person facing the normal stress and difficulty of quitting, especially being pregnant—again the emphasis here is on the woman’s identity as a person who is trying to quit and happens to be pregnant, not her identity as a mother.

In the third extract, the participant orients her disgust to smoking in general—not smoking in pregnancy—and pregnancy having less to do with her disgust. Her account is centred on repairing the troubled identity position of someone who is not inherently opposed to smoking in pregnancy (“not having a stronger opinion” against smoking in pregnancy) in the discursive context of the research project, which positions smoking in pregnancy as an area of legitimate concern. She repairs her position by working within the research context, suggesting that there is research evidence that quitting can be “more detrimental to the baby.” Interestingly, even this claim is situated in the good mother discourse by focusing on the baby’s and not the woman’s health. Nonetheless, it is the legitimacy of the source of the information (“research”) in the context of participating in a research study that allows the participant to make this claim to repair her less judgemental position towards smoking in pregnancy.

Discussion

In summary, the thematic interpretation led to the conclusion that our participants see women who smoke while pregnant as transgressing both medical and moral injunctions, and thus as failing to meet social criteria as good mothers. Through a social constructionist lens, we interpreted participants’ less judgemental responses as situated within this specific socio-cultural context, rather than as a veridical reflection of truly held, context-independent views of women who smoke while pregnant. Through a thematic interpretation we were able to identify the socio-culturally specific concepts that allowed individuals to contextualise women’s smoking during pregnancy (e.g., stress, addiction, choice).

In contrast, our discursive interpretation, while based on the same data, reached different conclusions. Using positioning theory, we could describe the contradictory and dynamic nature of participant’s positioning work, their negotiation of broader discourses surrounding smoking in pregnancy, and the micro-discursive context of our psychology experiment and the gendered and neoliberal tenets of our survey. We identified participants’ initial orientations as moral responses to smoking in pregnancy, where participants drew on dominant discourses of smoking in pregnancy that stigmatised women for their “irresponsible” and “selfish” behaviour, as well as on the “research” discourse that positioned such women as problematic. These articulations could be understood as a form of discursive rehearsal, in which participants narrate socially acceptable ways of talking about smoking in pregnancy as a way of paying lip service to these discourses before moving on to account for their contradictory positions on the topic, and ultimately to repair their position as potentially judgemental.
In all five extracts, we identified trouble and repair identity work (see Taylor 2005), arising from the conflict between statements made within the discursive context of the research project and those made within a broader social discourse of individual choice and respect for others’ choices. From a discursive perspective, we understood participants as reflexive speakers who are aware of saying thing in certain ways and therefore made conscious choices in doing their identity work (Taylor 2006). From this viewpoint, we can understand the rhetorical structure of participants’ responses and how these reflect negotiations of power and discourse, rather than see participants’ responses as merely referencing socially constructed themes.

Thus, a discursive approach allowed us to understand the ways in which participants took up, resisted, or negotiated different levels of discourse—levels that our thematic interpretation was not designed to identify, as it is a method that focuses on the socially constructed nature of the content. Lafrance (2011) has drawn attention to the limits of descriptive themes and suggested a shift of analytic attention to participants’ talk as a rhetorical device, “a way of talking that not only describes, but accomplishes things” (emphasis in original, p. 91).

In saying this, thematic and discursive approaches are not mutually exclusive. In fact, many researchers have described “thematic discourse analysis” (e.g., Clarke 2005; Peel et al. 2005; Taylor & Ussher 2001). This approach combines the identification of themes with a focus on how these themes serve a discursive function, described by Clarke (2005) as a focus on the “rhetorical design and on the ideological implications of the themes” (p. 7). An alternative approach was adopted by Peel et al. (2005), whose analysis was guided by the discursive concept of accountability to examine the ways in which participants attended to their own responsibility in their talk. Thus, there are various ways in which these methods are being mobilised, allowing researchers to be guided by the research question or a specific analytic technique.

Conclusion

We have used both thematic and discourse analysis in interpreting research participants’ responses to a hypothetical scenario about women who smoke while pregnant. We have shown that thematic analysis allowed us to identify a dominant theme of disapproval (*good mothers don’t smoke*), and to identify a small number of participants who sought to resist this. Discourse analysis offered us the reflexive space, and analytic tools, to interrogate both the participants’ and our own positioning in response to smoking in pregnancy. Rather than concluding that one of these approaches is better than the other, we hope to have shown how the two methods provide two very different accounts of the same data, and to add to the discussion about dynamic and reflexive approaches to qualitative data analysis and interpretation. We hope that this extended discussion of our own research experiences provides some points of consideration for other researchers embarking on the same journey.

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Chapter 6. “I think he’s immune to all the smoke I gave him”: How women account for the harm of smoking during pregnancy

In the previous chapter, I considered my role as the researcher in co-producing negative views in the data collected as part of Study 2. Initially, I was drawn to the sheer quantity of negative responses in the qualitative data and how very few participants provided sympathetic responses. This chapter examined the usefulness of two qualitative approaches in interpreting a selection of open-ended responses.

Chapter 5 demonstrated that discourse analysis allowed a consideration of the local and broader discourses that shaped participants’ responses, and of the usefulness of reflexivity in enhancing the interpretation of qualitative data. Furthermore, discourse analysis afforded the opportunity to reflect on the experimental conditions of the survey from Study 2 and the ways in which we, as the researchers, positioned pregnant women who smoke as a problematic group worthy of research attention. We considered the effect of this positioning on participants, who were positioned by us as entitled to express their views towards a homogenous group of women smokers. By contrast, a thematic interpretation of the same data produced an explanation that focused on the specific socio-cultural concepts that enabled a more contextualised understanding of women who smoke during pregnancy, with little methodological scope for considering the role of the local and broader discursive context and participants’ negotiation of this context.

Chapter 5, then, provided an opportunity to apply a new methodology to the data and enhance the interpretation of the previous two chapters (Chapters 3 and 4). However, the point of this chapter is not to undermine Study 2, nor the published article presented in Chapter 4, but rather to explicitly narrate my ontological and methodological shift in the hope of encouraging others, particularly in disciplines such as psychology that rarely practice reflexive dialogue, to engage more critically with the research process and their influence of their own socials positions.

While still approaching the concept of stigma as an expression of negative views (Link & Phelan, 2001), the attention in Chapter 5 turned to the contexts that may facilitate or hinder individuals’ resistance to stigma (Campbell & Deacon, 2006). As we discussed, the local and broader discursive contexts reproduced negative views about smoking during pregnancy through neoliberal, gendered and scientific discourses. Consistent with the arguments of Parker and Aggleton (2003), Chapter 5 shows how these broader social processes serve to legitimise the marking of differences between categories of people and, through this process, the maintenance of social order. In other words, the discursive context...
in which participants’ data were produced reinforced existing power structures and
inequalities, and therefore participants’ attempts to resist such constructions largely reflected
(and served) their own identity work in the reproduction of social order. Chapter 5 provides
an important reminder of the difficulty (but not impossibility) of challenging systems of
knowledge, or discourses, and how these systems function in the cultural production of
stigma (Parker & Aggleton, 2003).

Chapters 6 and 7 continue this methodological shift, and the focus on discursive
negotiations of the presumed stigma attached to smoking during pregnancy. In particular,
these two chapters use a discursive and reflexive methodology, applying discourse analysis to
women’s accounts of smoking during pregnancy. These two chapters stemmed from a
collaboration with Professor Michelle Lafrance. Chapter 6 revisits the telephone and face-to-
face interviews from Study 1 and re-analyses these data from a discourse analytic perspective
(note: the email interview is excluded in this chapter because during the peer-review process
a reviewer requested the email interview be removed from the sample). As argued in Chapter
5, thematic perspectives may usefully capture descriptive and latent patterns across the data,
but a discursive approach considers talk as action-oriented, and as a process that
accomplishes things in interactions and through discourse.

Chapter 6 focuses on the discourse that ‘smoking in pregnancy harms babies’ – a
prevalent discourse across the interviews – and asks how women who have smoked during
recent pregnancies orient to this discourse in the process of accounting for themselves and
their smoking. This discourse has similarities with the construct of stigma identified in
Chapter 3 (medical stigma); hence, this analysis provides a discursive perspective on how
medical stigma is mobilised and negotiated in women’s accounts. Although the focus of this
chapter is not explicitly on stigma, the analysis deals with the concept of moral trouble,
which from a discursive perspective offers a lens through which to examine participants’
accounting patterns and identity work. In this analysis, we attempt to show how the moral
trouble associated with smoking during pregnancy, that is, the reasons why the practice is
problematic and requires explanation, stems from the discourse that ‘smoking in pregnancy
harms babies’. Thus, this chapter provides a discursive lens on what we had originally framed
as an aspect of stigma: the discourse that ‘smoking in pregnancy harms babies’.

Following this, Chapter 7 re-visits stigma, with a discursive analysis of women’s
identity work. This chapter draws on multiple sources of data: 13 interviews from Study 1;
survey responses from Study 3; and a media article written by an Australian television host
who was ‘caught’ smoking while seven months pregnant. This chapter uses Goffman’s
(1963) concept of the ‘spoiled’ identity to explore how women manage their identities when accounting for smoking during pregnancy.

Chapter 6, a discourse analysis of 12 interviews from Study 1 (excluding the email interview), is presented in the form of a paper published in *Health, Risk & Society* in August 2014.

‘I think he is immune to all the smoke I gave him’: how women account for the harm of smoking during pregnancy

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‘I think he is immune to all the smoke I gave him’: how women account for the harm of smoking during pregnancy

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Despite women’s awareness of the risks of smoking in pregnancy to the developing foetus, a significant minority continue to smoke during pregnancy. In this article, we use a discourse analytic approach to analyse interviews with 12 Australian women who smoked during a recent pregnancy. We used these data to examine how women accounted for their smoking and identities in the light of the implicit but ever-present discourse that smoking in pregnancy harms babies. We found that the women in our study deployed two rhetorical devices in their talk, ‘stacking the facts’ and ‘smoking for health’, allowing them to situate their smoking within a discourse of risk or as a potential benefit to their health. Women ‘stacked the facts’ by citing personal observable evidence (such as birthweight) to draw conclusions about the risks of smoking in pregnancy to the baby. ‘Stacking the facts’ allowed women to show how they had evaded the risks and their babies were healthy. This device also allowed women to deny or cast doubt over the risks of smoking in pregnancy. Women’s accounts of ‘smoking for health’ involved positioning quitting as stressful and, as a result, more harmful than continuing to smoke a reduced amount. We found complex and counter-intuitive ways in which women dealt with the discourse that smoking in pregnancy harms babies and how these ways of accounting served to protect their identities. We argue that health promotion messages conveying the risks of smoking in pregnancy would benefit from contextualising these messages within women’s personal accounts (e.g. by ‘stacking the facts’ or ‘smoking for health’) and hence providing more ‘realistic’ health risk messages.

Keywords: smoking in pregnancy; tobacco; risk; harm; identity; discourse analysis; qualitative

Introduction

Although there is clear evidence that smoking during pregnancy poses significant risks to the unborn foetus and that most women are aware of these risks, a significant minority of women continue to smoke during pregnancy. In this article, we examine how women account for their ‘indefensible’ smoking and identities when risk messages regarding smoking in pregnancy are ever present.

Smoking during pregnancy: harming the unborn foetus

Smoking and pregnancy

The health effects of smoking tobacco in pregnancy are well documented, especially the potential harm to the unborn and developing foetus. Researchers have demonstrated the

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adverse effect of smoking in pregnancy on birthweight, gestation, perinatal mortality and placental complications (Cnattingius, 2004; Meyer, Jonas, & Tonascia, 1976; Rogers, 2008). The most robust indicators of harm associated with smoking are low birthweight and birth complications (e.g. preterm birth) (Agrawal et al., 2010). Epidemiological researchers have found a dose–response relationship between smoking and risk, where heavy maternal smoking is associated with increased risk of sudden infant death syndrome and premature birth (Cnattingius, 2004).

Public health agencies in most developed countries promote the message of complete smoking abstinence during pregnancy, highlighting the numerous potential harmful effects of smoking on the baby. For instance, recent Australian anti-smoking campaigns list increased the probability of harmful outcomes following smoking during pregnancy, including sudden infant death syndrome, miscarriage, low birthweight, premature labour, complications during birth, impaired foetal lung development and functioning and increased perinatal death (Australian Government, 2011; Queensland Government, 2013). Similarly, the Royal Australian College of General Practitioners recommends that women stop smoking during pregnancy as there is no safe level of smoking for the developing foetus (Zwar et al., 2011). This foetal-centred approach has dominated smoking cessation interventions that are based on the assumption that making women aware of the harm they are causing to their unborn baby will motivate them to stop smoking (Greaves et al., 2003).

In one way health promotion has worked well, in that women who smoke in pregnancy appear to be aware of the harmful consequences for their unborn foetus (Graham, Flemming, Fox, Heirs, & Sowden, 2014). Despite this, a substantial minority of pregnant women continue to smoke in Australia (17%: Laws, Abeywardana, Walker, & Sullivan, 2007), with higher rates among Indigenous pregnant women (50%: Australian Institute of Health and Welfare, 2011). There are similar statistics for other developed countries. In the UK, 17% of pregnant women smoke and 15% in Canada, with higher rates of smoking among socio-economically disadvantaged women (Al-Sahab, Saqib, Hauser, & Tamim, 2010; NHS Information Centre, 2007). To date, there is an incomplete conceptualisation of how women who continue to smoke in pregnancy interpret these highly publicised risks about their babies’ health in relation to their own experiences.

**Sociological accounts of smoking during pregnancy**

Sociologists have examined the ways in which women negotiate risk and responsibility for smoking in the context of mothering (Coxhead & Rhodes, 2006; Holdsworth & Robinson, 2008), including behavioural strategies to reduce their children’s exposure to second-hand smoke. Although not focusing specifically on women’s smoking in pregnancy, some of the women in Holdsworth and Robinson’s (2008) study spoke of smoking during pregnancy and justified their inability to quit by referring to personal inter-generational narratives of smoking and the absence of negative health outcomes. Swiss women in Hammer and Inglin’s (2014) study described their perceptions of risk messages relating to smoking during pregnancy. The women who had smoked during pregnancy considered stopping smoking abruptly as stressful to them and therefore harmful to their babies. Some described seeking professional support for their continued smoking.

Social science researchers who have sought to use in-depth qualitative methods to explore women’s experiences of smoking during pregnancy (e.g. Abrahamsson, Springett, Karlsson, & Ottosson, 2005; Wood, France, Hunt, Eades, & Slack-Smith, 2008) have consistently found that women were aware and knowledgeable of the health risks of
smoking while pregnant. Additionally, women have expressed concern about the health of their unborn babies (e.g. Edwards & Sims-Jones, 1998; Lendahls, Öhman, Liljestrand, & Håkansson, 2002). However, beyond acknowledging women’s ‘awareness’ of the potential health impact on the foetus, existing research has failed to capture the complexity of this ‘knowing’ and how these contradictions feature in women’s accounts of their smoking. There has been little discursive engagement with women’s accounts of smoking in pregnancy and in particular women’s identity work. In this article, we aim to rectify these limitations by using discourse analysis to engage with women’s contradictory and complex talk in accounting for the risks of smoking in pregnancy.

Methods

Discourse analysis

In this article, we use discourse analysis to examine how women who smoke during pregnancy account for their smoking and identities. Discursive approaches provide an important point of departure from existing research. In particular, discourse analysis allowed us to explore how women who smoked during pregnancy negotiated and managed dominant biomedical discourse that assert the health risks of this behaviour. To examine women’s identity work, we drew on positioning theory, taking the view that women are active producers of language, where they are both positioned by discourse and position themselves within discourse (Davies & Harré, 1990). From this perspective, discourses provide a lens of reality within which certain identity positions can be taken up, providing a scaffolding for individual experience and subjectivity. However, available identity positions are shaped by the cultural and discursive landscape. For instance, within biomedical discourse that asserts the health risks of smoking, these messages work in combination with social norms surrounding maternal responsibility and women’s efforts to ‘do best by baby’ to highlight the imperative for women to be smoke-free in pregnancy (Lupton, 2011; Oaks, 2001). In this way, discourses are reflected through social norms and together produce taken-for-granted ways of ‘doing’ and speaking about pregnancy or motherhood, thereby shaping the ways in which women can represent themselves and their behaviour. For instance, when women fail to adhere to culturally acceptable ‘pregnancy rules’ by smoking in pregnancy, women face immense social stigma and shame (Wigginton & Lee, 2013) and, as we will explore, this produces moral trouble for women’s accounts and identities.

Discourses provide a framework for identity construction, whereby one’s identity is not conceptualised as a static and measurable construct, but rather something that is continually accomplished in interactions and through discourse (Davies & Harré, 1990). In this way, we were interested in exploring how identity positions allow individuals to achieve particular social objectives within talk, that is, they do certain things and have certain effects (Willig, 2000). However, we do not suggest that women are consciously aware of, or necessarily intentional in, how they position themselves and their experiences. Rather, from a discursive perspective, we are interested in the available ways for women to construct themselves and their smoking and the rhetorical effects of these constructions.

We approach the dominant biomedical discourse that smoking in pregnancy is harmful to babies from a rhetorical perspective. In this way, we consider the ways in which women interpret and negotiate the validity of this ‘truth’. We focus on the rhetorical devices women deployed to account for their smoking, in light of the dominant biomedical discourse that smoking in pregnancy is harmful to babies, and how these constructions implicated their identity constructions.
Participants

With an initial interest in women’s experiences of the stigma associated with smoking while pregnant, the first author (Britta Wigginton) wanted to ensure she was engaging with women in a sensitive way. Following ethics approval from her University (School of Psychology, University of Queensland, Ethics Number: 11-PSYCH-PHD-30-MJ), she recruited two participants from her network of acquaintances to take part in pilot interviews. The pilot interviews were intended to check the appropriateness of the interview questions (for instance, whether or not they were framed in a non-judgemental way that allowed women to speak openly about their experiences of stigma). Following the successful completion of the pilot interviews, she attempted to advertise through community health centres, medical centres and a university campus in Brisbane, Australia. However, after experiencing difficulty in advertising in these places (including refusals and requests for additional ethics), she pursued online channels, specifically online pregnancy forums and email lists. Online channels lent themselves well to this topic because these spaces allowed a sense of anonymity for women. Further, online pregnancy forums proved to be a successful recruitment channel and, in combination with women’s preference for telephone interviews, enabled us to recruit women from a range of geographic locations in Australia including cities in Queensland, New South Wales and Victoria.

Twelve women living in Australia participated in the study. All stated that they had recently smoked while pregnant – the inclusion criteria for the study. All the participants described having smoked during pregnancies that occurred less than four years ago, with most being within the last two years. One woman was pregnant and smoking at the time of the interview. Participants ranged in age 22–35, most were in paid employment or described their occupation as a ‘stay-at-home mother’. All women had finished high school, two had completed a university degree, one was completing a university degree at the time and working and four had completed a technical qualification. Information about women’s ethnicity was not collected, although one woman identified herself as an Indigenous Australian. Most women were smoking prior to their recent pregnancy, though one woman described starting smoking during the pregnancy of her second child (because of the stress of motherhood) after having been smoke-free for 16 years. Although participants were not always asked explicitly about their tobacco consumption, several women described their pattern of smoking during pregnancy. Among these women, five described having significantly reduced their smoking, one described smoking the same amount prior to pregnancy and one woman described smoking more than she ever had because of the stress of being in a relationship with a man she described as an alcoholic.

The first author (Britta Wigginton) conducted the interviews between April 2011 and August 2011. After the initial two face-to-face pilot interviews, the remaining 10 were phone interviews. The interviews were relatively short, lasting between 10 and 20 minutes, which we understood to be reflective of the difficulty of speaking about an experience of this nature. We audio-recorded all interviews and transcribed them verbatim using pseudonyms to ensure anonymity. Interviews were semi-structured and included a general question about women’s experiences of smoking in pregnancy, the responses of partners, family members and health professionals, and any future plans to smoke in pregnancy. The first author analysed all interviews, except the pilots, exploring how women negotiated the stigma associated with being pregnant and smoking (Wigginton & Lee, 2013). Participants were each sent their anonymised transcript and a thematic summary of the interviews. Participants were then invited to comment on the summary; however, no one did.
**Analysis**

Our decision to re-analyse the interviews was driven by an interest in the opportunities of discourse analysis to explore the ways in which participants accounted for their smoking and identities in the context of pregnancy (Wigginton & Lee, 2014). In particular, discourse analysis enabled us to situate interpretations within the social and political context, thereby avoiding individualist understandings of behaviour and experience (Wood & Kroger, 2000). It also enabled us to focus on women’s agency in the construction and negotiation of meaning, including how women resist dominant discourses (Lafrance, 2011). Our purpose in this analysis is to show how these participants oriented to the broader social context in which biomedical discourses of risk circulate. Therefore, we aim to highlight the pervasiveness of the ‘smoking harms babies’ discourse in accounts of smoking in pregnancy and explore women’s accounting strategies and identity work.

We adopted a synthetic approach to discourse analysis (Wetherell, 1998), which was further informed by Wood and Kroger (2000). This approach acknowledges the local context which organises people’s talk, but also attends to broader political and ideological interests that language serves (Wetherell, 1998). This approach offers a method of analysis that combines attention to both the micro- and macro-organisation of accounts (i.e. the fine-grained details of what people do with their talk and the ways in which discourses shape what can be said). With an interest in identity construction, we take the view that individuals can speak themselves into being, but only within the discursive parameters of a particular cultural context. That is, an individual can construct a particular identity or experience drawing on culturally recognisable sets of meanings or discourses (Parker, 1992).

The current analysis involved an initial process of familiarisation and subsequent coding of the data by both authors. In coding the data, we attended to the discursive features, patterns and effects both within and across women’s accounts. We were interested in how the positioning of one’s actions has implications for one’s identities. In particular, we were interested in how women constructed and defended their smoking in relation to broader cultural discourses that sanction smoking in pregnancy, and, on a rhetorical level, how women negotiated their identities as moral actors.

