

UC Berkeley

Theses

Title

The Experiences of African American Women Smoking During Pregnancy: A Conflict of the Self

Permalink

<https://escholarship.org/uc/item/0tb9z5hv>

Author

Bennett, Ayanna

Publication Date

1999-04-01

Copyright Information

This work is made available under the terms of a Creative Commons Attribution-NonCommercial-NoDerivatives License, available at <https://creativecommons.org/licenses/by-nc-nd/4.0/>

**The Experiences of African American Women
Smoking During Pregnancy: A Conflict of the Self**

Ayanna Bennett
B.A. (Stanford Univeristy) 1995

Thesis completed in partial satisfaction of the
requirements for the degree of

Master of Science
in
Health and Medical Science

in the
GRADUATE DIVISION

of the
UNIVERSITY OF CALIFORNIA, BERKELEY

Committee in Charge:
Professor Patricia Morgan, Chair
Professor Tom Boyce
Professor Denise Herd

Spring 1999

The thesis of Ayanna Bennett is approved:

Patricia Morgan

Chair Date 6/21/99

Wesley Burt

Date 9/23/99

Roni H

Date 6/21/99

University of California, Berkeley

Spring 1999

Contents

ABSTRACT.....	i
CHAPTER I. INTRODUCTION.....	1
A. Why African American smokers?	
B. Smoking as a Perinatal Risk Factor	
C. Smoking among Pregnant Women	
CHAPTER II. LITERATURE REVIEW.....	7
A. The Influence of Pregnancy	
B. The Influence of Motherhood	
C. The Influence of Smoking	
D. The Health Belief Model	
CHAPTER III. METHODS.....	28
A. Sample	
B. Procedures	
C. Analysis	
D. Demographic Profile of Oakland, California	
E. Personal Profiles of the Respondents	
CHAPTER V. FINDINGS.....	36
A. The Self as a Pregnant Body	
B. The Self As A Smoker	
C. The Self As A Mother	
CHAPTER VI. DISCUSSION.....	66
A. The Determinants of Quitting	
B. The Meaning of Quitting: A Conflict Of Interests	
C. Deciding to Quit: A Conflict Of Informants	
D. Comparison to Theoretical Models	
CHAPTER VII. CONCLUSIONS AND RECOMMENDATIONS.....	75
A. Conclusions	
B. Recommendation 1: Support The Mother Identity	
C. Recommendation 2: Address Opposing Information	
REFERENCES.....	80

ABSTRACT

This study used grounded theory to examine the experiences and perceptions of pregnant African American smokers. Smoking during pregnancy has been linked to increased infant morbidity and mortality. This effect is especially troubling among African Americans who already have poorer birth outcomes than the general U.S. population, independent of smoking. Understanding how pregnant African American women conceptualized smoking and its risks is an important step in designing effective interventions that will influence them to change their behavior. **Methods:** Six pregnant African American women living in a small city were interviewed for one to two hours using a semi-structured instrument. The women were all current or recent smokers, meaning that they had been actively smoking for at least part of their pregnancy. The transcripts were analyzed using grounded theory. **Results:** Women conceptualized the decision to quit as a conflict between multiple images of the self as a smoker, a pregnant body, and a mother. Conflict between these self-images lead to behavior change, with the self-concept as a mother being a key motivator for quitting. Conflicts between sources of information occurred when personal and vicarious experience suggested that smoking during pregnancy was less harmful than doctors had predicted. Women use various strategies to resolve these conflicts. For example, several women focused on the healthy infants of fellow smokers as evidence that smoking would not be risky for them personally. Other women used their fear of harming their baby as a means of overcoming their craving to smoke. In either case, beliefs were made congruent with action, often in spite of scientific evidence. Barriers to quitting included: partner smoking, low assessment of personal susceptibility and interactions with smokers. **Conclusions:** 1.) Acceptance of a motherhood role was an important inducement for smoking cessation. 2.) The use of personal and familiar sources of information over the

opinions of professionals led women to feel invulnerable to the risks of smoking. Health education around smoking cessation during pregnancy should acknowledge these two findings by: 1.) Encouraging pregnant smokers to identify with motherhood, and 2.) Using immediate and individual examples of the effect of smoking rather than impersonal estimates of statistical risk.

CHAPTER I. INTRODUCTION

The study that will be discussed here examines the knowledge, attitudes, and behavior of pregnant African American women around smoking during pregnancy. Specifically, this study will attempt to illustrate how African American women conceptualize quitting during pregnancy. This goal can be expressed as a series of research questions.

- What risks and/or benefits do African American women attach to smoking?
- What risks and/or benefits do these women attach to smoking during pregnancy?
- What is the perceived attitude of the family and friends of these women toward their smoking, particularly during pregnancy?
- What perceived barriers exist to quitting?

Most of these questions are derived from social cognitive theories of health behavior. Many models exist within this category, but most include several basic factors as determinants of preventive action: perceived risks, perceived benefits, barriers to action, perceived susceptibility, self-efficacy, normative beliefs (approval of close contacts), attitudes toward the behavior, and motivation. The research questions in this study are essentially tests of the role these factors play in the decision to quit or continue smoking in the lives of the participants.

The reason I chose to structure this study around these particular health behavior models is that they are the basis of most public health interventions and policy around prenatal health risks. African American women, both because of poor birth outcomes and because of persistent poverty, are the targets of much of this policy. Yet, while interventions for pregnant smokers based on these models have been evaluated for effectiveness, these models have rarely been tested against the decision-making processes of the pregnant smokers, particularly African Americans.

Moreover, even if the models are correct in their structure, the specific risks, benefits, norms, and attitudes that are relevant in this population have been assumed

rather than investigated by researchers and policy makers. In similar studies of other populations, striking differences have been found in the way laymen and practitioners think about these factors. For example, one qualitative study of teenage girls found that they believed that smoking caused easier deliveries because it made babies smaller (Lawson, 1994). They considered this to be a benefit of smoking during pregnancy. A practitioner that views small babies as a problem is not likely to consider this benefit in designing interventions and therefore could not correct this belief or combat it with appropriate re-education. The larger goal of this study is to begin to characterize how African-American women think about smoking during pregnancy, so that the policies we develop will incorporate the voices of those they are intended to help.

A. Why African American smokers?

Perinatal mortality and morbidity is a huge problem within the African American population. Researchers have searched for some explanation of the gap between the health of white and African American infants with marginal success. Poverty, nutrition, lack of prenatal care and dozens of other potential culprits have been named but none explains very much of the variability in outcomes. Smoking, while no closer to being a total explanation than any other factor, draws particular attention because it offers the seductive possibility of primary prevention.

The data suggest that the potential for prevention is even greater for African American women for several reasons: 1.) Smoking causes premature birth and low-birthweight, which are both disproportionately high in African American births; 2.) Smoking cessation rates during pregnancy are poor for all women, including African American women; 3.) While smoking rates are lower among young African American women than white women, smoking rates are high among older African American women who have a higher birth rate than their white counterparts. These demographic

differences and more detailed discussion of the perinatal health effects of smoking are discussed further below.

B. Smoking as a Perinatal Risk Factor

Cigarette smoking is considered the leading cause of preventable mortality in newborns in the United States. These deaths, and the morbidity found in less affected infants, is mediated mainly through the negative effect of cigarettes on birth weight. For roughly 30 years doctors have had evidence that women who smoke during pregnancy have infants of smaller than average birth weight. In a large study done in Missouri during the mid-80's this decrease was quantified to an average decrement of 200 grams, shifting the normal curve of birth weight to the left (Wilcox, 1993).