**Findings**

**Smoking in pregnancy as moral trouble**

Each interview started with a general and non-accusatory question, designed to provide a non-judgemental platform from which to start the interview and emphasise the first author’s sympathetic position towards these women’s experiences: *Many women smoke during pregnancy but no one understands what it’s like from the woman’s perspective, can you tell me about your experience of being pregnant and smoking?* Despite efforts to avoid invoking blame or judgement, all women immediately oriented to the unstated problem of continuing to smoke in pregnancy and spent the remainder of the interview accounting for this moral trouble. Thus, it appears that smoking during pregnancy is so steeped in moral trouble that the mere invitation to discuss it requires immediate defence and justification. For example, Sarah and Jessica both orient to and then account for the moral trouble associated with smoking while pregnant:

I would say … that the biggest sort of feeling is absolute guilt … um of smoking like knowing that there’s a baby growing inside of you and how bad it is for you ya know not being pregnant, but being pregnant is even worse … um and basically um like the guilt sort of makes you [laughs] it continues like making you want to smoke, if that makes sense. Like it’s you basically
you’re feeling really bad about it but as opposed to just sort of like throwing cigarettes in the bin and getting rid of them you’re just even more drawn to um to doing it basically
(Sarah, telephone interview)

Um sure, like if, like, I know like it is bad and stuff to smoke, like they say the tobacco is not good for them and that. But at the same time like smoking is extremely addictive and I’ve been smoking since I was 14 … so it was really hard
(Jessica, telephone interview)

Although the first question invited a discussion of general experiences, both Sarah and Jessica immediately orient to the moral trouble of smoking during pregnancy (‘absolute guilt’; ‘it’s bad and stuff to smoke’), derived from the knowledge that smoking is harmful to the baby (‘there’s a baby growing inside of you […] being pregnant is even worse’; ‘the tobacco is not good for them’). Thus, both immediately position themselves as appropriately informed (and moral) actors who understand the problems associated with their smoking. Given this moral context, both Sarah and Jessica go on to account for why they did not quit. In her account, Sarah paradoxically situates guilt as the driving force that prevented her from being able to quit (‘the guilt sort of makes you […] want to smoke’). This hedged account (repetition of ‘sort of’; ‘if that makes sense’) has the effect then of protecting her identity and making sense of why, despite ‘knowing’ smoking is harmful, she continued to smoke. Further, the use of third person protects her identity by suggesting that anyone could be in her position (e.g. ‘you’re just even more drawn to doing it’).

Jessica’s account follows a similar discursive structure. She opens her interview by first situating herself as a reasonable informed person (‘I know like it is bad’) and then goes on to justify herself. She draws on an addiction discourse, buttressed by details of the length of time she smoked, to emphasise her difficulty in quitting. Ultimately, both women, like the majority of women interviewed, spent their interviews accounting for why they continued to smoke despite the knowledge that smoking harms babies.

Philamena deals with the opening question in a different way, using humour:

Philamena: What the ten fags that I smoked before I took the medical test (laughs)? Britta, my GP ok … … I smoked for about 15 … about 15 years
Interviewer: Before the pregnancy
Philamena: Yep before the pregnancy um … at the stage when I got pregnant I probably didn’t smoke very much while I was in a continual process of trying to give up
Interviewer: yep
Philamena: So … maybe 2 3 cigarettes a day or if I had a bad day and something happened then it would be higher, but on average that is what it was
Interviewer: yep
Philamena: My GP … … um stated unofficially that ‘anything under 5 was not going to be a massive stress.’

(Philamena, face-to-face interview)

Philamena orients to her smoking as problematic in a slightly different way to Sarah and Jessica, by using humour and laughter. Humour has been identified as facilitating difficult discussions in focus groups with low-income smoking mothers (Robinson, 2009) and, within conversation analysis, a prevalent feature of people’s ‘troubles-talk’ (Jefferson, 1984). Philamena quotes her doctor as a way of justifying her (reduced) smoking, which according to the doctor is ‘not going to be a massive stress [for her unborn foetus]’. Her reference to her doctor’s ‘unofficial’ support of low-level smoking underpins her implicit
argument that low levels could be safe and by implication her challenge to biomedical discourse that smoking any amount of cigarettes in pregnancy is harmful to the baby. Thus, similar to Jessica and Sarah’s accounts above, Philamena is also accounting for the implicit discourse that smoking harms babies.

However, Jade’s response to the initial interview question represents an exception to the general pattern of accounting. Whereas all other participants positioned smoking in pregnancy as a moral trouble, Jade’s account works to directly resist this construction by unproblematising smoking:

I actually had a very um, I had no complications whatsoever during my pregnancy. Um my job was very stressful though, at the time I worked for the dole advisor and as you can imagine you are abused constantly daily, um yeah it was very stressful. But yeah pregnancy wise there was no complications whatsoever … um yeah it was actually a pretty good pregnancy.

(Jade, telephone interview)

Jade positions her pregnancy as problem-free at both the start and finish of her statement using the phrase ‘no complications whatsoever’. Jade uses repetition and extreme case formulation (the use of words in their extreme limit, such as ‘whatsoever’ or ‘constantly daily’ (Wood & Kroger 2000)) to build the case that her job was a source of stress during her pregnancy and ‘pregnancy wise’ there is nothing to discuss. Although Jade does not make any mention of smoking, in claiming her pregnancy had ‘no complications’, she is implicitly dismissing the ‘smoking harms babies’ discourse and thus, the moral trouble of her behaviour. Jade offers the only opening response that does not problematise smoking in pregnancy, suggesting instead that ‘it was actually a pretty good pregnancy’. The word ‘actually’ signifies that this statement is not typical or expected. Therefore, although Jade’s response is an exception to the rest of the data in that she denies rather than concedes the moral trouble, her account fits within the analytic claims in that all participants immediately and directly orient to the unstated, but apparently dominant discourse that smoking harms babies as the basis for moral trouble, that is, why smoking in pregnancy is a problem and why they need to account for themselves.

‘I obviously know the risks’ (Tracey): smoking in pregnancy as a risk

One way in which women accounted for their smoking was to situate it within a risk discourse to downplay the seriousness of smoking in pregnancy and protect their identities as moral actors. Both Lisa and Tracey explicitly drew on the word risk, while many others drew on less direct means of accounting. For instance, Caroline stated ‘I knew it could harm the baby’ – here the qualifying verb ‘could’ rather than ‘would’ suggests that harming the baby is a possibility, not a certainty. Another indication of women’s use of risk language was the term ‘luck’. In the following extract, Philamena responds to a question about smoking in a future pregnancy, positioning herself as ‘lucky’ to have avoided harm to her first child, despite having smoked during the pregnancy:

\[
\text{Philamena:} \quad \text{That thought of … well you were really lucky the first time what if you’re not so lucky the second time and … um I would I would really like to say that I won’t smoke…}
\]

\[
\text{Interviewer:} \quad \text{Why do you say the guilt increases?}
\]

\[
\text{Philamena:} \quad \text{Cause your you got away with it the first time}
\]

\[
\text{Interviewer:} \quad \text{Is it like that?}
\]
Philamena: Yeaahh, anything you do naughty the first time [and] you get away with it, you think the next time you do it, you think oh I could still get caught but you do it because you didn’t get caught last time. And then it didn’t have terrible repercussions so you keep doing it. Yep I would really like to hope because I really like to quit, obviously not enough (laughs)

(Philamena, face-to-face interview)

In response to the question about whether she would smoke in a future pregnancy, Philamena accounts for the lack of evidence of harm to her child as a function of luck (repetition of the words ‘lucky’, ‘get away with’ and ‘get caught’). She defends her identity by presenting a divided self: the morally upstanding self that would ‘really like to say that (she) won’t smoke’ and the self that has successfully played the odds in the past. The use of the third person pronoun also serves to protect her identity by deflecting personal responsibility (‘you keep doing it’), as in Sarah’s excerpt earlier. In this account, then, Philamena presents harm as a risk, as the possibility of a harmful outcome, and goes on to minimise it, as not only unlikely, but merely ‘naughty’. The mobilisation of a luck discourse thus allows speakers to position smoking within a discourse of risk, where the consequences of smoking in pregnancy are acknowledged as serious, but as a matter of chance rather than certainty. In constructing smoking in pregnancy in these ways, these participants work to minimise the associated blame and shame and thus defend their identities against this moral trouble. In the remainder of this analysis, we explore the rhetorical strategies women deploy to account for their smoking despite ‘knowing’ the risks to babies.

‘I am lucky they are okay’ (Lisa): ‘stacking the facts’ to demonstrate evasion of harm

The women in our study negotiated the ‘smoking harms babies’ discourse by mobilising a rhetorical device we came to identify as ‘stacking the facts’. This involved engaging in ‘fact work’, that is, compiling relevant and observable evidence to evade the widely publicised biomedical discourse that smoking harms babies. Women overwhelmingly ‘stacked the facts’ to show how they and their babies had evaded the risks associated with smoking in pregnancy. For instance, Lisa accounts for the health of her two children to show how she was ‘lucky’ to have escaped the risks:

Interviewer: Was there anything else that I haven’t asked you that you wanted to tell me about?
Lisa: Ummm … … not really just that I have two very healthy children and yet they don’t have any real health complaints they weren’t born premature, they weren’t born with any problems that could have been due to smoking.
Interviewer: Yeah yeah.
Lisa: Umm which I think is very lucky knowing the risks. It certainly doesn’t excuse doing it, you know what I mean, but I think I am lucky that they are okay …

(Lisa, telephone interview)

In this account, Lisa conflates risk and luck to make sense of her ‘two very healthy children’. She acknowledges the risks of smoking, while demonstrating that she luckily evaded them by ‘stacking the facts’ of her children’s health – they are ‘very healthy’, ‘don’t have any real health complaints’, ‘weren’t born premature’ and indeed, ‘weren’t born with any problems that could have been due to smoking’. By presenting this list of
evidence, she persuasively argues against the ‘smoking harms babies’ discourse and absolves herself of the responsibility of causing harm to her unborn babies. In doing so, Lisa’s account works to account for her smoking behaviour and defend her identity. Sally’s account follows a similar rhetorical pattern, ‘stacking the facts’ to illustrate that she ‘thankfully’ avoided the risks of harm to her child despite having smoked during her pregnancy:

Sally: [...] I tried a couple of times to give up though while I was pregnant … and how did they go?
Interviewer: Oh they they it wasn’t obviously successful because I wasn’t allowed to have, they wouldn’t give me anything, so I wouldn’t couldn’t have nicabate or anything it would be just willpower and I didn’t have enough willpower … to get through … and with this baby it was born smaller than the others as well. But for the whole pregnancy I did stress out then whether I’d smoke so much that he was gonna be born with problems … but thankfully he wasn’t, but actually mind you he’s my healthiest but not that I’ll … I [laughs] encourage people to smoke while they are pregnant=

Interviewer: =[laughs]
Sally: the other two kids I didn’t smoke at all and they were born bigger babies but both ended up having asthma at ya know a very young age … and this one has been the healthiest of them all, I think he is immune to all the smoke I gave him

(Sally, telephone interview)

In describing her unsuccessful quitting attempts, Sally concedes a negative identity position, as someone who does not have ‘enough willpower’ to quit and is therefore left to account for the harm of her smoking on her ‘smaller’ baby. Sally repairs her negative identity position by focusing on the absence of any evidence to suggest her smoking was harmful, allowing her to celebrate her son’s health within a risk discourse (indicated by ‘thankfully’). This celebratory claim is rhetorically useful as it allows Sally the discursive space to make a more dangerous claim (indicated by her laughter). In particular, Sally challenges the ‘smoking harms babies’ discourse, concluding that ‘actually he’s my healthiest’. Sally repairs this threatening claim by clarifying that she does not promote smoking in pregnancy but then goes on to ‘stacks the facts’ to reinstate the health of her youngest child. She flips the ‘smoking harms babies’ discourse to suggest that, in her case, smoking led to a healthier baby – a baby that is ‘immune to all the smoke’. Having a child who is healthier despite her smoking provided Sally with the ammunition to make contentious claims which challenged the ‘smoking harms babies’ discourse.

As we have already noted, Jade’s interview was atypical as she was the only participant to explicitly deny the risks associated with smoking in pregnancy:

Interviewer: […] was there anything else that you wanted to tell me about the pregnancy and your experience?
Jade: Um not really, um the only thing was that they say there’s so many effects on the unborn child and that while preg[nancy] smoking, but um after the labour um with the placenta and everything the midwife actually said that my placenta um was probably the most healthiest she’s ever seen, even for a non-smoking woman.

Interviewer: Yep wow.
Jade: So I don’t entirely believe that smoking affects the unborn child, but yeah like she said it was um the healthiest she’d ever seen.

(Jade, telephone interview)

In this extract, Jade directly challenges the ‘smoking harms babies’ discourse by drawing on her own personal ‘evidence’ buttressed by the reported speech of her midwife. Jade starts by reiterating the widely accepted discourse, citing the authoritative ‘they’ (‘they say there’s so many effects on the unborn child’), and then recounts her ‘evidence’ to emphasise the contrast between what ‘they’ say and her own lived experience. Using the midwife’s reported speech, Jade’s placenta is compared to the placenta of a non-smoking woman to draw the conclusion that her placenta was the ‘most healthiest’ this midwife had ‘ever seen’. Despite the encouraging response of the interviewer, Jade continues to offer the hedged claim, ‘I don’t entirely believe that smoking affects the unborn child’. In doing so, Jade questions the proposed risks associated with smoking in pregnancy, emphasising the midwife’s conclusion about her healthy placenta. By quoting her midwife, Jade is able to ground her potentially threatening claim (and resistance to the dominant biomedical discourse) in the knowledge and experience of a medical authority – someone who is clearly in a position to provide an authoritative statement about the ‘facts’ in her case.

‘I never really knew’ (Donna): stacking the facts to destabilise the ‘smoking harms babies’ discourse

Some women ‘stacked the facts’ to cast doubt as to whether or not they beat the risks, highlighting how the harm of their smoking is ultimately unknown. Such accounts worked to destabilise the ‘smoking harms babies’ discourse, thereby minimising negative evaluations of women’s smoking and consequently the fitness of their identities as moral actors:

Interviewer: um was there anything else that you wanted to tell me about your last pregnancy?
Donna: Um … … well my last pregnancy went really really well um … my son was … six pound ten which apparently … is small, on the smaller side but um … … if you have a look at of the records in my husband’s side of the family … all of the kids were anywhere between four to six pounds and his mother never smoked during pregnancy and his brother’s … girlfriend never smoked during pregnancy … and apparently even his dad was … only most of his dad’s family was around about the five-six pound so they did have small babies. So I never knew whether that he was small because I was pregnant I was smoking while pregnant or I never knew ya know

Interviewer: You couldn’t really tell yeah=
Donna: =whether it affected him a lot=
Interviewer: =yeah that makes sense
Donna: Um and I do know that um two days before his two months needles my son actually contracted the whooping cough virus … …
Interviewer: oh … …
Donna: And I never really knew or understood whether that was because I smoked or because it was just an unfortunate thing where we were in the wrong place at the wrong time

(Donna, telephone interview)
In describing her previous pregnancy, Donna uses her baby’s weight as an indication of his health. She casts doubt over the claim that his weight was low (‘which apparently is small’), correcting herself (‘on the smaller side’) to minimise his weight as problematic. Donna’s account invites the listener to review the records of birthweight on her husband’s side of the family. The invitation to look at these facts (‘if you have a look’) asserts the objective and verifiable nature of the evidence. Using quantification and extreme case formulation (‘never’), Donna builds the claim that her son’s weight could have been a matter of family history rather than a product of her smoking. Donna also emphasises uncertainty when she discusses her son’s whooping cough, suggesting ‘she never knew’ the truth behind this diagnosis – which she proposes could have been a function of bad luck, ‘an unfortunate thing’.

Other women made similar claims of uncertainty as to harm of their smoking by drawing on ambiguous evidence:

Well my son um … he was he was fine but he was smaller than he should have been not by a lot, but he was small for his um gestational age and … and he’s now allergic to eggs and nuts … and I don’t know if it’s related or not um …

(Caroline, telephone interview)

Caroline ‘stacks the facts’ by drawing on her son’s weight and current allergies. Using a similar phrase to Donna, Caroline raises doubt about the relevance of her smoking to her son’s current health issues, stating ‘I don’t know if it’s related or not’. In accounting for the health of their children, women are implicitly being called to account for their own identities, whereby harming one’s child directly contravenes the good mother discourse and risks positioning women as ‘bad mothers’. Therefore, raising uncertainty in their account was rhetorically useful, as it allowed them to avoid having to make the ‘un-hearable’ or ‘un-speakable’ claims that they harmed their children by smoking during pregnancy.

**Smoking for health**

We found that women used a second rhetorical device which involved positioning smoking during pregnancy as a healthier and safer option than exposing the foetus to the stress associated with stopping smoking. Women almost always buttressed these articulations with the reported speech of health professionals, a pattern that has been identified in previous accounts of smoking outside of pregnancy (Gough, Fry, Grogan, & Conner, 2009; Heikkinen, Patja, & Jallinoja, 2010; Stengel, 2014). The consistent use of reported speech to support claims of ‘smoking for health’ orients to the threatening nature of this device and the need to legitimise such claims with an authoritative source. To highlight the diversity of how women articulate ‘smoking for health’, we will work our way from women’s least threatening claims (cutting down is better for my health than withdrawal) to their more extreme (quitting smoking killed my baby).

In the following excerpt, Kate defends having smoked during pregnancy by invoking the support of ‘any good doctor’ who would endorse cutting down rather than stopping smoking:

As much as I wanted to I don’t think I did want to … quit … […] I mean I was frustrated but I just … found it really hard because I used the cigarettes as a crutch … so it was um … and my defence was any good doctor would tell you that it’s easier to that it’s better for you and your baby to cut down while you’re pregnant rather than quit.

(Kate, telephone interview)
Like Philamena’s excerpt which we cited earlier, Kate also accounts for her smoking by presenting herself as being of two minds (‘as much as I wanted to I don’t think I did want to … quit’). Presenting a bifurcated sense of self is a common way in which women positioned themselves in their accounts, allowing them to pay tribute to the moral part of them that wanted to stop smoking. In doing so, these instances of talk have the effect of defending speakers’ identities, despite their smoking behaviour. Kate’s ‘defence’ for smoking is further buttressed by the reported speech of ‘any good doctor’, who would support cutting down because it is, not ‘easier’ but, ‘better’ for the woman and baby compared to quitting. Her correction from ‘easier’ to ‘better’ orients to the rhetorical strength of presenting her (reduced) smoking as not necessarily the ‘easy’ option but rather the healthier alternative. This correction also has constructive effects for her identity position as someone who takes the ‘healthier’, not ‘easier’, option. Kate’s use of third person (‘you’) in the doctor’s reported speech allows her to generalise this recommendation, directing the doctor’s words to women in general and not necessarily to herself alone. The legitimacy of the source of this statement means that Kate is able to leave this claim untroubled, without further explanation for why cutting down is ‘better’ than quitting.

Sarah and Tracey also describe smoking (less) as ‘better’ for their health than the harmful effects of withdrawal:

As the morning sickness got worse, which it did quite quickly, the urge to smoke and to feel normal again, ‘cause it was quite like anxiety as well, just to sorta feel normal by smoking again I actually thought that would be in some way better [half laugh] for my health than sort of like feeling sick and hungry and stressed out all the time … so … I decided like I started smoking again but I decided then that as opposed to sort of smoking 30 a day, ‘cause that’s what I was doing, I decided not to go over 10 a day.

(Sarah, telephone interview)

My best friend um used to give me handouts on what smoking does to babies and I use to get so cranky with her because I know what it does … but my doctor actually told me ‘it was better if’ because she saw me on a day that I had no cigarettes and she said it’s better for me if I cut right down rather than quit completely because I stress a lot and I use that I use smoking as a tool to calm me down … and yeah she sorta went ‘you’d do more damage than good if you quit completely’ so I cut right down.

(Tracey, telephone interview)

Sarah equates smoking with ‘feeling normal’ and contrasts this with the withdrawal effects of quitting (‘feeling sick and hungry and stressed out all the time’). Part of feeling ‘normal’ includes smoking a significantly reduced number of cigarettes in order to deal with anxiety. Therefore, her decision to significantly reduce her cigarette consumption is constructed as ‘in some way better [half laugh] for [her] health’. Her laugh orients to the controversial nature of such a claim in the face of the dominant biomedical discourse that asserts smoking as a health risk.

Tracey’s account of ‘smoking for health’ relies on the reported speech of her doctor. Tracey describes using cigarettes as a stress relief, and her doctor is quoted as supporting her decision to cut down rather than quit completely. In her doctor’s words, quitting smoking is more harmful than cutting down. As in Kate’s account, these contentious claims are left untroubled because of the legitimacy of the source. Lisa also described her smoking as better for her health than the stress of trying to quit (in the doctor’s words: ‘you’re going to do yourself more harm stressing about not being able to stop’). In many
of the women’s accounts, it is a doctor who is positioned as giving women permission to ‘smoke for health’. However, in their accounts, permission to continue to smoke is often granted on the condition that it is a reduced amount.

The most extreme instance of the ‘smoking for health’ device was from Donna’s interview:

I did actually cut down ... ... the smoking I was ... embarrassed about smoking while I was pregnant but I didn’t in my first pregnancy I actually tried to quit ... and I went 3 days without ... and my I ended up in bed crying and my husband threw a packet of smokes at me and told me to ‘go have a smoke and I want you to go have a smoke’ and it was actually the next day that I lost the baby. So I kind of mentally I couldn’t quit because I was scared that if I quit I was going to get to that 3 day stage and I was going to stress myself out again that I was going to lose my son that I had ... so it was a mental thing ... for me I was ... I was so embarrassed to smoke but I didn’t want to lose the baby again.

(Donna, telephone interview)

In Donna’s account, she describes her extreme circumstances of miscarriage while trying to quit smoking. Donna’s account revolves around the evidence that the stress of quitting smoking killed her baby. She expresses embarrassment about smoking but ultimately continued to smoke because she wanted her baby to live. Thus, Donna’s account represents an extreme articulation of the ‘smoking for health’ device and shows how this device (with her extreme evidence) works to protect her from the blame and responsibility associated with both the miscarriage and her continued smoking.

Discussion

Drawing on interviews with Australian women, in this article, we discursively analysed how women accounted for their smoking during a recent pregnancy. Despite deliberate attempts to create a non-judgemental space for women to tell their stories, all women immediately oriented their accounts to the potential harm of smoking to the baby as a basis for the moral trouble associated with smoking in pregnancy. Therefore, women spent their interview accounting for why they continued to smoke in light of the prevailing biomedical discourse that smoking in pregnancy harms babies. We focused on two rhetorical devices women mobilised to account for their smoking and identities. These devices allowed women to situate their smoking as either a matter of risk or a potential benefit to their health – both of which served to protect women from being positioned as knowingly or deliberating harming their babies.

Women ‘stacked the facts’ by detailing personal, observable evidence to show how their babies had evaded the risks associated with smoking in pregnancy. In this way, women located their smoking within a discourse of risk and cited various indicators of their child’s health to show how smoking had not caused harm. Women’s use of risk and luck language, in combination with counter-evidence of harm, was also found in interviews with mothers of children with a respiratory illness who were asked about their smoking (Holdsworth & Robinson, 2008). These women used inter-generational narratives to provide evidence-based accounts of how the risk of smoking was less prevalent than health promotion campaigns imply, suggesting that health is ultimately a lottery draw. Similarly, Finnish adult smokers also drew on their personal counter-evidence to make conclusions about the risks of smoking, where the absence of health problems allowed participants to justify their continued smoking (Heikkinen et al., 2010).
Women also ‘stacked the facts’ to raise doubt as to whether or not smoking caused harm to their babies, thereby destabilising the ‘smoking harms babies’ discourse. Women used phrases such as ‘I never really knew’ or ‘I don’t know’ in the context of ambiguous or mixed evidence to highlight their uncertainty about the risks of their smoking. A similar pattern of accounting was identified in interviews with people diagnosed with chronic obstructive pulmonary disease (a disease strongly linked with smoking) (Hansen, Walters, & Wood Baker, 2007). When asked about their smoking in relation to their diagnosis, participants commonly described scepticism surrounding the link between smoking and their illness as a way of casting doubt over the validity of their diagnosis. Raising doubt or uncertainty was a useful rhetorical strategy that allowed speakers to avoid making ‘un-hearable’ claims that could threaten their identities.

The second rhetorical device, ‘smoking for health’, allowed women to reposition smoking as beneficial to their health (instead of risky or harmful). Here, the harm of experiencing withdrawal symptoms was constructed as more harmful than smoking a reduced number of cigarettes. Women’s articulations of ‘smoking for health’ were almost always buttressed by the reported speech of their doctors. In our data, invoking the voices of doctors offered a source of legitimacy in women’s accounts, allowing them to make controversial claims that required no further explanation. This pattern has also been identified in interviews with adults who smoke who drew on health professionals as an authoritative source with sufficient expertise to support counter-intuitive claims about the benefits of smoking (Gough et al., 2009; Heikkinen et al., 2010).

The (counter-intuitive) repositioning of smoking as beneficial to one’s health compared to quitting has been identified in previous qualitative work. For instance, adolescents described smoking ‘to feel normal’ (like Sarah in our study) and to avoid unpleasant withdrawal effects (Johnson et al., 2003). Additionally, young adults described the health benefits of smoking, including ‘stress relief’, and in doing so emphasised the dangers of quitting (Gough et al., 2009). Although we are the first to label this form of accounting as ‘smoking for health’, this device appeared in the context of other research on smoking during pregnancy. For instance, a review of qualitative studies on smoking in pregnancy by Graham et al. (2014) showed health professionals were consistently described as supporting women’s reduced smoking. In particular, health professionals were quoted as advising women about the stress of quitting which may be harmful to the baby (see Greaves, Kalaw, & Bottorff, 2007; Haugland, Haug, & Wold, 1996; Nichter et al., 2007; Wood et al., 2008). In addition, in previous accounts of smoking in pregnancy, women described health professionals supporting their reduced smoking as opposed to quitting (Greaves et al., 2007; Hammer & Inglis, 2014; Haugland et al., 1996; Pletsch, Morgan, & Pieper, 2003). However, this body of work has failed to capture the discursive consequences of ‘smoking for health’, particularly in terms of women’s identity work. Drawing on our data, the reported speech of doctors – often conveyed as ‘permission’ to smoke – served to protect women’s identities and highlighted their compliance (not defiance) with medical advice. It was the legitimacy of the source of the advice that ultimately protected women’s identities.

In conclusion, our analysis explored two prevalent rhetorical devices women drew on to account for their smoking and identities in light of the ‘smoking harms babies’ discourse. These rhetorical devices had various implications for women’s subjectivity and the ways in which they positioned themselves in relation to this biomedical discourse. For instance, in situating their smoking within a discourse of risk, women re-positioned harm to the foetus as a possibility (rather than a certainty), thereby minimising the weight of this moral problem. Further, participants’ accounts worked to destabilise the dominant biomedical discourse that equates smoking in pregnancy with harm. Alternatively,
positioning oneself as following a doctor’s advice to ‘smoke for health’ similarly protected women’s identities by allowing them to make ‘controversial’ claims that were left without further explanation. Thus, our findings offer analytical insights into how women negotiate their precarious and ‘indefensible’ identity positionings as women who smoked during pregnancy.

Conclusion
Our findings highlight the need for health promotion campaigns to contextualise risk messages within lay accounts of health and risk and reconsider the effectiveness of medical jargon in the communication of health risks (Gilbert, 2005). For instance, in a recent Australian brochure for smoking pregnant women (Queensland Government, 2013), we identified an attempt to challenge the rhetorical device ‘smoking for health’ in their ‘fears and fallacies section’. Responding to the ‘fallacy’ that ‘smoking relaxes me and being relaxed is better for my baby’, the ‘truth’ is described in physiological terms, showing how smoke enters the body and affects the baby, to conclude that ‘this is definitely not better for your baby’. In this brochure, the risks of smoking in pregnancy are defended in medical terms and constructed as the legitimate explanation and source of ‘truth’. As a result, women’s understandings of smoking (including the psychological benefits) are positioned as a ‘fallacy’ that is unsupported by the medical community. However, our findings highlight two rhetorical devices women mobilised to interpret the widely circulating discourse that smoking in pregnancy harms babies. These devices were counter-intuitive yet based on women’s own ‘evidence’ or supportive health professional and allowed women the discursive space to account for (and defend) their smoking, their baby’s health and their identities. Although our analysis was based on a relatively small sample of 12 women’s accounts, it highlighted the prevalence of complex and contradictory ways in which smoking-related risks were taken up and negotiated. In future research, this type of nuanced analysis could be applied to understanding other ways in which people negotiate risk discourses related to smoking in the context of parenthood. We recommend that health promotion campaigns thoughtfully consider lay understandings of health and risk, such as ‘stacking the facts’ and ‘smoking for health’, in delivering health risk messages in order to effectively engage with the target audience.

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Chapter 7. How do women manage the ‘spoiled’ identity of a ‘pregnant smoker’? An analysis of discursive silencing in women’s accounts

Chapter 6 presented a discourse analysis of the interviews collected in Study 1, examining the ways in which women accounted for themselves and their smoking in light of the pervasive discourse that smoking in pregnancy harms babies. The findings from this chapter focussed on two rhetorical devices which women mobilised in their talk to deal with this discourse: ‘stacking the facts’ and ‘smoking for health’. Both of these ways of talking allowed speakers to cast doubt over (or deny) the validity of the discourse. These devices are similar to those identified in other accounts of smoking in other contexts, in which smokers have been observed to downplay the harm of smoking by drawing on personal ‘evidence’ (Holdsworth & Robinson, 2008) or sources of knowledge that are presumed to have legitimacy, such as doctors (Gough, Fry, Grogan, & Conner, 2009; Heikkinen Patja & Jallinoja, 2010). We found that these devices had the effect of protecting women from the threat of being positioned as deliberately harming their babies. Although we discussed identity in relation to this discourse in Chapter 6, we extend the analysis of how women negotiate their identity in relation to the stigma associated with smoking during pregnancy in Chapter 7.

Chapter 7 returns to the concept of stigma, a central focus of Chapters 3 and 4, to ask how women discursively manage the spoiled identity of a pregnant smoker. A discursive approach to identity involves paying attention to the ways in which women take up particular identities in their talk, and to the function and consequences of these identities. From this perspective, identity is viewed not as something someone has, but as something that is accomplished in interactions and through discourse (Davies & Harré, 1990).

This chapter uses several sources of data to examine both public and private (anonymous) accounts of smoking during pregnancy: 13 interviews from Study 1; responses from Study 3; and a media article written by an Australian television host who was ‘caught’ smoking in pregnancy (Appendix D). This chapter addresses the question of how women discursively negotiate and manage stigma in accounting for themselves and their experiences of smoking during pregnancy.

Dominant representations of motherhood are central to this chapter, since one of the focal points in this analysis is how women negotiate their maternal identities in relation to their smoking during pregnancy. Returning to Goffman’s (1963) conceptualisation of stigma, this chapter considers how women discursively negotiate stigma and their maternal identities. Goffman argued that stigma is not inherent in an individual, but is produced through social interactions (for instance, with non-stigmatised or ‘normal’ people). Therefore, depending on
the visibility of an individual’s ‘discrediting characteristic,’ that person may be able to ‘pass’ as ‘normal’ by concealing information about this characteristic in interactions with others. Using a media article as one source of data in this analysis provides a useful comparison, because this was written by someone who could not ‘pass’ or conceal her smoking during pregnancy (having had a photograph of her smoking appear in a magazine). Therefore, the identity work analysed in this chapter offers an examination of negotiating stigma across different discursive contexts but within a broader cultural context of idealised motherhood.

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How do women manage the spoiled identity of a ‘pregnant smoker’? An analysis of discursive silencing in women’s accounts

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Abstract
Drawing on public and private accounts of smoking during pregnancy (interviews, survey responses, and a public media article), we examine how women discursively manage the ‘spoiled’ identity associated with inhabiting the body of a ‘pregnant smoker’. We focus on two salient identities ‘the silenced smoker’ and ‘the bad mother’ and explore the discursive and material consequences of these identities. We found that references to smoker and maternal identities were largely absent in women’s accounts, and discuss how these absences enabled women to evade stigma and the rhetorical harm of these identities. Further, we discuss the material consequences of stigma including women’s need to conceal their ‘pregnant smoker’ body in the face of heightened surveillance. We propose ‘discursive silencing’ to explain how dominant motherhood and anti-smoking discourses serve to render women’s experiences as ‘untellable’ and therefore reduce women’s capacity to seek help or support to quit smoking.

Keywords
discursive silencing, smoking, pregnancy, stigma, discourse analysis, motherhood

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Motherhood holds one of the most glorified (and accordingly, the most vilified) identity positions available to women today. Constructed as a ‘natural’ and universal experience (Smart, 1996), motherhood is one of the most salient identities available to women, synonymous with femininity and womanhood (Arendell, 2000). Yet mothering is not an easy task, nor is it the imagined fantasy it is built up to be (Ussher, 2006). Although there is often a disjuncture between the imagined experience and the reality of mothering, the illusion of the ‘ideal mother’ is difficult to resist.

Today, ideal motherhood takes the form of ‘intensive mothering’, an approach that is ‘child-centred, expert guided, emotionally absorbing, labour intensive, and financially expensive’ (Hays, 1996: 15). Accordingly, the ideal mother willingly prioritises the needs and wants of her child over and above her own. Intensive motherhood ideology runs parallel to patriarchal, capitalist, and neoliberal discourses, which together shape dominant constructions of ‘good’ and ‘ideal’ mothers (Hays, 1996; Smart, 1996). It is not a coincidence that ideal motherhood is difficult or even impossible to attain, and even socio-economically privileged women struggle to meet the mark of the ‘good mother’ (Hays, 1996). For instance, despite women’s increased social and economic autonomy, the incompatibility of ‘ideal’ mothering and paid work persists, leaving women feeling guilty and inadequate as workers and as mothers (O’Reilly, 2004). However, those who are particularly oppressed and vilified by this ideology (because of their lack of resources to ‘intensively’ mother) include working class, single, poor, divorced, or disabled women (Phoenix & Woollett, 1991; Smart, 1996).

There are many ways in which women can fail as mothers, and subsequently face blame and vilification. For instance, women risk being positioned as ‘bad mothers’ in the context of childhood obesity (Bell, McNaughton, & Salmon, 2009), long-term breastfeeding (Faireloth, 2010), and drug use in pregnancy (Stengel, 2013). In their analysis of Australian media accounts of obesity, Warin et al. (2012) argued that mothers were consistently positioned as blameworthy for the intergenerational transmission of obesity. They argued that the media rely on overly simplistic explanations, which place mothers as responsible for passing on obesity to their children as a result of their own poor lifestyle ‘choices’ and mothering.

The marking of the ‘bad mother’ holds significant material consequences. In the context of drug use, this label can affect women’s custody rights and the extent of professional intervention imposed on their child rearing (Croghan & Miell, 1998). In some cases, this label may prevent women from seeking advice or assistance for fear of punitive institutional interventions (Murphy & Rosenbaum, 1999). As a result of the ease with which women can be stigmatised as ‘bad mothers’, and the serious and far-reaching consequences that this label invites, there is increased pressure for women to adhere to the ideology of motherhood.

Goffman (1963) defines stigma as a ‘mark’ of social disgrace, a deeply discrediting attribute that results in the social devaluation of a person for their ‘spoiled’ identity. In his terms, the markings of a mother as failed refer to an attribute that conveys her devalued (or tainted) status as a mother. This attribute might denote a person’s failure to produce a ‘healthy’ child, for instance having a child with a
disability (Craig & Scambler, 2006), attention hyperactivity disorder (Norvilitis, Scime, & Lee, 2002), or in the case of stillbirth (Murphy, 2012). Alternatively, this attribute may reflect a woman’s failure to perform as a mother, for instance in the context of postnatal depression (Edwards & Timmons, 2005), ‘obesity’ in pregnancy (Mulherin, Miller, Barlow, Diedrichs, & Thompson, 2013), or mothering with a disability (Malacrida, 2009).

To date, research has focused on describing how ‘bad’ mothers (re)assert their claim to ideal motherhood. For example, researchers who conducted interviews with mothers with postpartum depression (Abrams & Curran, 2010) and addiction (Hardesty & Black, 1999) have described these women’s attempts to reclaim a (positive) maternal identity. Additionally, an analysis of interviews with women who experienced stillbirth revealed women’s efforts to reclaim their identity as the ‘moral’ mother who was not to blame for losing the baby (Murphy, 2012). Additionally, research with American mothers who used substances showed how these women minimised the negative aspects of their mothering (e.g. neglect), instead emphasising their care and commitment to their child, and how substance use allowed them to better deal with everyday situations and be better mothers (Baker & Carson, 1999). We identified a similar rhetorical strategy in several qualitative studies with mothers who smoke tobacco, in that women repositioned smoking positively as a tool for relaxing which allowed them to be better mothers (Coxhead & Rhodes, 2006; Holdsworth & Robinson, 2008; Irwin, Johnson, & Bottorff, 2005).

Our focus is on women who smoke during pregnancy; women who are readily vilified as ‘bad mothers’ and face significant stigma (Oaks, 2001). As a result of tobacco denormalisation policies, smokers in many parts of the Western world have been stigmatised and face intense public surveillance (Stuber, Galea, & Link, 2009). For instance, British smokers and non-smokers described smokers as lepers, underclass and outcast members of society who effectively pollute the air by smoking (Farrimond & Joffe, 2006). The stigma against mothers who smoke is all the more intense given that dominant motherhood ideology situates ‘good’ mothers as unfailingly nurturing and consumed with the care and protection of their children (Irwin et al., 2005). Accordingly, the smoker identity is discursively incompatible with the ‘good’ mother identity, as evidenced by women’s experiences of stigma for smoking during pregnancy (Abrahamsson, Springett, Karlsson, & Ottosson, 2005; Edwards & Sims-Jones, 1998; Wigginton & Lee, 2013).

While smoking in pregnancy is relatively common in Australia (17%: Laws, Abeywardana, Walker, & Sullivan, 2007), we know little about how women who smoke during pregnancy manage their ‘spoiled’ identities. Studies that do explore experiences of smoking in pregnancy attend to women’s accounts of their smoking (such as attempts to quit), only tangentially considering women’s identities (Abrahamsson et al., 2005; Edwards & Sims-Jones, 1998). To our knowledge, no studies have explored how women who smoke during pregnancy negotiate their ‘spoiled’ identities. We investigate this topic with a view to exploring the discursive production of, and resistance to, stigmatised identities.
Identity is an important avenue for understanding how people speak themselves into being within the parameters of culturally available meanings. From a discursive perspective, identity is not a stable concept that someone has; rather it is something that is continually accomplished in interactions and through discourse (Davies & Harré, 1990). Discourse analysis allows attention to the ways in which women take up particular identities and the function and effects of these identities.

Our aim is to explore how women manage the stigma associated with inhabiting the body of a ‘pregnant smoker’. We use both public and private (anonymous) accounts to examine women’s identity work. This inquiry was carried out not with a view to further compound women’s shame but rather to understand their limited discursive positioning and thus better understand this common, but often ‘untellable’ experience.

**Method**

**Data collection**

To address our question, we explored three sources of data regarding women’s experiences of the stigma associated with smoking during pregnancy: 13 semi-structured interviews with women, a survey completed by 47 women and a media article written by an Australian radio and television host (February, 2013). The interviews (April–August 2011) and survey responses (March 2013–March 2014) were collected as part of the first author’s PhD research. Interview and survey participants were recruited on the basis that they had smoked during pregnancies that occurred fewer than four years ago, with most being within two years. Both projects received ethical clearance. There were no financial incentives offered for participation.

Being attuned to the stigma surrounding the topic and wanting to ensure that participants were made comfortable during the interviews, the first author conducted two pilot interviews to check the appropriateness and sensitivity of the questions. Following the successful completion of the pilot interviews, which are included in this analysis, the first author began formal advertising for the study.

With the knowledge that smoking during pregnancy is a sensitive topic, the posters used to recruit women for both studies included an attractive photograph of a pregnant woman alongside a prevalence statistic (‘Did you know that 17% of women say they smoke during their pregnancy?’). The use of positive imagery and a statistic was intended to normalise the practice and to convey the researchers’ non-judgemental position. The poster for the interview study also included a statement about foregrounding women’s voices (‘We want to explore your story of smoking during pregnancy, rather than the opinions of doctors or the public’).

All interviews started with an open-ended question about women’s experiences (‘A lot of women smoke during pregnancy but no one knows what it’s like from the woman’s perspective, could you tell me about your experience of being pregnant and smoking?’). The opening question was followed by general questions regarding the times and places they smoked during pregnancy, changes in smoking practices
during pregnancy, and responses of others (family, friends, health professionals). All interviews ended with a question about plans to smoke during a future pregnancy and a final question regarding anything that was missed during the interview that participants wanted to discuss.

The online survey questions were framed around women’s use (or non-use) of online pregnancy forums during pregnancy. Specifically, participants were asked whether and how they used online pregnancy forums for information and support about smoking during pregnancy. The survey included open-ended questions about disclosing their smoking (during pregnancy), others’ responses to forum posts on smoking during pregnancy, experiences of support and judgement online, and how their online experiences compare to offline.

Interview participants ranged in age from 20 to 35 years and were located across eastern Australia. Only one woman was pregnant and smoking at the time of the interview. All women had finished high school and some had received a technical qualification. Interviews were audio recorded and transcribed verbatim. Survey participants ranged in age from 19 to 37 years and were mostly from Australia, with three from New Zealand. Twenty-two were pregnant and smoking at the time of completing the survey, with most smoking daily. Twenty-five women had been pregnant within the last two years at the time of completing the survey, and almost all smoked daily. Most women had finished high school and had a technical qualification.

Ethnicity and income data were not collected for either set of participants in an effort to avoid women feeling like they were being profiled. Although not always asked specifically about their degree of tobacco consumption during the interviews, most women described their smoking patterns. In particular, five women described reducing the number of cigarettes they smoked per day, one woman described smoking the same amount during pregnancy, and another woman described smoking more during pregnancy than she ever had (because of the stress of being in a relationship with a man she described as an alcoholic). Survey participants were asked specifically about their tobacco consumption during pregnancy: 36 women reported smoking daily, eight smoked occasionally, and three did not answer.

Significant challenges were encountered during recruitment, and we note these here because they informed our analysis (this point is explored in more detail in ‘Discussion’ section). Starting with the interview study, of the seven women’s health and medical centres that were approached, only three agreed to advertise. Three refused to advertise: one indicated that the CEO had said no to advertising for this study, another refused because of the ‘sensitive’ nature of the study, and the third, because there was ‘no room to advertise’. A fourth requested additional ethics clearance because they work with Indigenous communities and are cautious of ‘overwhelming’ their clients. However, the first author decided not to pursue the additional ethics required to recruit through this centre because of the logistics involved. Additionally, two of the four online pregnancy forums approached to advertise for the interview study refused, only one explaining that smoking in pregnancy was a ‘very sensitive’ topic that we ‘try to avoid’ because discussions ‘inevitably deteriorate and become abusive’.
In addition to these significant obstacles, recruitment was slow, with a total of 13 women volunteering over a five-month period of active recruitment. Moreover, interviews were notably short, lasting between 10 and 20 min. What became clear over this time was the overwhelming preference for telephone interviews. Telephone interviews have been suggested as an appropriate method for collecting data regarding sensitive topics or with hard-to-reach groups (Sturges & Hanrahan, 2004). Other than the two women who took part in pilot interviews and knew the first author personally, none of the women agreed to be interviewed face to face, and one woman requested an interview over email.

As a result of the interview participants’ preference for anonymous channels of participation and recruitment, the first author became interested in the extent to which online spaces were potentially ‘safer’ spaces for women to discuss smoking in pregnancy. She approached 13 Australian pregnancy forums for advertising for an online qualitative survey, of which only six agreed. Similar challenges in recruitment were faced. Two of the forums refused advertising, five never responded to a request to advertise, three allowed advertising after obtaining moderator approval, and another three allowed advertising without moderator approval. Of the 13 forums approached, only one made it clear that research-related posts were strictly disallowed – this was one of the forums that refused our advertising. However, the other forum that refused advertising did so after email exchanges with the first author and after following their requests to provide formal approval from her supervisor, which included detailing the study’s aims and ethics approval. Recruitment for the survey was also slow with 47 participants over a total of 12 months, most completing 70% of the survey.

In the midst of data collection for these projects, an Australian radio and television personnel, Chrissie Swan, was ‘caught’ smoking while pregnant in her car by a paparazzi who sold the photographs to a national women’s magazine (Woman’s Day) for 55 000 AUD. Following the release of these photographs, there was an ‘outbreak’ of articles discussing her smoking during pregnancy (a total of 46 articles published in Australian media), to which she formulated a reply three days later, entitled: ‘Disgusting. Shameful. Illogical. A pregnant smoker butts out her demons’ (Swan, 2013). Given the timeliness and relevance of this article, we decided to include it as a third source of data. The public nature of her article offered another window from which to discursively examine how women manage the identity of a ‘pregnant smoker’.