This decrease in birth weight means that more infants of smokers are born with low-birth weight (LBW) or very low-birth weight (<2500g and <1500g respectively), conditions linked to increased mortality and morbidity (Wilcox, 1993). The Missouri data also showed that the infants of smokers had an increased risk of preterm delivery (which accounts for some, but not all, of the decrease in average birth weight), and an increase in perinatal mortality even at normal birth weights (Wilcox, 1993).

The Census Bureau reports that 7.6 percent of the infants born in 1994 had low-birth weight (Census, 1997). The contribution of smoking to this number can be seen when smokers and non-smokers are considered separately. The incidence of LBW births is clearly higher for smokers at 12.3 percent, versus only 6.7 percent in non-smokers. Race also plays a part here. While only about 10.6 percent of white smokers gave birth to LBW infants, for African-Americans smokers, the rate is dramatically higher at 22.8 percent. The rate for African-American smokers over 40 years old reaches above 30 percent!

The racial difference in the incidence of LBW is not explained by differences in the incidence of smoking. White women smoke more often and more heavily than African American women, particularly among the young women most likely to be pregnant; 26.8 percent of white women 18-24 reported smoking in 1993, compared to only 8.2 percent of African American women in this age group (Census, 1997). Also, at least one study has found that a greater percentage of LBW births to white women could be attributed to smoking (30.7 percent) than LBW births to African American women (14.4 percent) (Barnett, 1995). However, the negative impact of smoking for African American women comes on top of already high rates of infant morbidity and mortality (for reasons not fully explained to date). For this group, any added morbidity is an additional burden on an already burdened community.

C. Smoking among Pregnant Women

The morbidity and mortality described above is completely preventable, theoretically, through the prevention of smoking among pregnant women. In 1992, over 788,000 U.S. women smoked during at least the first trimester of pregnancy, and 590,000 reported having smoked during the three days before delivery (Census, 1996). Births to these women constitute a significant percentage of births in this country: 14.6 percent in 1994 (Census, 1997). However, this is an aggregate. The rate varies greatly when demographic variables are considered in the analysis.

For example, education has a clear impact on the likelihood of smoking during pregnancy. For women with 9-11 years of education, the prevalence of smoking during pregnancy was 29.0 percent (Census, 1996). For women with 13-15 years of education, the rate was only 11.3 percent. The rate drops to 3.1 percent when women have 16 or more years of education. Race also seems to be important. The proportion of live births delivered to smokers is lower for African-American women than in general

for the U.S. (14.6 percent vs. 11.4 percent) (Census, 1997). African Americans also smoked less heavily during pregnancy than other American women, particularly white women who smoke the most of any group; 40.3 percent of pregnant white smokers smoked more than ten cigarettes per day, while only 21.7 percent of African-American women smoked this much (Census, 1996). These statistics are consistent with racial differences in smoking prevalence for all women (both pregnant and non-pregnant).

The number of women who smoke during pregnancy is even more disturbing when you consider that the majority of smoking women fail to quit when they become pregnant. Only 22.6 percent of pregnant smokers report quitting completely during pregnancy (LeClere, 1997). Most women it seems reduce their consumption rather than abstaining all together, a change reflected in the consumption profile. While 60.9 percent of women smoking before pregnancy smoke a half a pack of cigarettes or more per day, only 28.3 percent smoke this much after learning they were pregnant (LeClere, 1997). This shift occurs partially through an increase in the proportion of light smokers rather than purely through cessation. African American women, already more likely to be light smokers before pregnancy, show an across-the-board reduction rather than a shift; the proportion of smokers in all categories decreases as more pregnant African American women become non-smokers than do so generally (LeClere, 1997). However, African American women lag far behind Hispanic women in their rate of smoking cessation during pregnancy; the vast majority of Latinas stop smoking when they become pregnant (NIDA, 1992)

Despite the suggestion that pregnant smokers may be changing their behavior, the problem with smoking is not helped much by these spontaneous actions. Even with higher cessation rates among African American women, more than three-quarters of pregnant African American smokers continue to smoke during pregnancy. Also, even women who reduce or even stop smoking at some point during their pregnancy are likely

to relapse during the pregnancy (NIDA, 1992). The message from the statistics is this: a woman who enters pregnancy as a smoker is very likely to spend the next nine months as a smoker. If cessation is our goal, we are far from reaching it.

The dismal cessation rate for pregnant smokers has inspired the public health community to direct considerable effort to improve these numbers. These efforts have been moderately successful, increasing quit rates over controls, though never reaching a majority of the smokers a given sample. For example, some behavioral interventions have shown quit rates over 40 percent (Hartman, et al. 1996; Dollan-Mullen, et al. 1994), and as much as 50 percent above quit rates for controls (Kendrick 1996). More typically, however, studies using these informational counseling methods have achieved quit-rates from 0 to 15 percent above controls (Windsor, et al 1998). Other methodologies have been used, such as acupuncture and hypnosis, but they have shown no significant impact on quit-rates (Valbo & Eide 1996).

The failure of the majority of pregnant smokers to quit, even with the often costly help of professionals, highlights how difficult it is to achieve smoking cessation during pregnancy. The limited time period, physical dependence, and stressful life changes that are part of pregnancy make the difficulty easy to understand. However, a pregnant woman who continues to smoke risks the health of her child, something we must believe is not what most women want. Why does the balance between these opposing forces seem to tilt toward continued smoking rather than cessation? Beginning to answer that question, at least for African American women, is the goal of this study.

CHAPTER II. LITERATURE REVIEW

All human decisions occur within a context, a complex tangle of personal attitudes and social constructions that make one option look better than another, or even determine what options occur to us at all. This study seeks to describe the context within which pregnant smokers decide to quit or to continue smoking. The literature on this topic to date includes little direct examination of the experiences of pregnant smokers. For the most part, both descriptive and experimental studies have drawn on survey research and psychological theory to determine what variables to consider. There are two limitations to these approaches in understanding the *experiences* of pregnant smokers. First, surveys cannot account for any variable that was unknown to the researchers. Since the academics and practitioners who conduct such research are often socially distant from pregnant smokers, and from African American women as a whole, some part of the experience is likely to be unrecognized. Secondly, the cognitive and behavioral models being used are intentionally general in order to be broadly applicable, putting into question their relevance for this behavior.

Yet, beyond these two type of studies, very little research on the experience of smoking during pregnancy specifically. In order to hypothesize what those meanings might be, we must divide the experience of smoking into its component experiences for which research does exist: pregnancy, motherhood, and smoking. In this following sections we will look at each of these contextual elements on two levels, both a personal psychological perspective and the social constructions of each experience. Both the literature particular to pregnant smokers and that on these topics in general terms will be reviewed together.

Because this study focuses on African American women, all of the influences mentioned above are discussed both in terms of mainstream American culture, African

American urban culture, and the specific social and cultural position of African American women. The 'Isms' – racism, sexism, classism – serve as both external and internal organizers, directing how we are treated in society and also shaping how we evaluate our own thoughts and behaviors. The role of these 'isms' will be discussed in each of the spheres of influence, both in terms of the personal views of African American women and how society views these women in these areas.

All of these topics can, of course, only be considered to the extent that information exists that is specific to African American women. Since these women have not been a popular subject of study (at least beyond serving as examples of deviance) [Woolett and Phoenix, 1991], the treatment of the influence of race and racism will, unfortunately, be limited. However, like all women, African Americans are the subjects of influences in multiple areas. The general discussion of these forces is applicable to this group and can serve as a foundation for understanding the context within which African American women decide about smoking cessation during pregnancy.

To end this review, the general models of health behavior are described, using the Health Belief Model as an object for comparison. While this model and its fellows are not specific to smoking during pregnancy, they are used to address this health problem in practice. In the Discussion chapter, we will revisit this model as a comparison to the findings of this study.