**Discourse analysis**

Operating from a material-discursive perspective (Ussher, 1997; Yardley, 1997), we conducted a synthetic discourse analysis (Wetherell, 1998). Such an approach to discourse analysis combines the fine-grained particularities of participants’ talk with an interest in how broader social, political, and institutional forces constrain what can be said (Edley & Wetherell, 1997). The analysis involved a process of familiarisation and subsequent coding of the data by both authors, during which we attended to the discursive features, patterns, and effects both within and across
women’s accounts. We were interested not only in what participants said (or did not say), but how they said it and with what effects. In particular, we were interested in the available ways for women to construct themselves and their smoking and the (rhetorical) implications of these constructions. Drawing on positioning theory, we take the view that women are active producers of discourse, where they are both positioned by discourse and position themselves within discourse (Davies & Harré, 1990). We acknowledge that certain discourses construct a specific version of reality, shaping people’s subjectivity and how they can experience or see the world and themselves.

Using three data sources, we examine how women account for themselves and their smoking across different discursive contexts (public, private, and anonymous). Our analysis attends to how women negotiate their ‘spoiled’ identity, acknowledging that these accounts are situationally co-constructed and contingent on their local discursive context (Laurier, 1999). We focus on two identities that emerged in women’s accounts (silenced smoker and bad mother) and consider the material and discursive consequences of these identities.

**The silenced smoker**

Across the three data sources, women’s accounts worked to distance themselves from a smoking identity. Notably, although all women discussed smoking, women almost never positioned themselves as ‘smokers’ (Kate’s account, which provides a striking exception to this trend, is described below). In the few instances in which women raised the smoking identity in reference to themselves, they did so in a way to minimise or downplay their claim to this identity position. For instance, some situated smoking as part of their past, but not current identity (‘I was a smoker’ (Caroline); ‘we were all smokers’ (Tracey)). Those who identified as currently smoking positioned themselves in opposition to the genuine member category of the ‘heavy smoker’ (‘I’m not a heavy smoker’ (survey participant; Chrissie Swan)).

In contrast, it was common for participants across the three data sources to position other people as smokers. In particular, participants typically positioned non-smokers as harshly judgemental of their behaviour, while smokers were situated as disqualified from passing judgement. The excerpts below illustrate how women typically qualified whether those who judged them were smokers or non-smokers, and as a result, whether or not their opinions were valid:

*Interviewer: how did your friends respond to your smoking?*

Ah nobody said anything yeah yeah ‘cause they were all smokers

(Caroline, interview)

*Interviewer: How did your ex-partner or partner respond at the time when they knew that you were smoking during your pregnancy?*

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Um he didn’t really say a lot because he was a smoker as well

(Jade, interview)

Interviewer: What about the people at work how did um how did people react?

The smoking areas away

Interviewer: ahhh

So obviously they wouldn’t know if I’m just going out on lunch or morning tea so you would just go away for lunch or morning tea and that would be fine and other smokers don’t generally judge you anyway cause that have done it themselves

(Sally, interview)

Across these interview accounts, women described other smokers as being unable to judge them for smoking (‘nobody said anything’; ‘he didn’t say a lot’; ‘smokers don’t generally judge’) ‘because’ they are smokers. That is, the smoker identity appears to leave individuals without moral authority to speak on such matters. For instance, in the next excerpt, Kate describes her aunties as having no right to comment on her smoking because they had also smoked:

Interviewer: could you tell me how family responded?

Yeah some of them were a bit you know um oh not disgusted but they weren’t happy but then they couldn’t say anything because [...] it was just like my Aunties and stuff but then they couldn’t say much because they’d all done exactly the same thing so yeah they were like “oh you know you shouldn’t be smoking na na na naa” and I’d be like “yeah I know but you know you can’t talk” and they’d be like “I know”

(Kate, interview)

Kate recalls the judgemental voices of her aunties regarding her smoking (‘you know you shouldn’t be smoking’), but given their positions as smokers, she is able to discount (‘na na na naa’) and then dismiss (‘you can’t talk’) their disapproval. Kate’s rhetorical power here is based on the assumption that as smokers, her aunties have no authority to voice judgement because ‘they’d all done exactly the same thing’. Kate reinforces her authority to discount their claims, by noting how her aunties also accepted her move to silence their judgement (‘they’d be like “I know”’). Kate’s account shows how smokers are granted limited credibility to voice an opinion on the matter of smoking, and when they do, their voice is readily dismissed. However, Kate’s attempt to silence her aunties’ voices is based on the same precarious position she holds. That is, both Kate and her aunties have limited authority to speak about, or judge, smoking because they all smoke, and as a result, are all
silenced in some way. Thus, her account highlights the limited footing available to smokers to construct themselves and their behaviour in socially acceptable ways.

To deal with the precarious identity of a smoker, and its limited discursive footing, we found that women often aligned with non-smokers and their negative judgement of smokers:

Interviewer: were the two pregnancies very different in terms of how you felt about your smoking and how people responded to your smoking

Not really like I still got we were living in a different town when I was pregnant with my second daughter and it was oh it’s a bit of a hole so ya know there’s a lot of ferals so no one really gives it second thought for them to see someone smoking who is heavily pregnant and there were a few like the older people they’d give you looks and make little comments as they were walking past but it wasn’t as I didn’t find it as bad as when I was pregnant with my first daughter

(Tracey, interview)

Tracey describes the lack of judgement she received for smoking during her second pregnancy (‘no one gives it a second thought’), positioning people who failed to judge her as ‘ferals’. Tracey’s account shows how people who do not judge smoking in pregnancy are vilified as holding a low-class social position: ‘ferals’ who live in a ‘hole’. This positioning allows Tracey to align with the vilification of smokers by essentially judging those who failed to judge her.

A similar rhetorical pattern was identified in the article Chrissie Swan wrote in response to being ‘caught’ smoking while pregnant. In an early part of her article, Chrissie similarly accepts the negative judgement towards smoking (and smokers) by highlighting the authority of non-smokers to pass such judgement:

My partner, my parents, my sisters, my best friends and my colleagues - all people I have intensely personal and close relationships with - and now I would have to tell them too. Not one of them smokes. Not one. I became nauseous within minutes. It is not easy to keep a secret from those around you. [...] It is also emotionally difficult - I didn’t want my loved ones to be repulsed by me. I didn’t want to shock them or make them think they didn’t know me at all. I didn’t want them to think I was an idiot. I just didn’t want them to feel about me the way I was feeling about myself. Loathsome. [...] I had to explain that the pics would appear in Woman’s Day. That his parents would know I was an idiot. That all his friends would be horrified. (Chrissie Swan, 2013)

In emphasising the non-smoking status of her family, friends and colleagues (‘not one of them smokes. Not one.’), Chrissie’s account is built around how ‘emotionally difficult’ it was to tell these people about her smoking and, in doing so, positions them as entitled to be ‘repulsed’, ‘shock[ed]’, and ‘horrified’ by her (and her smoking). These anticipated responses from people who know her indicate the extent of vilification a smoker identity invites, particularly in the context of
pregnancy. Chrissie aligns with the judgement by suggesting that these people (who do not smoke) are entitled to feel about her the way she feels about herself, that is, ‘loathsome’. Therefore, not only is Chrissie accepting these judgements against smokers, but by not arguing against their ‘entitlement’ to judge her, she also accepts this vilified identity. It is likely that her acceptance of moral judgement may be reflective of the local context in which this account was produced (a public article responding to her being ‘caught’), where she was called to essentially over-step the mark in terms of vilifying herself. That is, judging herself so harshly has the effect of inviting readers to soften their judgement or invite a degree of leniency in others’ evaluations of her behaviour. In a later section of the analysis, we will show how such self-vilification ultimately protected Chrissie who, having proclaimed herself as having quit smoking, reclaims a positive identity as a ‘natural mother’.

While women rarely stepped into the smoker identity and instead, aligned with others’ negative judgements of smokers, Kate’s interview was an exception to this pattern as she was the only participant to directly accept the smoker identity:

You get the big bag of information at your twelve week midwife appointment and that was all part of it . . . um to give the whole lecture of quitting smoking and ya know “not smoking so not smoking here and doing this and doing that” um but yeah people say “you dirty smoker” and I’d say “yeah I’m a dirty filthy smoker so” . . . . .

Interviewer: yeah and were the people that were saying that were they um people that you knew . . . . um

Oh no just like the care providers and stuff they’re like “oh” you know “do you smoke?” and that’s part of the I’d go “yeah I’m a dirty filthy smoker but you know let’s get over that point” [laughs]

Interviewer: yep ah yep . . . and . . . . and if you fell pregnant in the future Kate um . . . would things be different and if they were=

=I would hope so

Interviewer: yep . . . . . . . . . . . . and do you did you want to say anything more about that how it might be different

Um . . . . noo . . . . . . cause I just would hope they would be but I don’t expect it to be

Interviewer: yep . . . so it’s=

=it would be nice if I could=

(Kate, interview)
Kate’s account begins with a description of her experience with health professionals, which includes a ‘big bag of information’ and a ‘lecture’ on quitting smoking. In response to the judgement from others about smoking (‘people say “you dirty smoker”’) and questions from health professionals, Kate appears to have few options other than to take up the position of a ‘dirty filthy smoker’. Using repetition, Kate builds up this identity position as her automatic response to people (‘I’d go “yeah I’m a dirty filthy smoker”’), in the hope that accepting the negative identity will close down any further discussion and scrutiny (‘let’s get over that point’). The laughter in Kate’s account (and the absence of the interviewer’s laughter) points to the discomfort associated with stepping into this ‘spoiled’ identity position. Despite the interviewer’s attempt to engage with Kate, and in contrast to her account earlier in her interview, the remainder of her interview is filled with short responses and long pauses, and it was a markedly short interview, lasting only 10 min. Kate’s account shows how after stepping into the ‘spoiled’ identity of the ‘dirty filthy smoker’, there is little more she can say. It also speaks to the difficulty to repair one’s identity once this negative identity is claimed. However, it is notable that Kate claims a negative identity that is unrelated to harming her baby and her capacity as a mother – an arguably rhetorically ‘safer’ option than the identity of the bad (smoking) mother, a topic to which we will turn in the next section.

In summary, participants’ accounts worked to: distance themselves from a smoker identity and; dismiss and undermine (silence) smokers’ voices. These discursive patterns both construct and underscore the limited footing smokers are afforded as moral actors, and therefore as speakers. Accordingly, participants’ accounts clearly point to the ways in which endorsing smoking, particularly in pregnancy, is ‘unspeakable’. These patterns indicate women’s careful discursive footwork to align with, rather than challenge, broader anti-smoking discourse which works to vilify and silence smokers. The rhetorical risk for these women was in accepting the smoker identity, which, as we showed in Kate’s account, had the effect of leaving her in a constrained, or silenced, place from which to speak.

The bad mother

Across the three data sources, whenever a maternal identity (mother or pregnant woman) was raised in discussions of smoking, it was only to highlight how this combination was unacceptable, disgusting and ultimately, morally reprehensible. For instance, Chrissie described in her media account: ‘Everyone knows smoking while pregnant is wrong, especially those who are doing it. Especially me’. This sentiment was mirrored by interview participants:

Well no one actually likes looking at a pregnant woman with a ya know a fag hanging out of her mouth I know I don’t […] And I was just embarrassed because I was thinking people would be looking at me judging me and thinking “oh my god that’s disgusting that lady is pregnant and she’s smoking”

(Sally, interview)
Interviewer: So you never smoked in public?

Mmm no way nothing worse see that nothing worse than seeing a pregnant chick walking down the road smoking that’s gross that’s gross

(Philamena, interview)

Such negative evaluations of smoking while pregnant were common. As explored in the analysis on the smoker identity, women aligned themselves with the judgement against pregnant women smoking (‘especially me’, ‘I know I don’t’, ‘that’s gross’). We interpret these articulations of pregnant women who smoke as ‘wrong’, ‘disgusting’, or ‘gross’ as the only ‘hearable’ and ‘tellable’ reactions within a culture that morally and medically disapproves of smoking in pregnancy. Rhetorically speaking, aligning with the judgement against smoking in pregnancy is one way of avoiding a negative identity as someone who endorses the practice (a ‘feral’, according to Tracey).

Similar to the smoker identity, women almost never stepped into a maternal identity in their accounts. That is, with very few exceptions (described below), women did not refer to themselves as mothers, pregnant women, or mothers-to-be. Although women were recruited for the interviews and survey to discuss their smoking in the context of pregnancy, it is notable that almost none of the women oriented to smoker or mother identities in their accounts. In the few instances in which women did take up a maternal identity, these were often to challenge being positioned as a ‘bad mother’ – an identity invoked by their smoking:

I didn’t want people telling me how bad I was for smoking while pregnant and judging me as a bad mother. I’m happy with my decision.

(Survey participant)

I had comments about my age and comments about me smoking and pretty much that I was a no hoper and ya know a bad mum and everything and I know that’s not the case.

(Tracey, interview)

Being told you don’t deserve to be a mother, that you’re killing your child, that you should quit cold turkey and find it easy. It’s all bullshit and makes you feel worse, and therefore smoke even more.

(Survey participant)

Above, women recall criticism for their smoking during pregnancy and orient to their moral failing as mothers as the source of this judgement. Thus, the coupling of smoking and maternal identity immediately evokes the ‘bad mother’ identity; a
positioning speakers react against in their talk. Given this equation, it is no wonder that a maternal identity was notably absent in women’s accounts. However, the excerpts above are some of the few instances of data in which women articulate and defend against being positioned by others as a ‘bad mother’. The rhetorical structure of their accounts is similar, in that women spell out the dominant discourse (‘judging me as a bad mother’; ‘I was a no hoper and ya know a bad mum’; ‘don’t deserve to be a mother, that you’re killing your child’), and then resist it (‘I’m happy with my decision’; ‘that’s not the case’; ‘it’s all bullshit’).

As we have shown, any reference to a maternal identity and smoking was only to highlight the necessity to *not* smoke. We found women mostly avoided invoking the mother discourse because their only claim to this discourse (in the context of smoking) is negative. However, Chrissie’s media article is a notable exception to this pattern, in that she is the only one to stake her claim to the ‘natural mother’ identity.

With this one exception, the iconic identity of the ‘good’ or ‘natural’ mother (let alone any reference to a maternal identity) is notably absent across the data, suggesting that women were largely excluded from this glorified identity because of having smoked during pregnancy. That is, women were precluded from (or avoided) expressing themselves as good mothers and hence their legitimate claim to a positive maternal identity was silenced. As a result, their accounts worked to avoid both ‘smoker’ and ‘mother’ identities as a means of evading or deflecting the stigma of the ‘monstrous mother’ (Ussher, 2006).

Given the public vilification Chrissie Swan endured, we propose that such rhetorical moves of evasion were insufficient in her public article and that she was essentially forced to address her maternal identity directly. It could be argued that she was under a moral obligation to resolve her spoiled maternal and celebrity identity by presenting a ‘happy ending’ to her story – a story which would have significant consequences for her career. By stating that she had quit smoking (and righted her reprehensible wrong), she was able to repair her identity through reclaiming her rightful position as a ‘natural’ mother (a central part of her celebrity identity):

And it has been the worst, most guilt-inducing thing I have ever done. It is also completely illogical. Because despite knowing the horrific risks to me and my baby, I continued to do it. It defies logic because I am the sort of mother who buys organic fruit because I’m concerned about pesticides on my kids’ snacks. They never go anywhere without sunscreen. And I never even took a drag through my previous pregnancies. My kids have never seen me smoke. […]

It is easy to say there is no excuse for smoking through pregnancy. But I have found out this week that there actually is one. And that is, addiction. It is a terrible thing to admit. But it is true. There can be no other reason for continuing to smoke, despite the whole concept of it contravening the most consuming and powerful of my instincts; my maternal one. […]
So what now? The cigarette I got caught smoking was my last and tomorrow it will be a week since then. I have a counsellor from Quitline who is checking in on me on Wednesday. I feel relieved. I am enjoying the exquisite freedom of not needing to smoke, and being the mother I know comes naturally. […]

The day after I confessed my terrible secret, the phone calls to the Quitline doubled. Doubled. Twice as many people as usual picked up their phones and said: ‘I don’t want to smoke but I don’t know how to stop. Please help me.’ They say my revelation caused this. And that’s something anyone would be proud to tell their kids. (Chrissie Swan, 2013)

At several points in her account, Chrissie steps into the identity position of a natural mother. She builds up her rightful access to this identity by emphasising her efforts to care for, and protect, her children (e.g. buying organic fruit, using sunscreen). Her continued smoking, in the context of being a natural mother, is then positioned as ‘illogical’ and ‘guilt-inducing’. As Chrissie describes, there is ‘no excuse for smoking through pregnancy’. However, what ultimately allows the natural mother identity to be fully mobilised in this account is her declaration that she has quit smoking – again reinforcing the incompatibility of the smoking and maternal identities. Therefore, taking up a non-smoker identity is rhetorically necessary in Chrissie’s account, as it allows her to reframe her experience of being ‘caught’ as positive: a ‘revelation’, which led to double the usual calls to Quitline (a smoking cessation resource). Repositioning her otherwise vilified behaviour as something that has resulted in social good (something that she would be ‘proud to tell her kids’) – thereby reinstates her positive maternal identity.

**Surveillance and social control: Material consequences of a ‘spoiled’ identity**

We have examined the limited discursive footing women are afforded in accounting for smoking during pregnancy. We found women engaged in careful discursive footwork to evade or minimise these two dominant, but harmful, identities (silenced smoker and bad mother). We now focus on the material consequences of embodying the ‘spoiled’ identity of a ‘pregnant smoker’.

Across the data, women’s accounts were saturated with moral language (mobilised by all but one of the interview participants, the majority of the survey participants (33 of the 47), and peppered throughout Chrissie Swan’s account). In particular, women’s accounts were dominated by references to feelings of ‘guilt’ (Sarah, Sally, Chrissie Swan, survey participants), ‘shame’ (Philamena, Chrissie Swan, survey participants), and ‘embarrassment’ (Donna, Lisa, Sally, Caroline, survey participants), descriptions of their smoking as ‘bad’ (Donna, Sarah, Tracey, survey participants) and ‘wrong’ (Sally, Philamena, Chrissie Swan), something they ‘shouldn’t’ (Sally, Kate, Caroline, survey participants) and ‘don’t want to’ be doing (Chrissie Swan). These ‘guilty’ stories are similar to previous accounts of mothers who smoke (Holdsworth & Robinson, 2008; Irwin et al., 2005).
Further, women’s descriptions of hiding, surveillance, non-disclosure, and secrecy were prevalent, an indication of the kinds of stories women were telling – stories of moral failing. For instance, Jenny described the following in her email interview: ‘I found that I was judged as a disgusting, uneducated gutter rat. I found this by the way people would look/stare, question my motives, make comments on my parental ability etc. I found it quite horrible’. The extent of judgement and surveillance women experience for smoking during pregnancy is echoed in Chrissie’s media account: ‘As soon as I heard the clicking of the camera, I knew I would be forced to divulge, in public, my shameful and humiliating secret. I realised of course that the whole of Australia would want to hang me’. Similarly, an online survey participant stated: ‘On general [online] posts you get some slamming from mothers who really judge you for it, I never posted in those for that reason’.

An interesting feature in the data is the frequent use of violent language (e.g. ‘hang me’; ‘slamming’), which highlights the extent of surveillance and judgement (and potential punishment) associated with smoking in pregnancy. Women from the survey described feeling ‘ganged up on’, ‘lectured’, and ‘verbally bashed’ from ‘passionate keyboard warriors’. They also described fear of having ‘statistics chucked at them’ or experiencing ‘backlash’ online. Interview participants described feeling ‘pushed’ (Donna), ‘pressured’ (Jessica), ‘lectured’ (Kate), and ‘forced to stop’ (Donna) smoking. For instance, Kate describes her husband having a ‘crack’ at her, and Sally, below, described her aunty ‘hammering’ her about how unhealthy it is to smoke during pregnancy.

The use of such violent surveillance language indicates the common responses to smoking in pregnancy and the judgement women face from being ‘found out’. For instance, a survey participant described: ‘Part of the reason why I don’t talk about smoking on forums [...] is fear of someone I know finding that post and somehow figuring out it is me’. Accordingly, many women described actively hiding their smoking:

I wouldn’t smoke in front of my Aunty who’s a midwife

*Interviewer: ok and why is that*

Being a midwife I knew that she’d be hammering a ya know … about how it’s not healthy to smoke when you’re pregnant and cause I already knew that I didn’t wanna hear it so … … … I just chose not to I just didn’t smoke around ‘em

(Sally, interview)

I never smoked at work because I like I just wanted them to think that I had given up um but mainly at home and at my parent’s house but they were the only two places … … never ever in public because like [laughs] especially showing like with a baby bump there was absolutely no way I would do that mainly because I know what people would be thinking

(Sarah, interview)
Above, women describe deliberately controlling where they smoke, who they smoke in front of, and who they disclosed to, in order to minimise potential judgement. For these women, the ‘safe’ option was hiding their smoking from others, a strategy many participants identified. For instance, in her media article, Chrissie describes the lengths she went to hide her smoking from family. Ten of the 13 women interviewed described hiding their smoking from family, friends, doctors, and colleagues, and, in the survey, out of the 47 participants only four indicated ever posting about their smoking in online pregnancy forums. One of the survey participant’s describes:

I have never told anyone face to face that I still have the occasional smoke. I do it at home, when my husband is at work and I have time to shower or change before he gets home. I am deeply ashamed that I have not quit entirely and the forums are somewhat anonymous so I go there for help.

These accounts highlight the very real material consequences of inhabiting the position of the ‘pregnant smoker’, in that hiding one’s pregnancy (and pregnant belly) was routinely described as essential:

when I was at work I would ... you know go somewhere where no one from work would see me have a cigarette and ... and then just also out in general public like ... I wouldn’t just have one wherever I would normally have one when I was not pregnant like I would find somewhere where no one would really see me ... [...] like when you get out of the car or whatever I would kind of lean on the car a bit so no one could see my belly.

(Lisa, interview)

I got more embarrassed by smoking . . . . at work ... but where we are we’ve got like a little back area that ... not many people do see and if I sat down most people wouldn’t know I was pregnant so I could hide the fact that I was smoking while pregnant.

(Donna, interview)

Women’s accounts repeated the importance of minimising the visibility of their pregnant belly and their smoking since being observed to smoke during pregnancy necessarily evokes vilification. Together these data show that women described heightened levels of surveillance and judgement invited from inhabiting the body of a ‘pregnant smoker’.