A. The Influence of Pregnancy

Women have ample opportunity to decide their feelings about smoking and motherhood at any time. However, pregnancy makes both of these issues relevant at once. It forces the decision about smoking, whichever choice is made, to be made now rather than later. How pregnancy is viewed, if it is viewed as separate from issues of smoking or motherhood or integral to them, will ultimately determine the cessation

decision. In what ways then does pregnancy influence women? The most obvious are the physical changes that it causes, and the emotional transition that it demands as it creates a new person to be integrated into an existing lifestyle and family.

1. PERSONAL MEANING

Even the most eagerly anticipated pregnancy poses a challenge. A woman must accommodate often unpleasant changes in her body and anticipate unpredictable changes in her life. She must do both of these things at once and before an unavoidable deadline. Before we talk about how smoking relates to these changes, some background in what the emotional adjustment to pregnancy entails is necessary to inform our discussion of smoking in particular.

Regina Lederman (1984) outlines the emotional adjustment to pregnancy as consisting of three interrelated tasks, among others: 1.) acceptance of pregnancy, 2.) identification with a motherhood role, and 3.) establishing/revisiting the relationship with one's own mother. The pregnant woman, especially first time mothers, must create for herself a new identity. That process of creation is demanded both by society's expectations and her own need to accommodate the new behaviors and attitudes she will need to care for her child. Lederman (1984: 36-63) sees the creation of this new mother role as a process that usually involves modeling of oneself against some outside ideal, usually one's own mother. The relationship to her mother allows the pregnant woman to understand mothering from two perspectives, her memories of being mothered and her own mother's memories of mothering. Evidence for the importance of having both a mother model and a personal motherhood role was found in Lederman's study of labor progression; failure to complete any of the three tasks during pregnancy was related to prolonged labor at delivery.

What role do these challenges play in the decision to quit smoking? Some data suggest that how a woman feels about her pregnancy is related to her smoking behavior.

For example, Campbell & Reading (1982) found that women randomly assigned to see their ultrasound scans (rather than simply hearing the results) were more likely to reduce smoking and drinking during pregnancy. Campbell and Reading hypothesized that reduced anxiety or greater connection with the fetus encouraged action on the fetus' behalf.

This connection between the physical and emotional states of pregnant women has been shown to play an important role in other studies. Wolkind and colleagues (1981) collected data on British mothers' "wantedness" of pregnancy, physical symptoms, and psychosocial adjustment. They found that women who experienced nausea during their first trimester were significantly more likely to feel close to their own mothers, choose to breast feed, and even quit smoking (p. 83). The theoretical connection made by Wolkind between nausea and smoking cessation is that women who had nausea accepted their pregnancies and impending motherhood sooner than women who did not. This acceptance then motivated them to stop smoking during their pregnancy. While intriguing, this theory is somewhat weakened by the lack of direct data on the motivation for quitting recognized by the women in the study. It is equally possible that nausea made smoking unpalatable, or even that smoking during pregnancy caused nausea for some women. The causal direction in this sequence is unclear, but the link between the symptoms of pregnancy and smoking cessation has been tested in other ways that lend support to the Wolkind interpretation.

Other studies have found an even closer link between the physical experience of pregnancy and smoking cessation. In a qualitative study done in the United States, Pletsch & Johnson (1996) found that pregnant Latina smokers in focus groups talked about being nauseated by smoking or even the smell of cigarette smoke during their pregnancy. Women who wanted to smoke said that the nausea made them unable to do so. A similar finding comes from a study of pregnant smokers in the United Kingdom

(Haslam et al. 1997). Twelve percent of the 200 respondents in the British study mentioned nausea as a reason for giving up smoking. Whether this effect is widespread among pregnant smokers has not been established. Still, the possibility that pregnancy can change the physical relationship women have with cigarettes demonstrates how pregnancy can alter the lives of smoking women through many avenues.

Several studies have shown that the pregnancy history of women is also relevant to their feelings about smoking cessation. Pregnant smokers in one British study reported that their personal experience of delivering healthy babies, in spite of their smoking, made them feel that the dangers of smoking during pregnancy did not apply to them (Haslam et al. 1997). Latina women in the U.S. were found to have similar attitudes about their personal risk. Pletsch & Johnson (1996) reported that women in their focus group study doubted the risks based on the experiences of their friends or family. These findings suggest that personal pregnancy experiences and those of close contacts can act to counter fears about the risks of smoking.

The experience of being pregnant, such as the test one takes or the way one's body feels, can be a powerful influence on what women do about smoking. Similarly, personal or even vicarious experience with pregnancy outcome can impact what women believe about the need to stop smoking. Yet, the personal experience occurs in reference to the shared experience of pregnancy in a woman's environment and in our society. Next, we will examine this broader view of pregnancy.

2. SOCIAL CONSTRUCTION

On a social level, the American attitude toward pregnancy has been characterized by medicalization. The processes of gestation and birth now require professional investigation and management, and to go without medical care during pregnancy is to be deviant in some way. In this way, pregnancy can be seen as a sick role as defined by Talcott Parsons (1951). Within the sick role, the sick person is

allotted special privileges, such as freedom from work, but is also subject to unusual demands, such as medical procedures and restricted movement. The sick role serves to control the social disruption caused by illness and to limit the benefits of illness. This role may be even more restrictive for pregnant women in that they are asked to act in ways that are not directly beneficial to them the way medical treatment is for other sick persons. A pregnant woman, who may have no adverse symptoms, is expected to be under the care of a physician as a matter of necessity.

The attempts by the federal government to improve neonatal health are an example of how medical intervention, specifically prenatal care, has come to be seen as necessary to pregnancy. In their influential 1985 paper, *Preventing Low Birth Weight*, the Institute of Medicine cites early prenatal care as the key to infant health. Other variables such as poverty, nutrition, stress, or maternal health behavior have been shown in the literature to play in important influences on birth weight and neonatal health. Yet, these factors are subsumed under the heading of health education and social support to be delivered by medical practitioner. One could argue that other methods of dealing with such problems are available, but are ignored for cultural reasons.

Sheila Kitzinger (1992) argues that this medicalization process denigrates the mother in two ways. First, women in the U.S. internalize the technological emphasis of prenatal care to mean that they could not have a healthy baby without medical intervention, making the doctor rather than the mother the main actor in reproduction. Women in many cultures are considered especially vulnerable, but Kitzinger distinguishes the Western pattern by the type of risk it embraces. Rather than spiritual risk (of possession, of delivering a monster), pregnant women in the West are at statistical risk of developing medical conditions. This second risk, the chance of being in some predefined percentage of effected women is a risk which Kitzinger says is essentially unavoidable (Kitzinger, 1992). In the case of smoking, of course, this is not

completely true, but other risks, such as preeclampsia or breach delivery are bad outcomes that threaten all women with no means of primary prevention. This fact drives doctors to warn all patients of these problems even though most will not encounter them.

Secondly, Kitzinger notes that the preoccupation with the fetus in obstetrics also diminishes the importance of the mother. "Pregnancy is turned into a medical process in which the fetus is monitored, and its growth recorded and supervised. The woman who is bearing the child takes second place. In fact, she is an inconvenient obstacle to inspection of the fetus" (Kitzinger, 1992: 85). This is in contrast with the historical definition of the fetus as a not-quite human, and unformed thing visible only with its death as unformed tissue. Kitzinger sees this emphasis as part of the larger disregard for women during pregnancy that she sees in Western culture. Other authors have taken a less ideological view. E. Ann Kaplan (1992) relates the medicalization of pregnancy to a paradigm shift. The historic view that motherhood was natural and synonymous with womanhood was replaced by questions about women's roles in the last century. With this questioning came anxiety that pregnancy, previously thought natural and therefore automatic, was also not what it once seemed.