Discussion

In this article, we drew on interviews, survey responses, and a media article, to explore how women discursively managed the ‘spoiled’ identity of a ‘pregnant
smoker’. We found women’s accounts oriented to two identities: the silenced smoker and the bad mother. Women’s careful discursive footwork allowed them to manage stigma by: silencing (other) smokers and vilifying (other) pregnant women who smoke and; ultimately avoiding the evocation of either of these identities in accounting for their own smoking. In terms of women’s material efforts to manage stigma, women routinely described hiding the visibility of their smoking (or bellies) in order to conceal their ‘pregnant smoker’ body. In sum then, we found that women managed stigma through discursive and material evasion and concealment – they avoided positioning themselves as smokers and mothers and hid the markers of smoking in pregnancy.

Through data analysis and reflections on the research process itself, we came to conceptualise the discursive predicament faced by women who smoke during pregnancy as a form of ‘discursive silencing’, whereby dominant constructions of motherhood make smoking during pregnancy indefensible, and as a result, afford women limited discursive space to account for themselves. Confronted with the call to talk about smoking in pregnancy, women largely responded with silence, and when they did participate, they minimised and silenced their positioning as both smokers and mothers. This is notable given previous research with women who risk being positioned as ‘bad’ mothers found these women go to great lengths to assert their position as ‘good’ mothers (Abrams & Curran, 2010; Baker & Carson, 1999; Hardesty & Black, 1999; Murphy, 2012).

Discursive silencing was evident across the research process and data, including women’s reluctance to participate (and thereby identify as having smoked in pregnancy), participants’ overwhelming preference for telephone and online responding, and the unwillingness of third parties to advertise. In the face of dominant discourses of idealised motherhood, the best strategy to manage one’s spoiled maternal identity appears to be to remain hidden and silent, or at the very least, anonymous. Evidence of discursive silencing also emerged across the data whereby participants positioned smokers as having no moral authority to speak about smoking and in their alignment with non-smokers in echoing the only ‘hearable’ story of smoking – that it is bad, horrible, and indefensible. These findings highlight the extent to which anti-smoking discourse strips smokers of the moral authority to speak. Our analysis contributes a discursive perspective to existing literature examining how smokers negotiate their identity in the face of marginalisation (Frohlich, Poland, Mykhalovskiy, Alexander, & Maule, 2010; Gough et al., 2013) and the perception that non-smokers feel justified to speak negatively about smokers (Ritchie, Amos, & Martin, 2010).

Finally, we interpret the absence of claims to either smoker or maternal identities as further evidence of discursive silencing. By not identifying with either identity position, women were able to avoid the rhetorical (and material) harm of these identities – highlighting the various functions of silencing (Morgan & Coombes, 2001). We found that these identities failed to offer rhetorical traction in their accounts (e.g. smokers were disqualified from speaking) and that their only claim to the one identity that held any legitimacy for women’s subjectivity (mother) was
negative. Therefore, consistent with motherhood and anti-smoking discourses, we understand discursive silencing as serving to render women’s experiences as ‘untellable’.

The findings of this research have important implications for practice and research. First, our concern is that as a result of discursive silencing, women are exposed to reduced opportunities for seeking support and advice to quit or reduce their smoking (Burgess, Steven, & van Ryn, 2009; Irwin et al., 2005; Wigginton & Lee, 2013). When the problem of smoking in pregnancy is forced underground, creative and supportive solutions are less likely to be generated. This is especially concerning given a recent review found non-confrontational approaches (namely motivational interviewing, which involves expressing empathy) as more likely to lead to smoking cessation (Lai, Cahill, Qin, & Tang, 2010).

A second problem with discursive silencing involves the implications for women’s subjectivities – an area that is currently under-researched in the context of smoking and stigma (with the exception of: Irwin et al., 2005; Wigginton & Lafrance, 2014). We found Chrissie was the only woman to position herself within a ‘good’/‘natural’ mother identity, likely as a result of having quit smoking and the public nature of her account. Beside Chrissie, only a few women articulated and defended being positioned by others as a ‘bad mother’ – as a result of their smoking during pregnancy. All others silenced their maternal identity, avoiding the evocation of their positions as mothers and speaking about the ways in which they perform ‘good’ mothering.

Our findings have troubling consequences, then, for women’s subjectivities as mothers and the extent to which they can lay claim to their maternal identity. From a material-discursive perspective (Ussher, 1997; Yardley, 1997), discourse and materiality are inextricably linked such that who we can (and cannot) claim to be has direct implications for our subjectivities and actions in the world. Denying a woman claim to a positive maternal identity can only be harmful for her sense of self and her interpersonal relations with others, including her child(ren). While silencing oneself can be a useful discursive strategy for evading stigma, it does little to address the larger issue of stigmatised mothering and the material consequences that accompany it. Indeed, silencing or erasing from view the ways in which women can be ‘good’ mothers outside of idealised motherhood practices only works to maintain the hegemony of this ideology.

Moreover, at an individual level, ‘silencing the self’ has been identified as a central mechanism of depression in women (Jack, 1991; Jack & Ali, 2010). In her now classic study with women who were depressed, Jack argued that women’s understandings of how they came to be depressed relied largely on the concept the loss of one’s voice and self. She theorised that within a patriarchal society, women learn to govern and measure themselves against the impossible social standard of the ‘good’ woman. This pursuit ultimately leads to self-negation and distress (Jack, 1991; Jack & Ali, 2010).

Given the profound material and discursive consequences of the ‘silencing’ of women, it is essential that feminist scholars and practitioners continue to explore means of resistance (McKenzie-Mohr & Lafrance, 2014). Our research
offers important implications for psychological practice in that it can serve as a beginning point for discussions between therapists and clients about the totalising discourse of idealised motherhood as well as means of resistance. That is, our analysis provides insights into how hard (and essential) it is for women to resist the ‘spoiled identity’ of the ‘bad mother’. Notably, several women in our study resisted being positioned as ‘bad’ mothers and their efforts could inform therapeutic practice. In particular, clinicians should support women to embrace a positive sense of themselves, while being cautious of not reproducing idealised motherhood ideology and by implication the notion that ‘good mothers’ do not smoke during pregnancy. Clinicians’ efforts to promote a positive identity could also be inspired by women’s efforts to reduce or control their smoking during pregnancy.

More research is needed to explore the ways in which women can effectively resist being positioned as ‘bad’ mothers other than through evasion and silencing (see, for instance, Croghan & Miell, 1998). Directions for future research could include identifying useful rhetorical strategies that allow women to defend mothering on the margins of ‘proper’ motherhood. The usefulness of material-discursive approaches (Ussher, 1997; Yardley, 1997) in investigating this topic is also worth noting. For instance, we found that inhabiting the body of (visibly) pregnant smoker was central to women’s accounts of surveillance, hiding, and judgement. Analytical approaches that examine the symbolic, social, and communicative nature of bodily experiences, and how this relates to the sociocultural and linguistic aspects of experiences offer fruitful opportunities for future research (Ussher, 1997; Yardley, 1997).

Indeed, the results of this study have already generated interesting new avenues for inquiry. Encouragingly, through disseminating the survey results, one pregnancy forum has engaged with our recommendations and subsequently created a thread designed for supportive and non-judgemental discussions of smoking.1 The next steps would be to evaluate the effectiveness of such strategies for engaging with pregnant women who smoke, and other mothers who are similarly stigmatised. Through identifying the concept of discursive silencing we have demonstrated that uncovering ‘untellable’ stories is not an impossible task. Further, we demonstrate the importance of telling the ‘untellable’. As such, we urge researchers to further explore the (discursive and material) difficulties of mothering on the margins of ideal motherhood.

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Chapter 8: Discussion

The aims of the thesis are twofold: to (1) explore experiences and perceptions of smoking during pregnancy in the Australian context and (2) examine the ways in which the presumed stigma attached to smoking during pregnancy is discursively negotiated by both members of the public and women who engage in this practice. In this chapter, I trace the trajectory of this program of work, considering the empirical, methodological, theoretical and practical contributions and implications of this thesis. I then provide suggestions for future practice and research. Finally, I discuss the ways in which reflexivity has allowed me the space to reflect on the ethical nature and practical usefulness of my PhD work and, as a result, has shaped the ways in which I have chosen to represent women who smoke during pregnancy in the dissemination of my work.

This thesis started from the perspective that foetal-centred approaches to smoking during pregnancy, while helpful for some women in stopping smoking, problematically overlook the woman’s health and contribute to a culture of blaming and shaming women for harming their babies during pregnancy. In Chapter 2, I discussed how these approaches have been adopted in public health campaigns (e.g., Quit Now, 2012) that rely on foetal health as a motivator for women’s cessation, thereby reinstating women’s position as a reproductive vessel (Greaves & Poole, 2005). I argued that a foetal-centred approach positions pregnancy as a “window of opportunity” (DiClemente et al., 2000, p. iii16) for positive health behaviour change, and problematically positions women as rational, autonomous and self-governing subjects who willingly adopt healthy behaviour change in efforts to provide the best possible care and protection for their babies.

Such an approach is based on the good mother discourse, suggesting that good mothers unfailingly prioritise the health of their children over and above their own health (Hays, 1996). This discourse works alongside neoliberal discourse to promote individual responsibility, risk-awareness, and self-surveillance among women during pregnancy (Lupton, 2011; 2012). However, little is known about whether (and how) this discourse, in combination with the positioning of smoking as a sign of a lack of moral worth (Chapman & Freeman, 2008), contributes to the stigmatisation of women who smoke during pregnancy. Accordingly, this thesis focussed on how women construct, negotiate and respond to stigma in light of the cultural message that “good mothers do not smoke” (Bottorff et al., 2000, p. 132). Specifically, this thesis began with an interest in the extent of stigma and its material consequences (Chapters 3 and 4).
Chapter 3 analysed interviews with women who smoked during their recent pregnancies to explore whether, and in what ways, these women experienced stigma. Women’s descriptions of stigma included both medical and social dimensions, in which stigma was supported by a biomedical discourse that asserts smoking to be ‘unhealthy’ and ‘risky’ and by the maternal-foetal conflict discourse that positions smoking during pregnancy as morally wrong because, when the woman’s needs and wants are in opposition to those of the foetus, the foetus should always take priority. This chapter focussed on the ways in which women responded to these two dimensions of stigma (conceptualised as acceptance and resistance) and also the material ways in which women coped with stigma, which included justifying their smoking, using smokers as a safe haven, and passing as a non-smoker. Together these responses and coping mechanisms showed the complex and paradoxical implications of stigma for women who smoke during pregnancy.

This chapter concluded that, for the most part, stigma reduced women’s capacity to disclose (passing as a non-smoker) or come forward for support (using smokers as a safe haven) to the extent that, for some women, perceptions of stigma led to increased smoking and hiding. These (interactional) strategies for dealing with, or more accurately avoiding, stigma are consistent with broader stigma literature (Goffman, 1963; Hannem & Bruckert, 2012) and recent qualitative studies examining smokers’ experiences of, and ways of coping with, stigma (Bull et al., 2007; Greaves et al., 2010; Ritchie et al., 2010). The findings from this chapter support the conclusion that critical, directive and moralistic approaches which stigmatise women’s smoking during pregnancy are at best ineffective and at worst counterproductive, for at least some Australian women.

Chapter 4 built on this previous analysis by examining the issue of stigmatising women’s smoking during pregnancy from a different vantage point, that is, the views of university students. The aim of this chapter was to examine whether, and to what extent, a sample of university students expressed negative views of women who smoke during pregnancy, and whether altering information about a hypothetical smoking mother affected their views about that smoker. The sample of mostly young, white, university educated, non-smoking women reported highly negative views towards women who smoke during pregnancy. In this chapter, we discussed how participants viewed the hypothetical ‘pregnant smoking mother’ more negatively than the ‘non-pregnant smoking mother’, and that the use of individuating information, for the most part, did not reduce negative views of the hypothetical ‘pregnant smoking mother’.
Thus, Chapter 4 offered experimental evidence to conclude that pregnant mothers who smoke are subject to increased negative moral judgement for their smoking, compared to mothers who smoke when not pregnant. This was the first experimental investigation of the stigma concerning smoking mothers, with an interest in the possibilities of reducing stigma. Although the experimental manipulation was largely ineffective, suggesting that reducing the extent of judgement towards women who smoke during pregnancy is difficult in an experimental setting, this chapter offers some suggestions for future work. In particular, we recommend the use of personal video accounts to examine whether this is effective in contextualising and humanising a smoker (for the purposes of reducing stigma).

Following the publication of these two chapters, I became interested in the extent to which this ‘evidence’ of stigma and its material consequences was neutral and objective. Chapter 5, then, was a discussion of the research design, and our role as the researchers in the construction of women’s smoking during pregnancy as problematic and the positioning of university students (our participant sample) as entitled to express their views about this presumably homogenous group of women who are presented as apparently worthy of psychological investigation. In this chapter, we discussed the usefulness of discourse analysis in acknowledging the local and broader contexts in which the research took place, and how these contexts contributed to the production of data. In addition, we drew on positioning theory as a methodological tool that allowed us to approach the participants as both active in the construction of, and constrained by, discourse (Davies & Harré, 1990).

Specifically, Chapter 5 dealt with the prevalence of the theme ‘good mothers don’t smoke’, to consider how some participants sought to express this theme and at the same time avoid being positioned as judgemental. The purpose of this chapter was to engage in a reflexive and methodological dialogue about the data provided by university students, and specifically to consider our own role in shaping the production of negative views. What we found was that from a discursive perspective, the theme ‘good mothers don’t smoke’ can be conceptualised as discursive rehearsal, in that participants were reciting socially acceptable ways of talking about smoking during pregnancy before moving on to repair their own positioning as potentially judgemental. Discourse analysis afforded us the theoretical and methodological tools to approach participants’ responses in a way that was sensitive to the context in which these data were produced. This chapter led to the subsequent interest in how women discursively negotiate the stigma associated with smoking during pregnancy.

Chapters 6 and 7 examined the available discourses and identities for women who smoke during pregnancy. Chapter 6 focused on women’s negotiation of the discourse that
smoking during pregnancy harms babies – a discourse which has been mobilised in the dissemination of health warnings for smoking during pregnancy (e.g., Queensland Government, 2013). Based on our analysis of interview data from Study 1, we identified two rhetorical devices that women deployed to account for this discourse: ‘stacking the facts’ and ‘smoking for health’. Both devices allowed women to cast doubt over (or deny) the validity of this discourse. These devices are similar to other accounts of smoking (outside of pregnancy), in which smokers have been observed to downplay the harm of smoking by drawing on personal evidence (Holdsworth & Robinson, 2008) or presumably legitimate sources of knowledge who support their smoking, such as doctors (Gough et al., 2009; Heikkinen Patja & Jallinoja, 2010). Chapter 6 uniquely offers a discursive interpretation of women’s accounts of smoking during pregnancy and, in doing so, positions the deployment of these devices within the context of women’s interviews, in which protecting their identity was central to their accounting patterns. Extending our previous conclusions from Chapter 3 about medical stigma, we argued that these devices had the effect of protecting women from the threat of being positioned as deliberately harming their babies. For instance, we showed how ‘smoking for health’, supported by the reported speech of doctors, was conveyed as permission to smoke and therefore supported women’s identities by highlighting their compliance with (not defiance of) medical advice.

Returning directly to the concept of stigma, Chapter 7 explored how women discursively managed the spoiled identity of a pregnant smoker in both public and private accounts. This chapter analysed 13 interviews from Study 1, survey responses from Study 3, and a media article written by an Australian television host who was ‘caught’ smoking in pregnancy. This chapter examined how women discursively negotiated and managed stigma in accounting for themselves and their experiences of smoking during pregnancy. We identified two salient identities in women’s accounts, ‘the silenced smoker’ and ‘the bad mother,’ and explored the discursive and material consequences of these identities. We found that women’s careful discursive footwork allowed them to manage stigma by silencing (other) smokers and vilifying (other) pregnant women who smoke, and ultimately avoid either of these identities in accounting for their own smoking. In terms of women’s material efforts to manage stigma, women commonly described hiding the visibility of their smoking (or bellies) in order to conceal their pregnant smoker bodies.

Together, Chapters 6 and 7 contribute a discursive perspective to women’s accounts of smoking during pregnancy, a methodological approach that is currently lacking in this literature. Taking a discourse analytic approach allowed an acknowledgment of the role of the
researchers and research design in the construction of the data, by paying careful analytic attention the participants’ orientation to discourse. That is, focusing on how participants responded to and positioned themselves within the local (and broader) discursive setting.

Chapter 6 focussed on the biomedical discourse that smoking during pregnancy harms babies. This discourse was prevalent across the interview data and was also identified in an earlier analysis of women’s conceptualisations of, and responses to, stigma (Chapter 3). While the biomedical discourse was originally conceptualised as a ‘dimension’ of stigma in Chapter 3 (specifically, medical stigma), we showed how, from a discursive perspective, this discourse underpins the moral trouble associated with smoking during pregnancy – that is, why smoking during pregnancy is problematic and why engaging in this practice requires women to account for their moral failing (Chapter 6). This discourse, then, shapes the construction of women who smoke during pregnancy as problematic and the practice itself as unhealthy and risky to the developing foetus. This discourse is consistent with a foetal-centred approach to smoking during pregnancy as it problematically overlooks the woman’s health, wellbeing and social context (Greaves et al., 2003).

Chapter 7 offered a discursive perspective on the ways in which the good mother discourse serves to exclude the experiences of women who smoke during pregnancy. This chapter focused on whether (and how) women lay claim to the good mother discourse – a discourse that has been identified in women’s accounts of defending their ‘bad’ mothering practices (Abraham & Curran, 2011; Hardesty & Black, 1999; Murphy, 2012). In the context of smoking, previous research has pointed to the concept that “good mothers do not smoke” (Chapter 5, Bottorff et al., 2000, p. 132), the incompatible positions of a mother who smokes (Holdsworth & Robinson, 2008), or the ways in which smoking is no longer permissible in the context of motherhood (Abrahamsson et al., 2005; McDermott et al., 2006). However, these studies offered little theorising about why smoking is incompatible with motherhood (or pregnancy) and how this relates to women’s experiences of stigma. In Chapter 7, we argued that dominant motherhood and anti-smoking discourses work to discursively silence the experiences of women who smoke during pregnancy, leaving little discursive space for women to (positively) account for their smoking or their identities.

To address a central theme of this thesis, the stigmatisation of (pregnant) smokers (Chapter 2), I would like to reiterate a question posed by Burris (2008) in his scepticism of stigma-induced policy: “where is the evidence that inculcating a sense of spoiled identity is a good way to get people to adopt healthier behaviours?” (p. 475), and offer some concluding points. Together, the findings from the five empirical chapters in this thesis speak to the
pervasiveness of the cultural message that “good mothers do not smoke” (Bottorff et al., 2000, p. 132; Chapter 5) and point to the discursive and material ‘damage’ of a spoiled identity. Specifically, using multiple methods and sources of data these chapters shed light on the ineffectiveness of stigma, based on the material evidence of the extent of women’s hiding and non-disclosure, and spark concern over the ethics of stigmatising women’s smoking during pregnancy, in that stigma precluded women from staking their claim to the good mother discourse. Based on these chapters, it appears as though the strategy women commonly deployed in order to manage the spoiled identity of a pregnant smoker appeared to be to remain hidden and silent.

Returning to Burris’ question, my main concern is that stigmatising women’s smoking during pregnancy has serious material consequences, in that it significantly reduces women’s opportunities for seeking support and advice to stop or reduce their smoking (Bull et al., 2007; Greaves et al., 2003; Irwin et al., 2005). While silencing can be a useful material and discursive strategy that women mobilise to evade stigma, it does little to address the larger issue of stigmatised mothering. Indeed, silencing or erasing from view the ways in which women can be good mothers outside of idealised motherhood practices only works to maintain the hegemony of this discourse. Therefore, my concern is that the reproduction of gendered scripts, in combination with anti-smoking discourse, serves to stigmatisate women for the purposes of control and coercion over their reproductive bodies, and that this is not an ethical (or effective) approach to promoting smoking cessation among women during pregnancy.

Stigmatising women’s smoking during pregnancy, as I have shown, does not necessarily support women’s ‘coming forward’ to seek help to stop smoking. Instead, women engage in strategies that are often counterproductive. Further, these findings have troubling consequences for women’s subjectivity as mothers and the extent to which they can lay claim to their maternal identity. From a discursive perspective, who we can (and cannot) claim to be has direct implications for our subjectivities and actions in the world. Denying a woman her claim to a maternal identity can only be harmful for her sense of self and her interpersonal relations with others. Therefore, stigmatising women’s smoking by relying on the good mother discourse, and hence the notion that “good mothers do not smoke”, is not an ethical or effective approach to promoting smoking cessation among pregnant women.

Moving forward

In light of the extent of participants’ expressed stigma regarding women who smoke during pregnancy (Chapter 4), and qualitative evidence that stigma can make it difficult for
women to seek help or disclose their smoking (Chapters 3 and 7; Bull et al., 2007; Burgess et al., 2009), this thesis points to the need for a change in how we approach, and intervene in, women’s smoking during pregnancy. Specifically, there is a need for more supportive and non-judgemental campaigns and programs that move away from neoliberal discourse, in which smoking is positioned as an individual choice devoid of social context (Bell et al., 2011), and pregnancy as a “window of opportunity” (DiClemente et al., 2000, p. iii16) for positive health behaviour change. Instead, smoking could be positioned as a product of, and therefore constrained by, a combination of sex, gender, social, cultural and economic factors (Greaves et al., 2003; Greaves et al., 2014). Such a perspective would draw attention to immediate social factors, including partner’s and family’s smoking, and how this affects women’s capacity to stop smoking. In addition, shifting from a foetal-centred to a woman-centred approach would allow for interventions that promote women’s long-term cessation and hence discuss the relevance and use of harm-reduction practices, as supported by Australian drug policy (Australian Government, 2010).

An example of a US-based, online smoking cessation and information resource that takes a woman-centred approach is Smokefree Women (http://women.smokefree.gov/). Their website offers information catering to women’s smoking during pregnancy, including a video entitled “Reach out and offer her a helping hand”. This video describes the ways in which pregnant women want to but cannot magically stop smoking and, as a result, experience significant guilt, shame, and isolation from others who judge their smoking; this judgement can make it harder for women to stop smoking. The take-home message of this video is that women need the support of their families and friends in order to stop smoking in pregnancy and beyond. The next task then would be the development and evaluation of accessible, supportive and woman-centred campaigns such as this, especially in the Australian context where woman-centred campaigns are missing.