Kaplan (1992: 80) places the beginning of the fetus-as-central trend to a series of photographs by photographer Linnart Nilsson published by Life magazine in 1965. These photos used high-tech microscopes to chronicle development in the womb from zygote to fetus. The photos spawned a fashion in fetus-focused representations of pregnancy, where the mother is secondary or even absent from images of fetal life. The fetus, once given a face, became a character in its own right. As Kaplan puts it, "Suddenly, the foetus is the center of the narrative, the main protagonist, taking the place of the mother" (1992: 209-10). Kaplan calls this view the reproductive mother-discourse and contrasts it with older images of motherhood that centered on emotional

functions of motherhood. This fetal focus changes the function of the mother (at least during pregnancy) from emotional and nurturing, to that of a vessel and physical caretaker. "The mother is now asked to be responsible for (and subject to) her own foetus: the foetus now takes on a life of its own, with its own needs, demands and satisfactions" (Kaplan, 1992: 210).

As you can see, pregnancy and motherhood are inextricably linked. The representation of mothering engenders that of pregnancy, and the experience of pregnancy informs the practice of mothering. In fact, discussions of modern representations of mothering often center on reproduction and birth. Still, women do experience mothering beyond pregnancy and society does have expectations for mothers throughout their lives. The next section will examine these two levels of influence.

B. The Influence of Motherhood

Each pregnant woman has her own mothering history that includes multiple images of motherhood: herself as a 'mothered' child, as an imagined mother yet to be, and often, as a mother to other children in the present. Outside of that personal history, and interacting with it, is the surrounding cultural construction of motherhood, expanding outward from local customs to media representations.

What we know about the individual and public conceptions of motherhood is limited, particularly on the individual level. Little has been written about how women experience motherhood beyond a collection of autobiographical writings by mothers. These women, as academics and authors, do not necessarily represent a common experience of mothering. I will describe what women report as their own views about motherhood where such data exist.

There is also a dearth of information on the general public's image of motherhood. The bulk of writing on motherhood as a social construct come from

feminist critiques that suggest alternatives more than they describe what already exists. Presumably, the construct itself is so ingrained that simply describing it seems unnecessary to most academics. However, for our purposes, the representation itself is important. Women, to whatever degree, are influenced by society's expectations of mothers, not by what those expectations should be. First, we'll look briefly at the personal experience of mothering.

1. PERSONAL MEANING

The few studies examining women's feelings about motherhood suggest more variability in women's experiences and attitudes than one might expect. Woolett and Phoenix (1991) cite a British study of mothers of preschool children that shows this variability. Half of the women agreed that they enjoyed the tasks of childcare, but the other half found child care either stressful or a threat to their individuality. This second group was more likely to be middle than working classes. In light of this dissatisfaction, it's not surprising that a substantial minority found no sense of purpose in motherhood. Some women had congruent opinions, enjoying childcare and finding it rewarding, but many did not. Middle class women were more likely than working class women to experience a conflict between their feelings about child care and the meaning of motherhood (Woolett and Phoenix, 1991: 42).

A study of African American working mothers also found women in conflict. Harriet McAdoo (1991) asked African American single mothers about their coping strategies to reconcile mothering and work demands. McAdoo used an instrument that categorized coping strategies into three types: Type 1 - re-negotiating roles so that demands are made more reasonable (e.g. refusing to work overtime that conflicts with child care hours); Type 2 - redefining or eliminating roles (such a quitting a job, working at home, or getting child care help); Type 3 - attempting to meet all demands as they exist (found to be the most predictive of poor health). Previous research using the

instrument (cited by McAdoo: 157) had found that married mothers tended to use Type 2 strategies where single mothers used Type 3 strategies. Although both white women and African American women eliminated roles as a last resort, there were sharp differences. Where White women quit their jobs to concentrate on their children or husbands, African American women quit their marriages, sacrificing the wife role rather than fail their children or the jobs that keep their children fed.

In McAdoo's study, she applied this instrument to 318 African American single mothers working in Baltimore (McAdoo, 1992: 164). She found that these women were all under high levels of stress, but that those living in extended families had less stress than their solitary or cohabiting counterparts. Most women used the Type 3 strategy to cope with conflict between work and parenting, meaning that they tried to be everything for everyone. This wasn't, however, the strategy associated with the highest stress. For these African American women, the Type 2 strategy of eliminating or redefining roles was more stressful, e.g. leaving children with a grandparent or quitting work to go on welfare. This is contrary to research done on other groups, including the White middle class women from whom the instrument was developed (McAdoo, 1991). One could theorize that White middle class women found this an easier option to use because they had a better safety net. For them, redefining their roles may not involve depending on family or the government for support, but husbands or their own work income.

2. SOCIAL CONSTRUCTION

From this small glimpse into what individual women feel about motherhood, we turn to the culture of motherhood that helps to shape those feelings. What does society expect of mothers? There are two approaches to answering this question. One is to examine what professionals say to each other and to women about how to mother. Woollett and Phoenix (1991) discuss how psychology has shaped and been shaped by how our culture regards mothers. They begin by describing the 'normal' mother. Normal

mothering, synonymous with ideal or good mothering, involves mature, informed, sensitive, patient, and constant care for a child. Sensitivity and child-centeredness in mothering are the characteristics posed by psychology as the key to healthy child development (Woolett and Phoenix, 1991) . Attachment theory, mother-child bonding and authoritative parenting (negotiating with children) are all psychological tenets that embrace this idea. The ability to be sensitive is portrayed as natural and instinctive and yet at once is treated as if behaving sensitively requires skill and education (Woolett and Phoenix, 1991). This education is offered by doctors and psychologist through parenting manuals (a genre that should not exist if we truly believe in such a thing as 'maternal instinct'). Interestingly, these manuals take a traditional view of motherhood that takes the definition of the good mother described above to the extreme. While these manuals are intended to be used by real women, the mothers in the books are assumed to be married, without jobs, and with enough money to buy specialized toys or time to teach their child (Marshall, 1991). These books also implicitly or explicitly deny any personal goals of the mother that might conflict with those of the child (Marshall, 1991), reinforcing the idea that mothering involves instinctive sensitivity to the needs of the child, and that these needs supersede all others.

E. Ann Kaplan (1992) takes a different approach to illustrating the representation of motherhood. Kaplan uses ads and films to look directly at the image of mothers and argues that the representation of mothers today is complex and changing. The traditional American picture of mothers as domestic and nurturing gave way in the 1980's to succession of 'new mothers'. Kaplan shows a series of Mother's Day advertisements that show the transition of gift suggestions from blenders to nightgowns to VCRs, and the implied transition of mothers from rulers of the kitchen to sexy young women to androgynous consumers (185). Along with this transition came a series of critical discourses on the changing character of motherhood. The move of

women into the work force was translated by the media into the 'absent mother' (exemplified by the self-absorbed Meryl Streep in *Kramer vs. Kramer*) who was replaced by the 'nurturing father' (recall the series of single father sitcoms in the mid-80's) (Kaplan, 1992).