In considering recommendations for future research, the strengths and limitations of this thesis offer some important directions. First, the mixed methods design of this thesis offered an opportunity to examine different research questions surrounding stigma and smoking during pregnancy. Consistent with feminist methodology, the triangulation of methods (quantitative and qualitative) can provide more holistic portrayals of a given phenomenon, particularly if there are few existing qualitative analyses on the topic (Cook & Fonow, 1986). This led to a variety of data sources (and therefore contexts) being used in this thesis.
One of the major limitations of the thesis was that the interview and survey questions concentrated on women’s experiences of stigma, with less attention paid to the broader context of women’s lives, including the relevance of class, place, and family contexts, in understanding women’s continued smoking. The role of family contexts, for instance, is particularly important, since men’s smoking is largely unexamined yet directly affects women’s capacity to stop smoking during pregnancy (Hemsing et al., 2012). For instance, issues of power and control shape the negotiation of smoking practices among heterosexual couples (Greaves, Kalaw, & Bottorff, 2007). However, we know little about the extent to which male partners exert control over women’s smoking during pregnancy, nor how they might exercise and justify such control – an area for future research. Such suggestions for future research could also inform the development of more holistic and context-sensitive programs and campaigns that target smoking as a family issue, not only a women’s issue.

Another potential limitation of this thesis was the length of the interviews collected as part of Study 1. Although these interviews offered the quality and depth necessary to analyse them thematically and discursively, the interviews were typically short, lasting an average of 20 minutes. On reflection, I consider that the sensitive nature of the interview questions, combined with the impersonal medium (telephone or email) and my own relative inexperience in interviewing, meant that it was difficult to develop rapport with participants and encourage them to articulate their own voice and story, particularly within a narrow discursive space (specifically a discourse of idealised motherhood). In particular, the practice of nurturing women’s resistance to dominant and harmful discourses (McKenzie-Mohr & Lafrance, 2014) was unfamiliar to me at the time of the interviews. My limited training and experience in helping women to tell difficult and marginalised stories could have contributed to the relatively brief interviews. In reflecting on how the problem of short interviews could be avoided, it may be useful in future for me to work on developing rapport with participants through ‘small talk’ before the interview, discussing ‘safe’ topics early on in the interview (before asking more sensitive questions) or by listening for, and picking up on, when women are struggling to articulate themselves. However, as a learning experience, I feel that conducting these interviews was a very valuable process.

By focusing specifically on women’s smoking during pregnancy, this thesis has of course not considered women’s smoking and experiences of stigma outside the context of reproduction. Future research would benefit from examining women’s smoking across the lifespan, in order to prioritise women’s health and wellbeing independent of women’s reproductive capabilities (or events). This (alternative) focus would allow an understanding
of the age-specific effects of tobacco denormalisation policies on various groups of women and girls, an examination of the intersection of smokers’ social identities at various life-stages, and a contribution to advocacy for woman-centred and woman-positive campaigns and programs for women of all ages.

Regarding other future research directions, this thesis has highlighted the importance of examining lay perceptions of health and illness. For instance, Chapter 6 showed that women make sense of, and account for, their smoking and the risks it poses to the developing foetus in complex and contradictory ways that are not necessarily consistent with biomedical understandings of health and illness. Some women may view continuing to smoke as a safer or healthier option for the developing foetus (‘smoking for health’: Chapter 6). This is similar to previous accounts of smoking during pregnancy, in which women cited health professionals as supporting their continued, but reduced, smoking as a less stressful option for the baby (Graham et al., 2014).

The lack of research examining lay perceptions of smoking during pregnancy is perhaps a reflection of the dominance of biomedical perspectives, in that research is conducted in line with biomedicine in which smoking during pregnancy is positioned as undoubtedly harmful, and hence women’s accounts are interpreted through this lens. More work in the area of lay perceptions and negotiations of health risk messages is needed, particularly if we are to understand how smokers make sense of their smoking in an increasingly anti-smoking climate. Related to the rhetorical strategy ‘smoking for health’, research that explores accounts of safe (e.g., harm reduction) versus unsafe smoking practices from the perspective of both smokers and health professionals to examine how this affects (or limits) cessation may offer important recommendations for public health campaigns and practice.

In summary, this thesis has focussed on the stigma associated with smoking during pregnancy, from two vantage points, and has described the various consequences of stigmatising women who smoke during pregnancy. In my view, the broader issue that pieces together the chapters in this thesis is the dominant construction of smoking during pregnancy (and women who engage in such behaviour) as harmful, selfish, morally wrong, and shameful. Although this thesis attempts to make sense of and challenge this positioning of women who smoke during pregnancy, I came to realise that the research design was complicit in constructing women who smoke during pregnancy in these ways (Chapter 5).

I have come to conceptualise women’s smoking during pregnancy as an ‘untellable’ experience. The extent of this ‘untellability’ arises from the lack of positive discourses that
women have available to draw on, in storying their experiences, which was proposed as a form of discursive silencing in Chapter 7. For instance, the qualitative analyses (Chapters 3, 5, 6 and 7) showed the difficulty of speaking about, or storying, smoking during pregnancy in positive ways and therefore the discourses that make it easy and acceptable to stigmatise smoking during pregnancy. The quantitative analysis (Chapter 4) provided evidence of the pervasiveness of negative views concerning women who smoke during pregnancy and the difficulty of challenging such negative portrayals. This program of work raises questions about how women are able to resist the spoiled identity of a bad mother, beyond silencing their identities, and therefore the ethics and effectiveness of stigmatising particular groups of smokers through gendered discourses. Focusing on how women defend mothering on the margins of good motherhood is one example of how future research could examine this question and challenge the silencing of women’s experiences that fall outside of idealised motherhood.

I now turn to the ways in which reflexivity has allowed me the space to reflect on the ethical nature and practical usefulness of my PhD work. Further, I discuss how reflexivity has shaped the ways in which I have chosen to represent women who smoke during pregnancy in the dissemination of my work.

Challenging stigma: Dissemination, ethics and reflexivity

Murray (2004) has argued that critical health psychology can be organised into four interconnected areas: reflexive, relational, moral and experiential theory; a focus on contexts; critical, qualitative and ethical methods; and empowering, community based practice. In this thesis, I have favoured critical, (mostly) qualitative, and ethical methods to understanding the socially constructed nature of the stigma associated with smoking during pregnancy. In this section, I will discuss how I have taken up a critical and ethical agenda throughout the dissemination of my PhD work.

Throughout my PhD I have pursued both academic and non-academic channels in disseminating my research findings. While academic channels of dissemination undoubtedly benefit my professional career, they also contribute a critical, feminist perspective on the literature by presenting these women’s stories in a way that contextualises and politicises the topic of smoking during pregnancy. In relation to my strategies and decisions to share my research through non-academic channels, the aim of doing so was to offer an authoritative but sympathetic voice on the topic. Although I acknowledge that these findings and reports are not neutral, as they reflect my own research agenda, I will discuss how the dissemination of
my research in non-academic channels was intended to challenge dominant constructions of women who smoke during pregnancy.

Appendix A2 details a summary of the interviews from Study 1 with women who smoked during recent pregnancies (analysed in Chapters 3, 6 and 7), written to be shared with the participants. The purpose of sharing these findings with participants was to legitimise their experiences of stigma by providing ‘evidence’ of the widespread judgment women face for smoking during pregnancy, while still attending to the nuances of their experiences (e.g., different coping strategies). In addition, sharing these findings was intended to alleviate women’s experiences of shame and isolation, given that several women asked me at the end of the interview “Is this similar to what other women have said?” Given the extent to which women described hiding their smoking, it was unsurprising that many women had no one to talk to about smoking during pregnancy. Thus, disseminating the findings from the interviews was intended to offer women a sense of connection with other women who also smoked during pregnancy.

Appendix C3 includes a summary from the online survey, conducted as part of Study 3, with 49 women who smoked during recent pregnancies (analysed in Chapter 7), again written to be shared with participants. This survey explored women’s experiences of seeking information and support online regarding their smoking during pregnancy. The summary also aimed to validate women’s experiences of stigma and provide them with a sense of connection with other women’s experiences. In addition, part of this summary included two recommendations for online pregnancy forums. I developed these recommendations as a result of the trouble I had experienced in advertising my research on these forums and the relative success I had recruiting women in other online forums (see discussion of recruitment difficulty in Chapters 3 and 7). After my posts were removed on the basis that they were deemed “controversial” and “inappropriate” (according to emails from forum moderators), I was led to consider the difficulty women might face in attempting to discuss their smoking, despite the anonymous nature of online forums.

Encouragingly, two forums have since posted the summary on their websites, and one forum engaged with my recommendations and subsequently created a thread designed for supportive and non-judgemental discussions of smoking (entitled, Support for Quitting Smoking: http://www.bubhub.com.au/community/forums/forumdisplay.php?964-Support-for-Quitting-Smoking). The next steps would be to evaluate the effectiveness of such strategies for engaging with pregnant women and mothers who smoke and to ask whether these spaces assist women in their efforts to stop or reduce smoking.
In summary, sharing my research outcomes through non-academic channels is part of what I value about critical health psychology; a psychology that promotes research for social action (Hepworth, 2006). These dissemination strategies have ultimately been for the purposes of empowering women by validating their experiences of stigma as unjust, and challenging the stigmatised and ‘unspeakable’ nature of smoking during pregnancy. Specifically, in sharing this research, I have allowed these women’s voices to be heard among women in similar circumstances and in spaces where they have been previously silenced (online pregnancy forums).

**Conclusion**

In closing, this thesis has been conducted within a social constructionist and critical health psychology framework, in that I have been interested in the ways in which circulating discourses shape the stigmatisation of women who smoke during pregnancy and as a result constrain the meanings and identities available to these women. I have examined the ways in which women who smoke during pregnancy articulate, negotiate and respond to a cultural context that stigmatises their behaviour and in doing so precludes them from claiming their position as good mothers.

Throughout this thesis I have shown how stigma is both unethical and ineffective in that it works to exclude and silence women’s experiences, offering them no positive discourses to draw on in storying their experience and representing themselves, and as a result, stigma often leads to hiding, non-disclosure and secrecy. These moralistic, directive and critical approaches, which are steeped in foetal-centred rhetoric, remove the opportunity for sensitive, ethical and supportive engagement with women about (reducing or) stopping smoking during pregnancy, in the context of existing social and economic pressures and circumstances. Thus, a woman-centred approach to women’s smoking during pregnancy (and beyond) needs the urgent attention of researchers, health promotion and policy makers.
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Did you know
that 17% of women say they smoked during their pregnancy?

We are interested in hearing from women who smoked during their pregnancy (or who are currently pregnant and smoking). We want to explore your story about your pregnancy, rather than the opinions of doctors or the public. If you were recently pregnant (less than 2 years ago) and smoked during your pregnancy, then we would love to hear from you.

To talk anonymously and confidentially with a researcher about your experience, please contact Britta (b.wigginton@uq.edu.au), School of Psychology.

This study forms part of a PhD research project being conducted at the University of Queensland. The study has been approved by the Research Ethics Committee.
Appendix A2: Study 1 summary of the interviews

Thank you for your participation in the interview earlier this year. I am grateful that you contacted me to share your story, so that I can better understand Australian women’s experiences of smoking during pregnancy. I talked to a range of women from Australia, varying in age, number of children, occupation, and location (QLD, NSW, and Victoria). Across the eleven interviews many similarities and differences emerged and the aim of this document is to provide you with a summary of the findings from all the interviews.

Across the interviews most women expressed a strong desire to quit and while the reality of quitting was met with numerous challenges, cutting down was a more realistic or ideal option for most women. Some women were able to cut down significantly during their pregnancy, while others cut down as much as they could given the stressful circumstances that surrounded their pregnancy.

Cutting down or quitting smoking was described as ‘difficult’ and ‘hard’ by women for many different reasons. Some of the reasons that giving up smoking was difficult included: needing willpower to quit, the addictive nature of cigarettes, being a smoker for a long time, having other smokers around making it hard to be smoke-free, and feeling the ‘pressure’ to quit from others.

Some women talked about the benefits of smoking and why smoking was helpful in their life, examples included: it helped reduce stress levels, smoking was part of social situations (socialising with friends), and being a stay-at-home-mum meant more time to smoke. Women talked about how it was helpful when people were supportive of their decision to smoke, and the support sometimes came from their partner, family, friends, or care providers (doctors or midwives etc). However, women described receiving negative judgment from some people including: friends, family, partner or care providers. Most women found that having little support made it even more difficult for them to quit, sometimes this was because of the guilt or pressure from others.

Women talked about feeling ‘guilty’, ‘embarrassed’, or ‘uncomfortable’ about smoking, this was especially so in public places. Some women talked about feeling like there was an ‘expectation’ to quit either a personal expectation or one from their partner, family, friends or care providers. This expectation did not make it ‘magically’ easier for women to quit and instead provided an added pressure for them to be smoke-free.

Several women had experienced judgment from strangers or people they knew, and described experiencing confrontation about their smoking or getting ‘looks’. As a result of this judgment, or sometimes the fear of receiving this judgment, most women did not want to smoke in public places. Sometimes women used other people’s smoking status as an indicator of whether they might be against smoking.

Some women talked about how they felt that the care providers were against smoking to begin with, and that this made it difficult to establish a good (positive) relationship with them. However, some women had supportive care providers who agreed with their efforts to cut down and offered them the appropriate support if they wanted to quit at any time. After their pregnancy a few women were able to quit smoking completely and were smoke-free at the time of the interview. A few of these women described their experience of quitting as something they had to ‘put her mind to it’, and since quitting also stopped doing the things that went hand in hand with smoking (for example, drinking coffee or alcohol). Some women described wanting to quit in the future for reasons related to their own health or for financial...
Appendix A2: Study 1 summary of the interviews

reasons. Other women described that in future they would like their partner to quit with them as it would help make quitting easier with the support of their partner.

Overall, there were several overlaps in women’s experiences of smoking while pregnant. The difficulty experienced in quitting (or cutting down) as well as the pressure from others to quit was a significant hurdle for women.

Once again, thank you for your participation and sharing your story with me. I hope that these summaries having been helpful in outlining the findings that emerged across the eleven interviews. If you have any further questions or queries please do not hesitate to contact me, I am more than happy to help (b.wigginton@uq.edu.au).

Thanks again.

Best wishes,
Britta Wigginton
Appendix A3: Study 1 interview guide

**Interview guide**

1. A lot of women smoke while they are pregnant, although no one really knows what it’s like from the women’s perspective of being pregnant and smoking is like. I am really interested in hearing about your experience of being pregnant and smoking, could you please tell me about it?
   - How many times have you been pregnant?
   - How long have you been smoking?
   - Can you tell me about your smoking pattern during pregnancy?
   - Were there particular times or place that you smoked?
   - Did the places you smoked change as you progressed through the pregnancy?
   - How did people react to your smoking – in public, your partner, your family?
   - How did your care providers respond to your smoking?

2. If you fell pregnant in the future, would things be different and if so, how?
Study 2 participant information sheet

School of Psychology

Participant Information Sheet

Student’s views on women and pregnancy

The purpose of the study
The purpose of this study is to examine student’s attitudes towards women and pregnancy. This study is being conducted by Britta Wigginton as part of the requirements for a PhD in Psychology at the University of Queensland under the supervision of Christina Lee.

Participation and withdrawal
Participation in this study is completely voluntary and you are free to withdraw from this study at any time without prejudice or penalty. If you wish to withdraw, simply stop completing the survey. If you do withdraw from the study, the materials that you have completed to that point will be deleted and will not be included in the study.

What is involved
Participants are asked to read a vignette and then fill out a questionnaire about the vignette as well as more general views on pregnancy and women.
Participation in this study will take approximately 45 minutes.

Risks
Participation in this study should involve no physical or mental discomfort, and no risks beyond those of everyday living. If, however, you should find any question or procedure to be invasive or offensive, you are free to omit answering or participating in that aspect of the study.

Confidentiality and security of data
All data collected in this study will be stored confidentially. Only members of the research team will have access to identified data. No identifiable information will be requested from you. All data will be coded in a de-identified manner and subsequently analysed and reported in such a way that responses will not be able to be linked to any individual. The data you provide will only be used for the specific research purposes of this study.

Ethics Clearance and Contacts
This study has been cleared in accordance with the ethical review processes of the University of Queensland and within the guidelines of the National Statement on Ethical Conduct in Human Research. You are, of course, free to discuss your participation with project staff (contactable on: ________________). If you would like to speak to an officer of the University not involved in the study, you may contact one of the School of Psychology Ethics Review Officers: Jolanda Jetten (j.jetten@psy.uq.edu.au, tel 3365 4909), Melissa Johnstone (melissaj@psy.uq.edu.au, tel 3365 4496) or Jeanie Sheffield (jeanies@psy.uq.edu.au, tel 3365 6690). Alternatively, you may leave a message with Ann Lee (3365 6448, ann@psy.uq.edu.au) for an ethics officer to contact you, or contact the University of Queensland Ethics Officer, Michael Tse, on 3365 3924, e-mail: humanethics@research.uq.edu.au

If you would like to learn the outcome of the study in which you are participating, you can contact me on b.wigginton@uq.edu.au (after October), and I will send you an Abstract of the study and findings.

Follow this link to the survey:
http://uqpsych.qualtrics.com/SE/?SID=SV_di0bcZC9so3CN2A

Use this ID Code to access the survey:

Thank you for your participation in this study.

Britta Wigginton
b.wigginton@uq.edu.au
PhD Candidate
School of Psychology
University of Queensland, St Lucia
Appendix B2: Study 2 survey: Attitudes toward pregnant smokers

Q1 What is the ID code the researcher provided you with?
   ID (1)

Answer If What is the ID code the researcher provided you with? ID Is Greater Than or Equal to 401 And What is the ID code the researcher provided you with? ID Is Less Than or Equal to 500

Q20 Please read the following information, and then answer questions about it: Marge is due in early September with her second baby. She looks forward to the arrival of her new baby. Marge has been smoking half a pack of cigarettes a day throughout her pregnancy.

Answer If What is the ID code the researcher provided you with? ID Is Greater Than or Equal to 301 And What is the ID code the researcher provided you with? ID Is Less Than or Equal to 400

Q19 Please read the following information, and then answer questions about it: Marge is due in early September with her second baby. Early on in her pregnancy her fiancé left her and since then she has been busy looking after her 2 year old, working full-time, and preparing for the new arrival. She looks forward to the arrival of her new baby.

Answer If What is the ID code the researcher provided you with? ID Is Greater Than or Equal to 501 And What is the ID code the researcher provided you with? ID Is Less Than or Equal to 600

Q21 Please read the following information, and then answer questions about it: Marge is due in early September with her second baby. Early on in her pregnancy her fiancé left her and since then she has been busy looking after her 2 year old, working full-time, and preparing for the new arrival. She looks forward to the arrival of her new baby. Marge has been smoking half a pack of cigarettes a day throughout her pregnancy. She has been cutting down her smoking as much as she can and plans to continue this throughout the pregnancy. She says the cigarettes are the only thing keeping her from breaking down at this point.

Answer If What is the ID code the researcher provided you with? ID Is Greater Than or Equal to 101 And What is the ID code the researcher provided you with? ID Is Less Than or Equal to 200

Q18 Please read the following information, and then answer questions about it: Marge is due in early September with her second baby. She looks forward to the arrival of her new baby.
Using the information you have read about Marge, please indicate where you think Marge best fits on the following characteristics:

<table>
<thead>
<tr>
<th></th>
<th>1 (1)</th>
<th>2 (2)</th>
<th>3 (3)</th>
<th>4 (4)</th>
<th>5 (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empowered:Passive (1)</td>
<td>⬜</td>
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<tr>
<td>Dependent:Independent (2)</td>
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<td>⬜</td>
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<td>Controlled:In control (3)</td>
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<tr>
<td>Good mother:Bad mother (4)</td>
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<tr>
<td>Guilty:Innocent (5)</td>
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<td>Aware:Ignorant (6)</td>
<td>⬜</td>
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<td>Stressed:Relaxed (7)</td>
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<td>Proud:Embarrassed (8)</td>
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<tr>
<td>Sceptical:Believing (9)</td>
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<tr>
<td>Healthy:Unhealthy (10)</td>
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<tr>
<td>Accepting:Dismissive (11)</td>
<td>⬜</td>
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<tr>
<td>Selfish:Selfless (12)</td>
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</tbody>
</table>
Q2 Using the information about Marge, please indicate how much you think these statements are likely to be true of Marge (from strongly disagree to strongly agree):

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree (1)</th>
<th>Disagree (2)</th>
<th>Neither Agree nor Disagree (3)</th>
<th>Agree (4)</th>
<th>Strongly Agree (5)</th>
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</thead>
<tbody>
<tr>
<td>She is in control of her smoking (1)</td>
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<td>She is a victim to her addiction (2)</td>
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<td>She does not feel defensive about her smoking (3)</td>
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<td>She feels bad about her smoking (4)</td>
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<td>She is unaware of the negative impact smoking has on the unborn child (5)</td>
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<td>She continues to smoke to avoid the stress of quitting (6)</td>
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<tr>
<td>She lies about her smoking to her family or friends to avoid the shame (7)</td>
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<td>She will be a good mother (8)</td>
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<tr>
<td>She is defensive about her smoking (9)</td>
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<tr>
<td>She is sceptical about the negative effects of smoking during pregnancy</td>
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<td>(10)</td>
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<td>She denies that her smoking has any negative impact (11)</td>
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<td>Her smoking only benefits herself (12)</td>
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</tbody>
</table>
Q28 Using the information about Marge, please indicate how much you think these statements are likely to be true of Marge (from strongly disagree to strongly agree):

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree (1)</th>
<th>Disagree (2)</th>
<th>Neither Agree nor Disagree (3)</th>
<th>Agree (4)</th>
<th>Strongly Agree (5)</th>
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</thead>
<tbody>
<tr>
<td>She is aware of the consequences of smoking on the baby</td>
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<td>(3)</td>
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<tr>
<td>She thinks there is little harm in smoking while pregnant</td>
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<td>(2)</td>
<td>(1)</td>
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<td>(3)</td>
<td></td>
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<tr>
<td>She feels guilt free about her smoking</td>
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<td>(3)</td>
<td>(1)</td>
<td>(2)</td>
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<td>(3)</td>
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<tr>
<td>She is aware of the effects of smoking on herself and the baby</td>
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<tr>
<td>(4)</td>
<td>(1)</td>
<td>(2)</td>
<td></td>
<td>(3)</td>
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<tr>
<td>She continues to smoke for the pleasure</td>
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<td>(5)</td>
<td>(1)</td>
<td>(2)</td>
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<td>(3)</td>
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<tr>
<td>She will be a bad mother</td>
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<td>(6)</td>
<td>(1)</td>
<td>(2)</td>
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<td>(3)</td>
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<tr>
<td>She feels pleased about her smoking</td>
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<td>(7)</td>
<td>(1)</td>
<td>(2)</td>
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<td>(3)</td>
<td></td>
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<tr>
<td>She has a low addiction to cigarettes</td>
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<tr>
<td>(8)</td>
<td>(1)</td>
<td>(2)</td>
<td></td>
<td>(3)</td>
<td></td>
</tr>
<tr>
<td>She believes that smoking causes harm to unborn babies</td>
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<tr>
<td>(9)</td>
<td>(1)</td>
<td>(2)</td>
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<td>(3)</td>
<td></td>
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<tr>
<td>The cigarettes</td>
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</tbody>
</table>
Q8 The following questions are about pregnant women in general: Imagine seeing a pregnant woman smoking in a public place (e.g. shopping centre). How would that make you feel? What might you think about her? (Please write in the box below)

Q9 In your opinion, what are some reasons why a pregnant woman might smoke? (Please write in the box below)

Q10 In your opinion, if a pregnant woman smokes, how many cigarettes is reasonable for her to smoke per day? (Please write in the box below)
Q4 The following statements are about smoking and pregnancy, in general. Please indicate how much you agree with the following statements, from strongly disagree to strongly agree:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree (1)</th>
<th>Disagree (2)</th>
<th>Neither Agree nor Disagree (3)</th>
<th>Agree (4)</th>
<th>Strongly Agree (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>If women cut down their smoking while pregnant there is no need for them to quit (1)</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<tr>
<td>Cutting down smoking is not enough during pregnancy, abstinence is the only solution (2)</td>
<td>○</td>
<td>○</td>
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<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Women should be monitored during their pregnancy to ensure that they are doing everything right (3)</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>It takes a high level of smoking on the woman's part to cause serious harm to the foetus (4)</td>
<td>○</td>
<td>○</td>
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</tr>
<tr>
<td>A partner (or family) has a say in what a woman does during her pregnancy (5)</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<tr>
<td>It only takes a few</td>
<td>○</td>
<td>○</td>
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<td>○</td>
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</tr>
<tr>
<td>Cigarettes to cause harm to the foetus (6)</td>
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<tr>
<td>Many pregnant women smoke to cope with problems in their lives (7)</td>
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<tr>
<td>There are others things a pregnant woman could do that are more harmful to the baby than smoking (8)</td>
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<tr>
<td>If women stop smoking it is likely that the baby will be healthier (9)</td>
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<tr>
<td>Pregnant women should abstain from smoking (10)</td>
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<tr>
<td>Smoking during pregnancy has little effect on the unborn child's health (11)</td>
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<tr>
<td>Women who smoke during pregnancy seriously endanger their baby's health (12)</td>
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<tr>
<td>Pregnant women should be</td>
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</tbody>
</table>
able to make up their own minds about whether or not to smoke (13)
Q29 The following statements are about smoking and pregnancy, in general. Please indicate how much you agree with the following statements, from strongly disagree to strongly agree:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree (1)</th>
<th>Disagree (2)</th>
<th>Neither Agree nor Disagree (3)</th>
<th>Agree (4)</th>
<th>Strongly Agree (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is little doctors can do to influence whether a pregnant woman carries on smoking or quits (1)</td>
<td>◯</td>
<td>◯</td>
<td>◯</td>
<td>◯</td>
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<tr>
<td>Smoking is often an enjoyable activity for pregnant women (2)</td>
<td>◯</td>
<td>◯</td>
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<td>Just because a woman is pregnant, it is unlikely she will want to change her behaviour (3)</td>
<td>◯</td>
<td>◯</td>
<td>◯</td>
<td>◯</td>
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</tr>
<tr>
<td>Doctors who advise pregnant women to quit smoking make them feel guilty (4)</td>
<td>◯</td>
<td>◯</td>
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<tr>
<td>Midwives and other medical professionals should intervene when women’s behaviour puts the unborn child at risk (5)</td>
<td>◯</td>
<td>◯</td>
<td>◯</td>
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<tr>
<td>Giving up</td>
<td>◯</td>
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<td>smoking depends mainly on the woman's will power (6)</td>
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<tr>
<td>Pregnant women with a high consumption of cigarettes must reduce it (7)</td>
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<tr>
<td>Smoking is the woman's business, midwives or doctors should not be giving any advice regarding that topic (8)</td>
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<tr>
<td>If the woman wants to discuss her smoking it is her business to bring it up, not the doctor's (9)</td>
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<tr>
<td>Many pregnant women would like to give up smoking, but need advice from professionals on how to do it (10)</td>
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<tr>
<td>Women have the right to make their own decisions during pregnancy,</td>
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including how much they smoke (11)
Pregnancy is a time when all women who smoke want to change their smoking habits (12)
Pregnant women should reduce smoking (13)

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</table>
Q30 The following statements are about pregnancy and smoking, in general. Please indicate how much you agree with the following statements, from strongly disagree to strongly agree:

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree (1)</th>
<th>Disagree (2)</th>
<th>Neither Agree nor Disagree (3)</th>
<th>Agree (4)</th>
<th>Strongly Agree (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women who smoke during their pregnancy lack control over their smoking (1)</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>A woman who smokes during her pregnancy is considerate of others (2)</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<td>○</td>
</tr>
<tr>
<td>Women who smoke during their pregnancy lack awareness about the effects smoking has on their baby (3)</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<td>○</td>
</tr>
<tr>
<td>Stress is what keeps a woman smoking during her pregnancy (4)</td>
<td>○</td>
<td>○</td>
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<tr>
<td>Women who smoke while pregnant do not question the facts, they know what harm they are doing (5)</td>
<td>○</td>
<td>○</td>
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</tr>
<tr>
<td>Good mothers do not smoke during their pregnancy (6)</td>
<td>○</td>
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</tr>
</tbody>
</table>
Pregnant women who smoke would deny any information in favour of quitting while pregnant (7)

Pregnant women who smoke tend to under-report how much they smoke to a doctor or midwife, due to feelings of shame (8)

Women who smoke during their pregnancy are sceptical about the effects of smoking on the fetus (9)

Women who smoke while pregnant have actively made the decision to continue smoking (10)

Pregnant women who smoke only look out for themselves (11)

Pregnant women who smoke are vulnerable to the addictive nature of
| cigarettes (12) |   |   |   |   |
Q31 The following statements are about pregnancy and smoking, in general. Please indicate how much you agree with the following statements, from strongly disagree to strongly agree:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree (1)</th>
<th>Disagree (2)</th>
<th>Neither Agree nor Disagree (3)</th>
<th>Agree (4)</th>
<th>Strongly Agree (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant women would not feel defensive about their smoking</td>
<td></td>
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</tr>
<tr>
<td>A pregnant woman can still be a good mum even though she smokes</td>
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<tr>
<td>It is somewhat accepted in our society for a pregnant woman to smoke from time to time</td>
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<tr>
<td>Pregnant smokers would be able to cite specific health consequences of smoking on the foetus</td>
<td></td>
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</tr>
<tr>
<td>Often women who smoke while pregnant do not feel guilty about their smoking</td>
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<tr>
<td>Pregnant smokers are aware of what smoking does to a foetus</td>
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</tr>
</tbody>
</table>
Pregnant women who smoke would be ignorant of any strategies they could engage in to help reduce the harm to the baby (e.g. Cutting down) (7).

Stress does not explain why some women smoke during pregnancy (8).

No one is tolerant of a pregnant woman smoking (9).

Women who smoke while pregnant are often defensive about their smoking (10).

A woman who smokes while pregnant is unlikely to be in denial about the negative impact of smoking (11).

A pregnant woman who smokes would have little dependence on nicotine (12).
Q32 If a pregnant woman were smoking in a public place (e.g. shopping centre) how likely do you think people in general would be to do the following: (From strongly disagree to strongly agree)

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree (1)</th>
<th>Disagree (2)</th>
<th>Neither Agree nor Disagree (3)</th>
<th>Agree (4)</th>
<th>Strongly Agree (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confront her and say something (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shake their head (2)</td>
<td></td>
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</tr>
<tr>
<td>Give her a “death stare” or “dirty” look (3)</td>
<td></td>
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<tr>
<td>Mind their own business (4)</td>
<td></td>
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<tr>
<td>Stare at her until she notices their stare (5)</td>
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<tr>
<td>Tell someone they are with (e.g. whisper) (6)</td>
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<tr>
<td>Other: (7)</td>
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</tr>
</tbody>
</table>
Q33 If a pregnant woman were smoking in a public place (e.g. shopping centre) how likely would you be to do the following: (From strongly disagree to strongly agree)

<table>
<thead>
<tr>
<th>Action</th>
<th>Strongly Disagree (1)</th>
<th>Disagree (2)</th>
<th>Neither Agree nor Disagree (3)</th>
<th>Agree (4)</th>
<th>Strongly Agree (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confront her and say something (1)</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Shake your head (2)</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Give her a “death stare” or &quot;dirty&quot; look (3)</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Mind your own business (4)</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Stare at her until she notices your stare (5)</td>
<td>○</td>
<td>○</td>
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</tr>
<tr>
<td>Tell someone you are with (e.g. whisper) (6)</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Other: (7)</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<td>○</td>
</tr>
</tbody>
</table>
Q34 The following statements are about pregnant women who smoke. Please indicate how much you agree with the following statements, from strongly disagree to strongly agree:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree (1)</th>
<th>Disagree (2)</th>
<th>Neither Agree nor Disagree (3)</th>
<th>Agree (4)</th>
<th>Strongly Agree (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women should be refused service when buying cigarettes if you can see they are visibly pregnant (1)</td>
<td></td>
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</tr>
<tr>
<td>Women who smoke during pregnancy would hide their smoking from people (2)</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Pregnant women who smoke in public should be confronted (3)</td>
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</tr>
<tr>
<td>As her pregnancy progresses it is likely that a pregnant woman would hide their smoking (4)</td>
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<tr>
<td>A woman smoking is not as bad as a pregnant woman smoking (5)</td>
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<tr>
<td>Women who are pregnant are capable of making the decision to</td>
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</tbody>
</table>
A teenager smoking is worse than a pregnant woman smoking.

Q11 The final set of questions are about yourself. What is your age (in years)? (Please write in the box below)

Q12 Gender:
- Male (1)
- Female (2)

Q25 What is your country of birth?
- Australia (1)
- Malaysia (2)
- Singapore (3)
- UK (4)
- China (5)
- South Africa (6)
- Other (please specify) (7) ____________________

Q31 What is your current relationship status?
- Married (1)
- De Facto (2)
- In a relationship, not living together (3)
- Single (4)
- Other (please specify) (5) ____________________

Q14 Which of the following do you identify with:
- Daily smoker (1)
- Social or occasional smoker (2)
- Ex-smoker (3)
- Non-smoker (4)

Q17 Are you a parent?
- Yes (1)
- No (2)
Q29 Are you currently employed? If yes, how many hours per week do you work in paid employment?
- Yes, 1-15 hours (1)
- Yes, 16-24 hours (2)
- Yes, 25-34 hours (3)
- Yes, 35+ hours (4)
- No (5)

Q15 Do any of the following smoke? Tick all that apply:
- Parent (or parents) (1)
- Friends (2)
- Partner, boyfriend, or girlfriend (3)
- Sibling (or siblings) (4)
- Other family members (e.g. Cousin, Aunty etc) (5)

Q27 Are you:
- Studying full-time (3 or 4 2-unit courses this semester) (1)
- Studying part-time (1 or 2 2-unit courses this semester) (2)
- Other (please specify) (3) ____________________
Appendix B3: Study 2 survey: Attitudes toward mother smokers

Q1 What is the ID code the researcher provided you with?
   ID (1)

Answer If What is the ID code the researcher provided you with? ID Is Greater Than or Equal to 401 And What is the ID code the researcher provided you with? ID Is Less Than or Equal to 500

Q20 Please read the following information, and then answer questions about it: Marge is the mother of a 2-year-old. Marge has been smoking half a pack of cigarettes a day.

Answer If What is the ID code the researcher provided you with? ID Is Greater Than or Equal to 301 And What is the ID code the researcher provided you with? ID Is Less Than or Equal to 400

Q19 Please read the following information, and then answer questions about it: Recently, Marge’s fiancé left her and since then she has been busy looking after her 2 year old and working full-time.

Answer If What is the ID code the researcher provided you with? ID Is Greater Than or Equal to 501 And What is the ID code the researcher provided you with? ID Is Less Than or Equal to 600

Q21 Please read the following information, and then answer questions about it: Recently, Marge’s fiancé left her and since then she has been busy looking after her 2 year old and working full-time. Marge has been smoking half a pack of cigarettes a day. She has been cutting down her smoking as much as she can and plans to continue this. She says the cigarettes are the only thing keeping her from breaking down at this point.

Answer If What is the ID code the researcher provided you with? ID Is Greater Than or Equal to 101 And What is the ID code the researcher provided you with? ID Is Less Than or Equal to 200

Q18 Please read the following information, and then answer questions about it: Marge is the mother of a 2-year-old.
Using the information you have read about Marge, please indicate where you think Marge best fits on the following characteristics:

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>1 (1)</th>
<th>2 (2)</th>
<th>3 (3)</th>
<th>4 (4)</th>
<th>5 (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empowered:Passive</td>
<td>☒</td>
<td>☒</td>
<td>☒</td>
<td>☒</td>
<td>☒</td>
</tr>
<tr>
<td>Dependent:Independent</td>
<td>☒</td>
<td>☒</td>
<td>☒</td>
<td>☒</td>
<td>☒</td>
</tr>
<tr>
<td>Controlled:In control</td>
<td>☒</td>
<td>☒</td>
<td>☒</td>
<td>☒</td>
<td>☒</td>
</tr>
<tr>
<td>Good mother:Bad mother</td>
<td>☒</td>
<td>☒</td>
<td>☒</td>
<td>☒</td>
<td>☒</td>
</tr>
<tr>
<td>Guilty:Innocent</td>
<td>☒</td>
<td>☒</td>
<td>☒</td>
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<td>☒</td>
</tr>
<tr>
<td>Aware:Ignorant</td>
<td>☒</td>
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<td>☒</td>
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<td>☒</td>
</tr>
<tr>
<td>Stressed:Relaxed</td>
<td>☒</td>
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<td>☒</td>
<td>☒</td>
<td>☒</td>
</tr>
<tr>
<td>Proud:Embarrassed</td>
<td>☒</td>
<td>☒</td>
<td>☒</td>
<td>☒</td>
<td>☒</td>
</tr>
<tr>
<td>Sceptical:Believing</td>
<td>☒</td>
<td>☒</td>
<td>☒</td>
<td>☒</td>
<td>☒</td>
</tr>
<tr>
<td>Healthy:Unhealthy</td>
<td>☒</td>
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<td>☒</td>
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<tr>
<td>Accepting:Dismissive</td>
<td>☒</td>
<td>☒</td>
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</tr>
<tr>
<td>Selfish:Selfless</td>
<td>☒</td>
<td>☒</td>
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</tr>
</tbody>
</table>
Q2 Using the information about Marge, please indicate how much you think these statements are likely to be true of Marge (from strongly disagree to strongly agree):

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree (1)</th>
<th>Disagree (2)</th>
<th>Neither Agree nor Disagree (3)</th>
<th>Agree (4)</th>
<th>Strongly Agree (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>She is in control of her smoking (1)</td>
<td></td>
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</tr>
<tr>
<td>She is a victim to her addiction (2)</td>
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</tr>
<tr>
<td>She does not feel defensive about her smoking (3)</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>She feels bad about her smoking (4)</td>
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</tr>
<tr>
<td>She is unaware of the negative impact smoking (second-hand smoke) has on the child (5)</td>
<td></td>
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</tr>
<tr>
<td>She continues to smoke to avoid the stress of quitting (6)</td>
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</tr>
<tr>
<td>She lies about her smoking to her family or friends to avoid the shame (7)</td>
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</tr>
<tr>
<td>She will be a good mother (8)</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>She is defensive about her</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
She is sceptical about the negative effects of smoking (second-hand smoke) on the child (10).

She denies that her smoking has any negative impact (11).

Her smoking only benefits herself (12).
Q28 Using the information about Marge, please indicate how much you think these statements are likely to be true of Marge (from strongly disagree to strongly agree):

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree (1)</th>
<th>Disagree (2)</th>
<th>Neither Agree nor Disagree (3)</th>
<th>Agree (4)</th>
<th>Strongly Agree (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>She is aware of the consequences of smoking (second-hand smoke) on the child (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>She thinks there is little harm in smoking near children (2)</td>
<td></td>
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</tr>
<tr>
<td>She feels guilt free about her smoking (3)</td>
<td></td>
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</tr>
<tr>
<td>She is aware of the effects of smoking on herself and the child (second-hand smoke) (4)</td>
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</tr>
<tr>
<td>She continues to smoke for the pleasure (5)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>She will be a bad mother (6)</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>She feels pleased about her smoking (7)</td>
<td></td>
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</tr>
<tr>
<td>She has a low addiction to cigarettes (8)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>She believes that smoking causes harm to children (second-hand</td>
<td></td>
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</tr>
</tbody>
</table>
smoke) (9)
The cigarettes are in control of her (10)
Her decision to smoke was made with the consideration of others (11)
She admits the impact of her smoking on the child (second-hand smoke) (12)

Q8 The following questions are about pregnant women and smoking: Imagine seeing a pregnant woman smoking in a public place (e.g. shopping centre). How would that make you feel? What might you think about her? (Please write in the box below)

Q9 In your opinion, what are some reasons why a pregnant woman might smoke? (Please write in the box below)

Q10 In your opinion, if a pregnant woman smokes, how many cigarettes is reasonable for her to smoke per day? (Please write in the box below)
Q4 The following statements are about smoking and pregnancy. Please indicate how much you agree with the following statements, from strongly disagree to strongly agree:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree (1)</th>
<th>Disagree (2)</th>
<th>Neither Agree nor Disagree (3)</th>
<th>Agree (4)</th>
<th>Strongly Agree (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>If women cut down their smoking while pregnant there is no need for them to quit (1)</td>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
</tr>
<tr>
<td>Cutting down smoking is not enough during pregnancy, abstinence is the only solution (2)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>Women should be monitored during their pregnancy to ensure that they are doing everything right (3)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>It takes a high level of smoking on the woman's part to cause serious harm to the foetus (4)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>A partner (or family) has a say in what a woman does during her pregnancy (5)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>It only takes a few 200</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</table>
cigarettes to cause harm to the foetus (6)

Many pregnant women smoke to cope with problems in their lives (7)

There are others things a pregnant woman could do that are more harmful to the baby than smoking (8)

If women stop smoking it is likely that the baby will be healthier (9)

Pregnant women should abstain from smoking (10)

Smoking during pregnancy has little effect on the unborn child's health (11)

Women who smoke during pregnancy seriously endanger their baby's health (12)

Pregnant women should be
able to make up their own minds about whether or not to smoke (13)
Q29 The following statements are about smoking and pregnancy. Please indicate how much you agree with the following statements, from strongly disagree to strongly agree:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree (1)</th>
<th>Disagree (2)</th>
<th>Neither Agree nor Disagree (3)</th>
<th>Agree (4)</th>
<th>Strongly Agree (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is little doctors can do to influence whether a pregnant woman carries on smoking or quits (1)</td>
<td></td>
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</tr>
<tr>
<td>Smoking is often an enjoyable activity for pregnant women (2)</td>
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<tr>
<td>Just because a woman is pregnant, it is unlikely she will want to change her behaviour (3)</td>
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<tr>
<td>Doctors who advise pregnant women to quit smoking make them feel guilty (4)</td>
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<tr>
<td>Midwives and other medical professionals should intervene when women’s behaviour puts the unborn child at risk (5)</td>
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<tr>
<td>Giving up</td>
<td></td>
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</table>
Smoking depends mainly on the woman's will power (6)

Pregnant women with a high consumption of cigarettes must reduce it (7)

Smoking is the woman's business, midwives or doctors should not be giving any advice regarding that topic (8)

If the woman wants to discuss her smoking it is her business to bring it up, not the doctor's (9)

Many pregnant women would like to give up smoking, but need advice from professionals on how to do it (10)

Women have the right to make their own decisions during pregnancy,

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</tbody>
</table>
including how much they smoke (11)
Pregnancy is a time when all women who smoke want to change their smoking habits (12)
Pregnant women should reduce smoking (13)
Q30 The following statements are about pregnancy and smoking. Please indicate how much you agree with the following statements, from strongly disagree to strongly agree:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree (1)</th>
<th>Disagree (2)</th>
<th>Neither Agree nor Disagree (3)</th>
<th>Agree (4)</th>
<th>Strongly Agree (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women who smoke during their pregnancy lack control over their smoking</td>
<td>○</td>
<td>○</td>
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</tr>
<tr>
<td>A woman who smokes during her pregnancy is considerate of others</td>
<td>○</td>
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<tr>
<td>Women who smoke during their pregnancy lack awareness about the effects</td>
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<tr>
<td>smoking has on their baby</td>
<td></td>
<td></td>
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<tr>
<td>Stress is what keeps a woman smoking during her pregnancy</td>
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</tr>
<tr>
<td>Women who smoke while pregnant do not question the facts, they know</td>
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<td>○</td>
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<td>○</td>
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<tr>
<td>what harm they are doing</td>
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<td></td>
</tr>
<tr>
<td>Good mothers do not smoke during their pregnancy</td>
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<td>○</td>
<td>○</td>
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</tr>
</tbody>
</table>
Pregnant women who smoke would deny any information in favour of quitting while pregnant (7)

Pregnant women who smoke tend to under-report how much they smoke to a doctor or midwife, due to feelings of shame (8)

Women who smoke during their pregnancy are sceptical about the effects of smoking on the fetus (9)

Women who smoke while pregnant have actively made the decision to continue smoking (10)

Pregnant women who smoke only look out for themselves (11)