Kaplan goes on to show how the 'absent mother' image pervaded discussions of working mothers, child care, and child abuse by women that were fashionable news stories in that period and today. It is as if when the mother left the home she brought into question all of the virtues that had been assigned to her there; nurturing became neglect, sensitivity gave way to abuse, selflessness to ambition. Kaplan sees a transition in the mid-80's back to the nurturing mother image. However, rather than a given or a duty, motherhood is a deliberate act of self-fulfillment. This 'self-fulfilled mother' (e.g. *Baby Boom, thirtysomething*) demonstrates that mothering is the only satisfying thing women can do and to be unable to mother is a tragedy (Kaplan, 1992). This trend noted by Kaplan seven years ago seems more in evidence today. Anyone watching a talk-show or reading a popular magazine recently could not avoid noticing women proudly proclaim their status as "stay-at-home-moms", something that would not have been done ten years ago, or necessary in the historical atmosphere of maternal duty that Kaplan describes.

To whom do these images of motherhood apply or refer? Although there is no identity assigned to 'mother' beyond her function and behavior, these are not universal representations. Ann Kaplan prefaces her discussion of mother representations of the 1980's with a qualifier that explains this false generalization: "Not accidentally, most of these discourses either address the white middle class or assume that speaking position when representing other classes and races" (1992: 184). What does this default position of the white middle class say about how African American mothers are viewed by the media and the public?

Phoenix and Woollett (1991) believe that the definition of good mothering is so narrow that those who fall outside of it for practical or cultural reasons (the working poor, single mothers, teenagers, the uneducated) are necessarily deemed to be deviant. Many African American mothers fall into one or all of these deviant groups. Psychological theories have used studies of White middle-class women to define the process of mothering. Therefore, the traits particular to this group have come to stand for normal, while the habits of other groups are consequently defined as abnormal (Phoenix and Woollett, 1991). This bit of circular logic may result from society's narrow definition of good mothering, but it also reinforces it. Phoenix and Woollett explain the reasons for this bias toward white middle-class women as images of normality: "This omission [of Black and working class mothers from research on mothering] has been partly deliberate because it is considered that the marginal, devalued status of black people and sections of the working classes makes it unlikely that they will illuminate processes of normal development" (1991: 21). A reverse of this bias is the use of poor and African American women as subjects in studies of abnormal mothering (Phoenix and Woollett, 1991). The fact that evidence of the impact of poor mothering are most often based on the behavior of African American and poor white women lends support to the popular bias that these women are what Phoenix and Woollett call "pathological mothers" (1991: 21).

In the U.S., the 'pathology' attributed to African American mothers stems from an amalgamation of classist and racist misconceptions. The image of the African American mother is imbued with negative stereotypes of the poor, women, single mothers, and African Americans in general. This is particularly true for African American single mothers, the most common status for African American mothers today. Shirley Geiger described the misconceptions around welfare that demonstrate this complex entanglement:

For example: that most poor people are on welfare, that AFDC mothers have more children to collect greater benefits, that AFDC is draining the national treasury, that Black welfare dependency is transmitted intergenerationally, that most single-mothers are Black, that most welfare recipients are Black, and that fraud and cheating are rampant among welfare recipients. (1995: 248)

These misconceptions are perpetuated through public discourse, legislation, and entertainment in spite of their inaccuracy; the majority of single mothers and Welfare recipients are White (as seems reasonable in a country where Whites are the majority); Welfare expenditures are a fraction of the expenditures on other programs like Social Security (5% in 1984) and fraud is rare; African American children raised by Welfare recipients are no more likely than other children to become adult recipients themselves (Geiger, 1995). Yet, these ideas continue to dominate the public image of African American mothers.

In addition to these negative images, African American women are also burdened with socio-economic disadvantages not faced by women in the mainstream. African American mothers are more likely to be unmarried than married; over 68 percent of African American women who gave birth in 1992 were unmarried (NCHS, 1995). Their families are poorer than White single mothers' families, and poorer than families that include a man (whether he be White or African American) (Simms, 1986). Whatever the source of this increased disadvantage, the fact that African American women as a group are affected most harshly suggests that both gender and race play some role. African American women approaching motherhood are invited by society to measure their own behavior against this standard. How that invitation is taken and what impact it has on the choices women make are unknown, but presumably this standard is a potential factor for at least some women. Whatever the particulars of their real lives, we have seen above that women are bombarded by images of motherhood that constrain mothers while they celebrate motherhood, exalt nature while they seek to improve upon it, and

place responsibility and blame for the lives of children almost exclusively with their mothers.

C. The Influence of Smoking

Smoking has become an increasingly unpopular habit over the last twenty years. Per capita cigarette consumption peaked in the late seventies and has dropped dramatically since then, perhaps due to increased awareness of their dangers (Viscusi, 1992). In California, the proportion of smokers in the population was 21.2 percent in 1990, less than the 27.3 percent national average (UCSD, 1990). It could be said that smokers are a smaller population in California than most other states, yet the number of smokers in this state is greater than the number of African Americans. Why do so many people smoke? This question is an important one to answer if we are to understand how and why women decide about smoking cessation during pregnancy. There seem to be obvious reasons not to smoke in the health consequences alone. Add to that the unpopularity of the practice, particularly in California where smokers have been a perpetual target of regulation and taxation, and there seems to be little reason not to quit. Yet many people don't quit, including 77.4 percent of pregnant women according to national statistics (LeClere, 1997).

The central question of this study is how women decide whether or not to quit smoking during pregnancy. Clearly, to answer that question we must first understand what the consequences of smoking or quitting are for smokers, both the personal consequences and the social or environmental consequences. In other words, what meaning does smoking and the identity as a smoker play in the lives of women. From that we can perhaps extrapolate what outcome women might expect when deciding to quit.

1. PERSONAL MEANING

Most of us, whether or not we've ever smoked, can probably imagine some of the difficulties in quitting cigarettes. No matter how much we think smokers *should* quit, especially pregnant women, we don't assume that to do so is a casual act. Our culture's long experience with addiction tells us that, beyond the loss of the 'drug high' (if there is a 'high' in smoking), not taking something you are addicted to causes a painful longing and even suffering. Trying to avoid such a state is understandable if not defensible; we *accept* the fact that quitting is difficult even when we don't *excuse* people for failing to quit. For that reason, this chapter will not review the physiologic barriers to quitting, but instead consider the personal meaning and function of smoking in the lives of smokers.

Most non-smokers do not understand the attraction of smoking. There seems to be no euphoria as there is with other addictive drugs. So what then could justify the risk? David Krogh (1991) gives an enlightening explanation of the reasons smokers smoke in his book *Smoking: The Artificial Passion*. Krogh traces the desire to smoke not simply to addiction (which punishes for *not* smoking), but to the pharmacological effect of nicotine and even further to the smoking lifestyle. Nicotine acts as both a mild stimulant and a mild depressant; an effect that gives smokers an emotional steady-state that is neither euphoric nor sedate. Krogh equates the preference for this state to the choice of one beer over a six pack. Cigarettes can then be envisioned as a portable, convenient, readily available package for a mild tranquilizer. No equivalent product is available in our marketplace. Add to this the habituation to the behavior of smoking (holding a cigarette, the feeling of smoke in the throat) and quitting becomes a foray into unfamiliar territory where at every moment something is missing.

Sherwin Feinhandler (1986) has described other personal uses for cigarettes as ordering functions, based on observations of smokers. These include all the ways in which smoking a cigarette acts as a marker of time and events. The amount of time it

takes to smoke a cigarette is both a unit of time, a time filler, and an excuse to break from other activities. Cigarette breaks, particularly as they are separated by the craving to smoke, mark the beginning and ending of events. Finally, cigarettes focus attention through pharmacological effect and by occupying the hands (like doodling or tapping a pen). Feinhandler also developed two other categories of smoking function, personal functions and social functions. The personal functions are the pharmacological and psychological effects that Krogh describes, as well as a form of self-presentation or style. The social functions will be discussed in the next section.