Pregnant women who smoke are vulnerable to the addictive nature of
| cigarettes (12) |   |   |   |   |
Q31 The following statements are about pregnancy and smoking. Please indicate how much you agree with the following statements, from strongly disagree to strongly agree:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree (1)</th>
<th>Disagree (2)</th>
<th>Neither Agree nor Disagree (3)</th>
<th>Agree (4)</th>
<th>Strongly Agree (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant women would not feel defensive about their smoking (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A pregnant woman can still be a good mum even though she smokes (2)</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>It is somewhat accepted in our society for a pregnant woman to smoke from time to time (3)</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Pregnant smokers would be able to cite specific health consequences of smoking on the foetus (4)</td>
<td></td>
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</tr>
<tr>
<td>Often women who smoke while pregnant do not feel guilty about their smoking (5)</td>
<td></td>
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</tr>
<tr>
<td>Pregnant smokers are aware of what smoking does to a foetus (6)</td>
<td></td>
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</tr>
</tbody>
</table>
Pregnant women who smoke would be ignorant of any strategies they could engage in to help reduce the harm to the baby (e.g. Cutting down) (7)
Stress does not explain why some women smoke during pregnancy (8)
No one is tolerant of a pregnant woman smoking (9)
Women who smoke while pregnant are often defensive about their smoking (10)
A woman who smokes while pregnant is unlikely to be in denial about the negative impact of smoking (11)
A pregnant woman who smokes would have little dependence on nicotine (12)
Q32 If a pregnant woman were smoking in a public place (e.g. shopping centre) how likely do you think people in general would be to do the following: (From strongly disagree to strongly agree)

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree (1)</th>
<th>Disagree (2)</th>
<th>Neither Agree nor Disagree (3)</th>
<th>Agree (4)</th>
<th>Strongly Agree (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confront her and say something (1)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Shake their head (2)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Give her a &quot;death stare&quot; or &quot;dirty&quot; look (3)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Mind their own business (4)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Stare at her until she notices their stare (5)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Tell someone they are with (e.g. whisper) (6)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Other: (7)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
Q33 If a pregnant woman were smoking in a public place (e.g. shopping centre) how likely would you be to do the following:(From strongly disagree to strongly agree)

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree (1)</th>
<th>Disagree (2)</th>
<th>Neither Agree nor Disagree (3)</th>
<th>Agree (4)</th>
<th>Strongly Agree (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confront her and say something</td>
<td></td>
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</tr>
<tr>
<td>(1)</td>
<td>○</td>
<td>○</td>
<td></td>
<td>○</td>
<td></td>
</tr>
<tr>
<td>Shake your head (2)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Give her a “death stare” or &quot;dirty&quot; look (3)</td>
<td></td>
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<tr>
<td>Mind your own business (4)</td>
<td></td>
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</tr>
<tr>
<td>Stare at her until she notices your stare (5)</td>
<td></td>
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<tr>
<td>Tell someone you are with (e.g. whisper) (6)</td>
<td></td>
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</tr>
<tr>
<td>Other: (7)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

212
Q34 The following statements are about pregnant women who smoke. Please indicate how much you agree with the following statements, from strongly disagree to strongly agree:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree (1)</th>
<th>Disagree (2)</th>
<th>Neither Agree nor Disagree (3)</th>
<th>Agree (4)</th>
<th>Strongly Agree (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women should be refused service when buying cigarettes if you can see they are visibly pregnant (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women who smoke during pregnancy would hide their smoking from people (2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnant women who smoke in public should be confronted (3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>As her pregnancy progresses it is likely that a pregnant woman would hide their smoking (4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A woman smoking is not as bad as a pregnant woman smoking (5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women who are pregnant are capable of making the decision to</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
smoke (6)
A teenager smoking is worse than a pregnant woman smoking (7)

Q11 The final set of questions are about yourself. What is your age (in years)? (Please write in the box below)

Q12 Gender:
☒ Male (1)
☒ Female (2)

Q25 What is your country of birth?
☒ Australia (1)
☒ Malaysia (2)
☒ Singapore (3)
☒ UK (4)
☒ China (5)
☒ South Africa (6)
☒ Other (please specify) (7) __________________

Q31 What is your current relationship status?
☒ Married (1)
☒ De Facto (2)
☒ In a relationship, not living together (3)
☒ Single (4)
☒ Other (please specify) (5) __________________

Q14 Which of the following do you identify with:
☒ Daily smoker (1)
☒ Social or occasional smoker (2)
☒ Ex-smoker (3)
☒ Non-smoker (4)

Q17 Are you a parent?
☒ Yes (1)
☒ No (2)
Q29 Are you currently employed? If yes, how many hours per week do you work in paid employment?
- Yes, 1-15 hours (1)
- Yes, 16-24 hours (2)
- Yes, 25-34 hours (3)
- Yes, 35+ hours (4)
- No (5)

Q15 Do any of the following smoke? Tick all that apply:
- Parent (or parents) (1)
- Friends (2)
- Partner, boyfriend, or girlfriend (3)
- Sibling (or siblings) (4)
- Other family members (e.g. Cousin, Aunty etc) (5)

Q27 Are you:
- Studying full-time (3 or 4 2-unit courses this semester) (1)
- Studying part-time (1 or 2 2-unit courses this semester) (2)
- Other (please specify) (3) _________________
Did you know
that 17% of women say they smoked during their pregnancy?

We are researchers from the University of Queensland, interested in how women use pregnancy forums for information and support. In particular, we are focusing on pregnant women who smoke, and whether you use pregnancy forums to discuss questions or issues about smoking.

If you are currently or recently pregnant (in the last year) and smoked during your pregnancy, then we would love to hear from you.

If this describes you, please scan the QR code or follow the link (https://exp.psy.uq.edu.au/pregnancyforums/) to share your experience with us via an online survey. If you have any questions, feel free to email me (b.wigginton@uq.edu.au).

The survey will take around 15 minutes to complete. There are lots of opportunities to tell us about your experience of using pregnancy forums.

Important information:
- Your responses will be anonymous
- You won’t be asked to share any identifying or personal information
- Your participation is voluntary
- You are free to stop the survey and leave the site at any time

Thanks,
Britta
Appendix C2: Study 3 survey

Pregnancy forums

Q1 Thanks for following the link to our survey. The next few questions are about you. Are you a woman?
- Yes (1)
- No (2)

Q2 Are you 18 or over?
- Yes (1)
- No (2)

Q4 Are you pregnant?
- Yes, I am _____ months pregnant (1) __________________
- No, but I was pregnant in the last 12 months (2)
- No, but I was pregnant more than 12 months ago (3)
- No, I have never been pregnant (4)

Q3 Thank you for your time and interest in our survey. Unfortunately, you are not eligible for our survey. If you have any questions or issues with the survey please feel free to email me. All the best, Britta b.wigginton@uq.edu.au

Q48 If at any time you feel that you need to talk with a professional about smoking or any other personal matter, please call Quitline (13 QUIT) or Lifeline (13 11 14). This survey has received Ethics approval 13-PSYCH-PHD-18-JJ. This study has been cleared in accordance with the ethical review processes of the University of Queensland and within the guidelines of the National Statement on Ethical Conduct in Human Research. You are, of course, free to discuss your participation with project staff (contactable on: ____________________). If you would like to speak to an officer of the University not involved in the study, you may contact one of the School of Psychology Ethics Review Officers: Jolanda Jetten (j.jetten@psy.uq.edu.au, tel 3365 4909), Jeanie Sheffield (jeanie@psy.uq.edu.au, tel 3365 6690), Thomas Suddendorf (tsuddend@psy.uq.edu.au, tel 3365 8341) or Alex Haslam (uqhasla@uq.edu.au, tel 3346 7345). Alternatively, you may
leave a message with Ann Lee (3365 6448) a.lee@psy.uq.edu.au, for an ethics officer to contact you, or contact the University of Queensland Ethics Officer, Michael Tse, on 3365 3924, e-mail: humanethics@research.uq.edu.au

Q9 Are you currently smoking?
- Yes, I smoke most days or every day (1)
- Yes, I smoke occasionally (2)
- No, but I was smoking during a previous pregnancy (3)
- No, I have smoked but not when I was pregnant (4)
- No, I’ve never smoked (5)

Q19 Please tell us more about why you didn’t use pregnancy forums.

Q34 Almost there … These are the last set of open-ended questions. Have you ever felt judged on the pregnancy forum, about smoking or about anything else? If yes, can you tell us more about feeling judged?

Q35 Have you ever felt judged anywhere else online? Can you tell us more about feeling judged?

Q36 Do you think there are some topics that are easier to discuss on pregnancy forums than face-to-face? Is smoking in pregnancy one of these topics?

Q37 Is there anything else you would like to tell us that we haven’t asked about?

Q38 Would you like a summary of the findings or to provide feedback on the findings from this survey? (Note. For confidentiality reasons your email address will be kept separate from your responses to this survey) If so, please leave your email here:

Q39 Before you go, could you please fill out the last few questions to help us understand a bit more about you. I am _______ years old

Q40 Which of the following best describes you [tick as many as apply]:
- I’m married (1)
- I’m engaged (2)
- I’m living with my partner (3)
- My partner and I live separately (4)
- I’m single (5)
- I’m separated (6)
- I’m divorced (7)
- Other (8) ____________________
Q41 Do you live in Australia?
☑ Yes (1)
☑ No, I live in (2) ____________________

Q42 Which best describes you:
☐ I didn’t finish high school (1)
☐ I finished high school (2)
☐ I have a certificate or trade qualification (3)
☐ I have a degree (4)
☐ Other (5) ____________________

Q43 Are you in paid work at the moment?
☑ Yes (1)
☑ No (2)

Q44 Please describe your usual occupation

Q45 Could you tell us how did you find out about this survey

Q46 Thank you for your time! We appreciate hearing about your experience online! All the best, Britta b.wigginton@uq.edu.au

Q47 If at any time you feel that you need to talk with a professional about smoking or any other personal matter, please call Quitline (13 QUIT) or Lifeline (13 11 14). This survey has received Ethics approval 13-PSYCH-PHD-18-JJ. This study has been cleared in accordance with the ethical review processes of the University of Queensland and within the guidelines of the National Statement on Ethical Conduct in Human Research. You are, of course, free to discuss your participation with project staff (contactable on: ____________________). If you would like to speak to an officer of the University not involved in the study, you may contact one of the School of Psychology Ethics Review Officers: Jolanda Jetten (j.jetten@psy.uq.edu.au, tel 3365 4909), Jeanie Sheffield (jeanie@psy.uq.edu.au, tel 3365 6690), Thomas Suddendorf (tsuddend@psy.uq.edu.au, tel 3365 8341) or Alex Haslam (uqshasla@uq.edu.au, tel 3346 7345). Alternatively, you may leave a message with Ann Lee (3365 6448) a.lee@psy.uq.edu.au, for an ethics officer to
contact you, or contact the University of Queensland Ethics Officer, Michael Tse, on 3365 3924, e-mail: humanethics@research.uq.edu.au

Q15 Are you using pregnancy forums (for any reason)?
   - Yes (1)
   - No (2)

Q14 While pregnant, did you smoke?
   - Yes, I smoked most days or every day (1)
   - Yes, I smoked occasionally (2)
   - No, I have smoked but not when I was pregnant (3)
   - No, but I smoked during a previous pregnancy (4)
   - No, I’ve never smoked (5)

Q16 Did you use pregnancy forums (for any reason) while you were pregnant?
   - Yes (1)
   - No (2)

Q20 Please tell us which pregnancy forums you used.

Q21 Please tell us about why you first started using online pregnancy forums.

Q22 Did you tell your family or friends that you were using a pregnancy forum?
   - Yes (1)
   - No (2)

Q23 How did your family or friends respond to you using a pregnancy forum?

Q24 Can you tell us more about why you didn’t tell your family or friends you were using a pregnancy forum?

Q25 Did you tell anyone on any forum that you were smoking (while pregnant)? Why or why not?

Q26 Were there opportunities to talk to women who had also smoked while pregnant on the pregnancy forum? Please tell us more about this.

Q27 Did you ever post about smoking on the pregnancy forum?
   - Yes (1)
   - No (2)

Q29 Can you tell us about why you didn’t talk about smoking? Did you wish you did?
Q28 Can you tell us more about posting about smoking on the forum? How did people respond?

Q30 Did you read posts from other people about smoking on the pregnancy forum?
- Yes (1)
- No (2)

Q32 With no one else posting about smoking, did this influence you and what you were willing to post?

Q31 Can you tell us more about reading others posts about smoking? How did people respond?

Q33 How do your interactions about smoking on the pregnancy forum compare with offline face-to-face interactions?
Appendix C3: Study 3 summary of online data

**Online conversations about smoking in pregnancy: An online survey of women’s experiences**

Britta Wigginton  
School of Psychology, University of Queensland.  
18 June 2014  
Email: b.wigginton@uq.edu.au

PhD Project supervised by: Professor Christina Lee

Ethics clearance received from the School of Psychology, University of Queensland. (#13-PSYCH-PHD-18-JJ)
What was the purpose of our research?

We were interested in understanding whether or not women used online pregnancy forums to discuss questions, issues or concerns about smoking during their pregnancy.

What did we do?

Fifty women completed a survey about using online pregnancy forums while pregnant and smoking.

What did we find?

This report provides a summary of the survey findings. The results will be of interest to the women who kindly participated, women using online pregnancy forums and the wider community.

Findings

Looking for support and advice

Most women started using pregnancy forums for information, support and advice, often for reasons unrelated to smoking or quitting. Women spoke about wanting to read about other women’s experiences of pregnancy and gaining a sense of support during and after pregnancy. For instance, one woman wrote about going online:

“To talk to other mums going through what I was”

More than half of the women who participated said that they had told family or friends they were using pregnancy forums.

Several women did not tell anyone because they wanted to remain anonymous online or felt that others (friends or family) wouldn’t understand why they were going online for support or information.
Appendix C3: Study 3 summary of online data

For instance, one woman stated:

“Part of the reason why I don’t talk about smoking on forums is a fear someone I know will find that post and somehow figure out it’s me”

However, only four women indicated that they had posted about smoking in pregnancy on a pregnancy forum.

**What stops women posting online?**

- Fear of judgement or backlash
- Shame and embarrassment about smoking in pregnancy
- The topic was never raised by others

Many women had read very negative and judgemental posts from other women about smoking in pregnancy.

Here are some examples of what women wrote:

- “Some were supportive, some just bragged on how they ‘instantly gave up that easily’ and others were really rude about it”

- “Most people were very critical even of those who had cut down considerably, like myself”

- “Some people are really passionate keyboard warriors. A lot were negative and ‘verbally bashed’ women who smoked”
Appendix C3: Study 3 summary of online data

Some women felt their experience of being pregnant and smoking had to remain hidden, and they had no one to talk to about it. For instance:

“I looked up women’s experiences of trying to quit smoking in online forums because I literally don’t know a single real life person experiencing the same thing, not because I felt I would be more or less judged”

“I don’t know anyone else who is pregnant and smoking, so yes, it’s easier to discuss [smoking in pregnancy] online than with my non-existent pregnant smoking friends”

For women who did post, very few women described any support, understanding or empathy online regarding their smoking.

Only a few women spoke of receiving support and advice online in discussions of smoking in pregnancy.

For the minority of women who described positive experiences online, what did support look like?

“On general posts you get some slamming from mothers who really judge you for it, I never posted in those for that reason. In the quitting group there was a lot of support and encouragement. When a woman would post saying she was smoking but not quitting there was always help, advice offered, but never judgement or criticism”

“Others [had] created posts seeking help and support. I often commented on them giving them tips I used to cut down”

“Women who had smoked during pregnancy were less critical about doing it and more supportive about quitting, decreasing or lightly
smoking. Heavy smoking was discouraged. I could chat without being judged and they understood”

“There was a group specifically for women trying to quit during pregnancy, offering advice, support and just somewhere to vent”

From these few positive experiences, there was some common ground. Positive experiences usually occurred within forum threads that were specifically about “seeking support” or “quitting smoking”. In these threads women felt less likely to be judged because the title (and content) of the thread meant that smoking would be discussed, implying that this was not the space for judgement.

In addition, women emphasised the value of personal advice about reducing or quitting smoking. Other women (who had also smoked in pregnancy) were generally supportive by providing tips for cutting down or quitting - as long as heavy smoking wasn’t being promoted. Some women spoke of the importance of ‘understanding’ what it’s like to smoke in pregnancy – or to smoke at all. Women described non-smokers as not understanding addiction, shame, guilt and the need to remain ‘hidden’ – all of which were very difficult aspects for women who smoked during their pregnancy.

**Take home messages**

Women described their need for support, advice and information about reducing or quitting smoking and the overwhelming difficulty in discussing or disclosing their smoking online. In the context of smoking in pregnancy, it is important that women are able to disclose, or ask questions about, smoking (e.g. tips for reducing or quitting) in order to help them in their journey towards cessation.

**Recommendations for forums***:

Pregnancy forums are an important source of information and support for women. The following are suggestions to provide a “safe” space for women to talk more openly online, reducing the fear of backlash or judgement.

1. **Threads specifically designed for discussions about quitting and reducing smoking in pregnancy.** A space like this provides women with an opportunity to share advice and tips on reducing smoking and
Appendix C3: Study 3 summary of online data

managing cravings. A clear title to show that “quitting” smoking will be discussed sets the tone for supportive discussions.

2. **Women need options online to report an inappropriate post or to alert forum moderators to offensive comments.** Many women who participated in the survey feared being ‘verbally bashed’ online for disclosing their smoking. It is important that women with a range of life experiences are able to talk to each other in online pregnancy forums without feeling judged or shamed for their behaviour.

*Notably, we experienced significant difficulty in advertising this research study in online pregnancy forums. Many forums were reluctant to carry our advertisement, replying that smoking in pregnancy is a “controversial” topic that elicits strong opinions. Although many forums prefer to avoid discussions of smoking in pregnancy, we believe that avoidance does not help women to quit smoking and suggest that a supportive space should be offered to women.*

Silencing an experience because it is considered “controversial” does not help women in their journey towards cessation.
Appendix D: Media article


When Sunday Life columnist Chrissie Swan was photographed smoking in her car, her shameful secret was out. As this week's column had already been printed, she agreed to tell her full story today.

LAST Monday, about midday, I had a cigarette in my car. Within 48 hours I had made two tearful, soul-baring and shame-fuelled confessions. One on radio and one on national television. Because it wasn't just a cigarette. I am pregnant. And smoking. And I'd been photographed by a paparazzo who had tailed me from work and was following me home. Despite my work, I lead a very ordinary life and keeping my eyes peeled for photographers is not something I've ever done. So I had no idea what was going on. I am not a heavy smoker. I am not even a light smoker. But I am a smoker, and I have been having an occasional cigarette throughout this pregnancy. Not good enough. I would do it in my car, alone, and never more than once a day. That was the creepy deal I struck with myself. It disgusts me. And it has been the worst, most guilt-inducing thing I have ever done. It is also completely illogical. Because despite knowing the horrific risks to me and my baby, I continued to do it. It defies logic because I am the sort of mother who buys organic fruit because I'm concerned about pesticides on my kids' snacks. They never go anywhere without sunscreen. And I never even took a drag through my previous pregnancies. My kids have never seen me smoke. I will be keeping them away from newsagencies this week and doctors' surgeries for the rest of their lives so they don't come across a copy of Woman's Day. The thought gives me palpitations. Anyway, I told all this to my Quitline counsellor and was heartened to hear: "Classic case. Third baby. Busy mum. You didn't have time to quit." It is easy to say there is no excuse for smoking through pregnancy. But I have found out this week that there actually is one. And that is, addiction. It is a terrible thing to admit. But it is true. There can be no other reason for continuing to smoke, despite the whole concept of it contravening the most consuming and powerful of my instincts; my maternal one. Let's go back to that fateful Monday, though. As soon as I heard the clicking of the camera, I knew I would be forced to divulge, in public, my shameful and humiliating secret. I realised of course that the whole of Australia would want to hang me, but what was actually worse was that I had kept my addiction a secret from my partner, my parents, my sisters, my best friends and my colleagues - all people I have intensely personal and close relationships with - and now I would have to tell them too. Not one of them smokes. Not one. I became nauseous within minutes. It is not easy to keep a secret from those around you. It is physically difficult. I had to hide my cigarette stash in a glovebox, under the car seat or in the zippered pocket of my handbag. I'd get nervous if my one-year-old started rifling through my bag. I wouldn't let my partner use my car. It is also emotionally difficult - I didn't want my loved ones to be repulsed by me. I didn't want to shock them or make them think they didn't know me at all. I didn't want them to think I was an idiot. I just didn't want them to feel about me the way I was feeling about myself. Loathsome. I shouldn't have been so worried. Because when I made my tearful admission to my fella, he was calm and more concerned that I could barely breathe because I was so upset. I had to explain that the pics would appear in Woman's Day. That his parents would know I was an idiot. That all his friends would be horrified. None of which turned out to be true, and he assured me of this, and said we would get through it with no problems. He didn't even have to check if I would stop smoking. He knew I'd quit five seconds after the pic was taken. The reaction of those around me has been nothing but supportive, and though I have steered clear of social media and news websites for the past five days, I have been told the general vibe from Australia is one of understanding. Everyone knows smoking while
Appendix D: Media article

pregnant is wrong, especially those who are doing it. Especially me. Secrecy makes it easier to stay addicted. I was surprised at how many people have confessed their secret smoking habit to me. Sometimes keeping it under wraps is the only way we can keep the lie. By telling everyone - to be honest, millions more people than I would have liked - the secrecy was gone and with it the ability to keep smoking. So if you're a smoker and you hate it and you're being sneaky - tell someone. Anyone. Perhaps it will break the cycle. So what now? The cigarette I got caught smoking was my last and tomorrow it will be a week since then. I have a counsellor from Quitline who is checking in on me on Wednesday. I feel relieved. I am enjoying the exquisite freedom of not needing to smoke, and being the mother I know comes naturally. A few times a day I get the urge to smoke and I do something else. Alex from Quit has identified my trigger place as the car, as it is the only place I could smoke, and together we've decided that I'll listen to my own music (not The Wiggles!) or call a friend on hands-free while I'm driving. Every time I do this I forget I used to smoke. Human beings have vices. We all do. It's not a good thing but it happens. It's true, I have had the kind of week I wouldn't wish on my worst enemy, but ultimately, it's actually been positive because I have asked for help, I have stopped smoking and I feel peaceful and authentic and truthful. I am also not alone. Quit Victoria told me that the day after I confessed my terrible secret, the phone calls to the Quitline doubled. Doubled. Twice as many people as usual picked up their phones and said: "I don't want to smoke but I don't know how to stop. Please help me." They say my revelation caused this. And that's something anyone would be proud to tell their kids.