There is evidence that smoking serves these multiple functions for pregnant smokers. In their study of pregnant Latina smokers, Pletsch and Johnson (1996) found that relaxation and stress reduction were important uses of cigarettes for the women they studied. A qualitative study of teenagers (Lawson, 1994) reports that one group of teenager women used smoking to reduce weight (including postpartum weight) and to decrease pain in labor (by reducing infant birth weight). Whatever the personal function of smoking for any individual woman, smoking is a social activity and has social rewards and costs.

2. SOCIAL CONSTRUCTION

The social meaning of smoking has two levels: the way in which smoking acts as a social organizer and the attitude of society toward smokers. Smoking serves to ease the social relations of smokers in many ways. Feinhandler (1986) observed five distinct examples of this function. First, smoking breaks down barriers between stranger; smokers can join groups of other smokers without awkwardness. Smoking also serves to exclude non-smokers from groups where smokers predominate. This may be especially true as smoking becomes less socially acceptable. In a similar vein, smoking serves as a badge of membership (and non-membership in some subcultures). The exchange of cigarettes between smokers creates a web of debt and favors that establishes the links of

trust that define a community. Pregnant women have been shown to use cigarettes in these socially beneficial ways in various studies (Pletsch & Johnson, 1996; Lawson, 1994).

In addition to these social benefits, smoking also exacts social costs. Once a social norm, cigarette smoking has become socially unacceptable in much of mainstream American culture. The changes began with legislation restricting smoking which began to appear in the 1980's (Tollison, 1986). Cities and now even states have severely limited the public or private space where smoking is allowed. These restrictions have been coupled with increased financial penalties to cigarette users (through taxes) and manufacturers (through litigation). Some analysts have tied this public disapproval to actions of a vocal minority they call the anti-smoking movement and equate it to other ideological movements in its emotional tone (Tollison, 1986). Whatever the source, public opinion and the public policy have created an environment where it is difficult and costly to smoke.

The changes in the government tobacco policy have mirrored and sometimes trailed public feelings about cigarettes. Polls and referendums (especially in California) suggest that these feelings are negative and unsympathetic. One poll, a phone survey that asked smokers and non-smokers to free associate about smoking, showed that 55 percent of non-smokers volunteered that they thought smoking was annoying (Viscusi, 1992: 49-50). This was a greater percentage than mentioned that smoking caused lung cancer (18.4 percent). Surprisingly, smokers too seem to be unhappy with smokers; 15.7 percent of smokers also mentioned that smoking was annoying.

The extent to which this objection to smokers extends to pregnant smokers is as yet not quantified, but can be extrapolated from other data. A 1981 Gallup poll showed that 64 percent of non-smokers agreed that smoking caused birth defects (compared to 34 percent of smokers) (Viscusi, 1992: 50). A similar question was asked

of women in California in 1991 (UCSD, 1991: 33). Seventy-eight percent of women agreed that smoking when pregnant would harm the baby. This number jumps to eighty-six percent when only African American women are considered, 100 percent for African American women pregnant in the last five years! In light of this level of awareness, we can presume that pregnant women might perceive some public censure, even if no objections were voiced. Both pregnant and non-pregnant smokers seem to pay social costs for smoking and to lose social benefits by quitting; there is no choice available to pregnant women deciding about smoking cessation that does not impose some attendant penalty.

The list of personal and environmental influences on pregnant smokers could easily be expanded beyond those mentioned here: pregnancy, motherhood, and smoking (e.g. general attitudes toward health, access to health services, extended family relations), but these three serve as sufficient foundation. Now that we have an idea of what the influences on pregnant smokers might be, we will examine the relationship those influences are thought to have on the decision to quit.

D. The Health Belief Model

Most smoking cessation programs and research studies for pregnant women use education as the primary intervention (Windsor et al., 1998). The dependence on education to change behavior, as opposed to pharmacological or even political solutions, can be traced back to the 1950's when the U.S. Public Health Service developed the Health Belief Model (HBM) (Strecher & Rosenstock, 1997). The model was based on psychological theories about cognition and learning that were flourishing at the time.

These theories (and the HBM) portray behavior as the result of thought and desires, placing the causes of action almost completely within the mind of the actor. In the HBM this assumption places the perception of threat and the perception of net

benefit as the final determinants of change (Strecher & Rosenstock, 1997). These perceptions are influenced by modifying factors, such as socioeconomic status, knowledge, physical symptoms or media information (Figure 2.1; Strecher & Rosenstock, 1997). Regardless of the number or variety of additional factors, the central concern of the Health Belief Model is *belief*, the conscious perception of reality. Attempts to change behavior based on the HBM have been attempts to modify belief, to make people believe the thing that would lead them to change. In smoking cessation interventions, the correct belief that pregnant women are thought to need is a belief in the harmful effects of smoking on the fetus. Pamphlets, counseling, and public service announcements all strive to instill this belief.

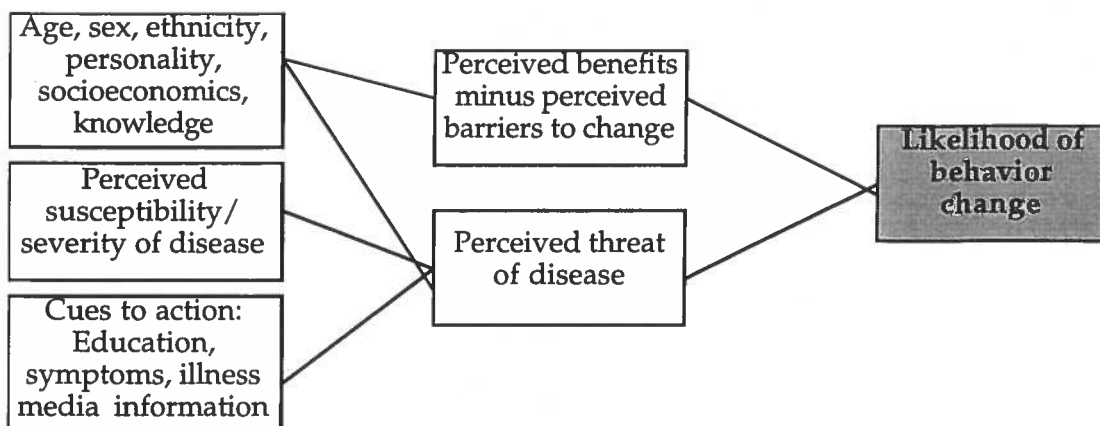


Figure 2.1 Modified from Strecher and Rosenstock (1997: 48).

The HBM has been evaluated many times since its development. In 1984, a review of prospective studies of the HBM constructs found support for the model (Strecher & Rosenstock, 1997). The HBM construct of perceived barriers was the most predictive of preventive health behavior and health maintenance behavior (often called sick-role behavior or compliance). Perceived susceptibility was mainly predictive of preventive behavior, while perceived benefits were predicted health maintenance behaviors more strongly. Perceived severity was the least useful predictor.

With these constructs in mind, let's turn again to the influences on pregnant smokers: pregnancy, smoking, and motherhood. Since these factors are not explicitly considered in interventions, no model is available of how these particular influences would be operationalized within the HBM. The reason for that omission may be that these influences lie one step outside the scope of the HBM; they are influences on the influences recognized in the model. For example, the physical symptoms of pregnancy may be a 'cue to action' within the HBM. However, a pregnant woman's relationship with her mother doesn't fit quite so easily. It isn't exactly a cue or a perception about the risks, benefits, or threat of smoking during pregnancy. It could be said to relate to how those perceptions are framed. Benefits to the baby might only be important as far as a woman had desired to be pregnant. The personal and social influence of motherhood is an even further stretch. Do women who see themselves as normal mothers hold different beliefs about smoking and pregnancy? Perhaps the socioeconomic factors that underlie this social expectation, such as not working or being married, could be called structural variables and therefore modifiers of the perception of threat. The simplest connection may be between the symptoms of smoking withdrawal and perceived barriers to change.

As you can see, there is some continuity and discontinuity between the HBM (and other general theories of preventive health action) and the contexts of this specific behavior, smoking cessation during pregnancy. The way in which these influences act and interact in the lives of African American pregnant smokers is the central concern of this study, regardless of whether they can be framed within any given model. However, since health education as it is practice presumes that such a fit can be made, the findings chapter (IV) will revisit this comparison.

CHAPTER III. METHODS

The purpose of this study was not to test or describe the experiences of African American pregnant smokers, but to generate theory about motivation behind smoking behavior during pregnancy. In generating theory, according to Glaser and Strauss (1967: 30), the purpose is not to "provide a perfect description of an area, but to develop a theory that accounts for much of the relevant behavior." Past research and logic suggest the most important influences on behavior are attitudes, beliefs, behaviors and lifestyle. Qualitative methods were chosen as the best tool for obtaining such subjective data as these methods allow the subjects to direct the focus of the data collection.

Other studies using qualitative methodology to study pregnant smokers have found that the way some populations of pregnant women, such as urban teenagers or Latinas, conceptualize smoking in ways that have not been explored by quantitative research and are not intuitive for those outside of these groups (Pletsch & Johnson 1996, Lawson 1996). As a marginalized group, urban African American women might be expected to have a similarly unique perspective. The uniqueness of this perspective is a second reason why qualitative rather than quantitative methods were preferable. Any quantitative study of this group, simply by the nature of the closed-ended questions used, would necessarily include some assumptions about the relevant influences on behavior. These assumptions could only be derived from extrapolations of past research, which has used primarily White middle class respondents (Haslam, 1997; Wolkind, 1981).

Individual interviews were selected as the methodology because of the stigmatized nature of the behavior. Smoking during pregnancy is portrayed in the media and health education campaigns as dangerous and irresponsible maternal behavior. Women who are unsuccessful their attempt to quit might feel stigmatized even in a group of women who considered themselves to be pregnant smokers. Without this element of

comparison, women might be more forthcoming about their behavior and their own perception of normal behavior for pregnant women.

A. Sample

Six pregnant African American women between the ages of 18 and 43 were interviewed for the study. The average pregnancy length was 20 weeks, with most women being in the 1st or 2nd trimester and three of the women were primiparas. However, all of the women had had one or more past pregnancies (ending in abortion for the primiparas). Four women were in a relationship with the father of their child at the time of the interview (one of these being a marriage). The other two women had separated from their partners before learning they were pregnant.

All of the women were residence of Oakland, California, a large city in the San Francisco Bay Area. All six of the women were unemployed (only one by choice due to obstetric complications) and all but one received public assistance. Two of the women had some college education, two were still in high school, and two had not completed. The individual profiles of the women, at the end of this chapter, have been edited to remove identifying information (the names are fictitious).

B. Procedures

Six pregnant African American women were interviewed individually about their attitudes, knowledge, and beliefs about smoking during pregnancy. The women were recruited through flyers placed in economically depressed areas of Oakland, which are also areas with high concentrations of African American residents. Flyers were placed in and outside of businesses and near a community health center. Women interested in the study called a phone number and were screened over the telephone. The inclusion criteria called for African American women over 18 years of age whom were currently

pregnant and had been regular smokers immediately before and during at least part of their pregnancy. All of the women who called to be interviewed fit this criteria, and no interested women were excluded.

The interviews were conducted by the researcher in a quiet and private location chosen by the subject and ranged from 60-90 minutes in length. Most interviews took place in the subject's home, and all initial meetings occurred in homes. Before the interview began, each respondent was given ten dollars in compensation as stated in the recruitment flyer. The researcher then verbally explained the objective of the study, the confidentiality of the responses and asked the respondent to read and sign a statement of consent. The University of California at Berkeley Committee for Protection of Human Subjects approved the consent form and research protocol before any interviews were conducted.

The interviews were semi-structured using a schedule of open-ended questions. The schedule was expanded between interviews to include emerging themes that appeared in the on-going analysis of previous interviews. The interviews were recorded and later transcribed by either the interviewer or a professional. The transcripts were then compared to the audiotapes for accuracy. When a professional transcriptionist was used, sections of dialogue were deemed indecipherable, usually due to dialectical differences. These sections were later transcribed by the interviewer based on the recordings and familiarity with the speech pattern.

The transcripts and audiotapes were stored in a University locker during data collection and at the home of the researcher during analysis. Disk copies of the transcripts will be saved for future analysis with all identifiers removed.

C. Analysis

Grounded theory, as defined by Glaser and Strauss (1967), was used to analyze the transcribed interviews. Glaser and Strauss characterized the process of theory generation as one of comparative analysis. In this case the units of comparison concepts

or conceptual categories which are generated from the data. Ideas, attitudes, or behaviors all imply or support conceptual explanations for their existence or interrelation. These concepts are labeled as categories and then these categories are compared within and across individuals. Comparisons generated unifying theories that offering explanations for the patterns of thought or behavior that were discovered, or grounded, in the data. In the case of this study, the transcribed interviews were the data which generated the categories and theories.

The transcripts were coded as suggested by Lofland and Lofland (1995). Each section of dialogue in a given transcript was reviewed by the researcher and assigned one or more codes for the concepts it implied. Multiple codes were used on items whenever appropriate to enrich the diversity of theories being tested and to account for relationships between concepts. For example, a description of an encounter with a physician about smoking might be coded as 'warning by doctor about smoking', 'social censure for smoking', and 'information about risks'. When similar topics were discussed across interviews, these sections received similar codes. Categories were collapsed, eliminated, or subdivided over the course of analysis as theories emerged which organized the data more cleanly.

Interviews were analyzed initially as they were completed so earlier interviews had usually been transcribed and coded before the next interview was done. When multiple interviews had been coded, the codes were re-evaluated for patterns and broad meaning. These relationships and implications were labeled theoretical memos and were noted on a coding sheet with the codes to which they referred. These memos were assessed for occurrence in multiple interviews and for their relationship to other patterns in the data. Memos ranged from brief notes to lengthy considerations of the core influences, key actors, and cognitive processes contained in the data. From these memos and the relationships between them, theory was developed about the content and structure of women's conception of smoking during pregnancy within the contexts of

their lives.

D. Demographic Profile of Oakland, California

The section presents a brief demographic and socio-economic sketch of Oakland, California, the site of this study. However, relevant statistics are only available at the city, county or even state level, which makes them imperfect descriptors of a single community, specifically low-income African American women in Oakland. In light of those limitations, the data given here should be taken as a rough picture of the population from which this sample was drawn.

The general characteristics of Oakland as a municipality show it to be a medium sized city of roughly 400,000 people. Nearly one in five residents of Oakland were living in poverty in 1989, and 43 percent of the residents are African American, two of the characteristics of the sample taken for this study (Horner 1998). Roughly 20 percent of the births in Alameda county (of which Oakland is the largest city) are to African Americans (CDHS 1996). Among those births to African Americans, 64.8 percent are to unmarried women and the majority (85.3 percent) of pregnant African Americans seek prenatal care in the first trimester of pregnancy. The incidence of infant morbidity in the county is similar to national levels; ten percent of births are preterm and 7.5 percent are low birth weight.

The level of smoking in the county was measured in 1990 to be 22 percent, 17 percent if only daily smokers are considered (UCSD, 1990). The prevalence was slightly higher for African American women across the state who had a 26 percent smoking rate. Whether this increased prevalence extends to African Americans in Oakland is unknown. Among California smokers, 38.8 percent had attempted to quit in the last year. Forty-two percent of smokers were advised to quit smoking by their doctor in the last year. Specific data on pregnant women were not available at the city or county level.

E. Personal Profiles of the Respondents

The six women interviewed were similar in many ways: they all were smokers, pregnant,

low-income, African American, residents of Oakland. However, they differed in many ways as well. Two of the women were older with several children, while the other women were very young and had one child or no children at all. For the most part, these women lived in large extended families, though only one could be considered traditional in its members; most included boyfriends, distant relatives, and friends as much as grandmothers or cousins. The following descriptions are clearly not exhaustive analyses, but rather simple sketches of distinguishing characteristics. The traits mentioned are those that were most important to the woman described and dominated her discussions of herself during the interview.

1. **ANGELA:** Angela is a stoic 43 year-old mother of four adult children. She was eight weeks pregnant with her fifth child at the time of the interview, nearly 20 years after the birth of her last child. Angela was tentatively resigned to her pregnancy, but was still shocked that she could have become pregnant after so many years. She was also a little unsettled by the fact that her granddaughter would have a younger uncle or aunt. Angela has never held a job consistently, though she has had incomplete training in various fields from cooking to cosmetology. Angela's life is currently dominated by practical concerns such as finding a home outside of her uncle's small apartment. She has never lived outside of Oakland, California where she was born.

2. **BRANDY:** Brandy is 25 years old and recently married to a 40 year-old man with grown children of his own. Brandy is overjoyed to be pregnant after losing another pregnancy one year ago. She had surgery early in this pregnancy to correct the weak cervix that was discovered because of this miscarriage (she was 12 weeks pregnant at the time of the interview). Brandy was advised to leave her job as a certified nursing assistant and restrict her activities to avoid a second miscarriage. Brandy's main goal in life is to be a wife and mother. To that end, she was preoccupied with concerns about

finding a home for her new family outside of her father-in-law's apartment.

3. **CHANTELLE:** Chantelle is an 18 year-old high school senior pregnant for the second time in two year by her long time boyfriend. This pregnancy, while unexpected, is eagerly awaited by both Chantelle and her boyfriend. Chantelle aborted the first pregnancy because of conflicts with her boyfriend over his alcohol use. With this pregnancy (ten weeks along at the time of the interview) Chantelle's boyfriend has gotten a well-paying job and is very supportive. Chantelle's mother is also very supportive though Chantelle is not living with her. Chantelle has lived with various members of her large extended family since her mother lost her home a year ago. Chantelle plans to move in with her mother when the baby is born if her mother's public housing application has been accepted by then.

4. **DIONNE:** Dionne has had six children in her 41 years and was only a few weeks away from delivering a seventh when she was interviewed. Dionne has also lost a husband and two children, the most recent a five year-old son killed over a year ago. Dionne considers this pregnancy a comfort for her grief and even considered naming this child after her dead son. Most of Dionne's other children are teenagers or young adults. She spent much of their childhood as a heroine addict, only beginning methadone treatment in recent years. Dionne's boyfriend and children live with her eldest daughter who supports the family. Dionne herself does not work and did not finish high school.

5. **ERICA:** Erica is the 25 year-old mother of a small son and was six months pregnant at the time of the interview. She is single and has had no support from the fathers of either of her children. Erica moved to Oakland to be near family members during this pregnancy. Erica is not happy to be pregnant as she sees it as a step backward in her efforts to become self-sufficient. Erica had finished most of the class-work needed for

her Bachelor's degree on an extended course because of the demands of raising her son. Erica was on public assistance while in college and had just begun to look for work when she became pregnant. She had long-term plans for her life and was struggling to integrate the pregnancy into this plan.

6. **FATIMA:** Fatima is 18 and committed to creating a family with her boyfriend and her coming child. Though she was only in her fourth month of pregnancy at the time of the interview, Fatima had already picked out names for her child. Fatima's main concerns were her child and her boyfriend. She had no close connections to friends or relatives. Fatima was raised by relatives off and on due to her mother's cocaine addiction. She had no stable home during her childhood or at present. Fatima saw her problems with violence and school (she had briefly dropped out of high school) as stemming from this instability.

These outlines of individual personalities will be enriched in the Findings chapter by the voices of the women themselves. These profiles may serve to help coalesce the disparate comments into the complex attitudes and lifestyles that the quotes are intended to represent.

Chapter V. FINDINGS

The central objective of this study was to explore the experience of African American women smoking during pregnancy. Experience is necessarily personal and relating it can be a reflection of the self. That was the case in this study. The themes that emerged from the analysis relate the experience of being a pregnant smoker as a redefinition of self. Accommodating pregnancy into the lives of these women required the coexistence of several 'selves'; the pregnant smoker is at once a woman (and a smoker), a temporary home for another human being, and a mother (even before she has given birth). This chapter will describe the experiences of these pregnant smokers within the context of these identities: the self as a pregnant body, the self as a smoker, and the self as a mother. First, the issue of whether to quit or to smoke is examined in relation to the pregnant self, the state of living in part for another person, is experienced by these smokers. The second topic will be the ways in which women continue to live as smokers while pregnant, both maintaining and modifying this part of their lifestyle in response to their pregnancy. Third, example will be given of women discussing both themselves as mothers and motherhood in general. Within these three sections lies the story of how these women reconcile the three identities of smoker, mother, and pregnant woman in the face of societal and often personal objections to their coexistence.

A. The Self as a Pregnant Body

All of the women in the study expressed some concern that smoking could harm their baby. Some had gotten specific warnings from doctors or family members. Others had seen information in the media or in the news. All of the women could point to a source of knowledge that told them that smoking could injure their baby in some way. However, each woman had a different idea of what that injury would entail and of the risk that such an injury would occur. Some predicted *severe* but *unlikely* outcomes, while others thought that less dramatic but certain injuries would occur. First, I will discuss

the *kind* of risk that women thought they were taking by smoking; what exactly they thought cigarettes could do to their baby. The next section will illustrate the *level* of risk women saw in smoking.

1. OUTCOME EXPECTATIONS

Each woman was asked, or volunteered, what effect she thought smoking could have on unborn babies. The responses ranged from visible defects to invisible functional problems. For example, several women thought smoking caused malformations in the infant. These women painted inaccurate, and sometimes very graphic, portraits of the physical deformities their child could acquire. The risk of deformity was the most emphasized risk in their discussion. In fact, Angela, a very stoic older woman with several children, listed no other risk of smoking.

Yeah, cause I know there could be a possibility that something could be wrong with it. But...I'm just gonna hafta try and see what I can do. [*What kind of things have you heard about it?*] That your baby can be deformed. [*Where did you hear that?*] On the news. In the paper.

Chantelle, an 18 year-old high school student, also points to the media as the source of her concern about deformity; she tells a very specific and frightening story of being convinced to quit by a television show. The story of a premature infant, while potentially related to smoking, includes a host of other problems that were likely not caused by cigarettes alone.

And I be watchin' TLC where the little babies be in the incubator. And they was tellin'...they showed this little bitty baby on there. He was so tiny. They said he was only four months in the lady's stomach. And she went into labor. And they said his heart wasn't developed all the way. His lungs, one of 'em was developed and the other was just half a lung. And it was so sad I started cryin'. He was so tiny. And his little face wasn't all the way developed. His eyelids wasn't open yet. It was so sad. And my auntie said, "You see what that girl did to her baby?" 'Cause they was questioning the mother. "Now, did you drink alcohol?" She said yeah. "Well, is you a drug addict?" She said no. "Did you smoke cigarettes?" "Yeah" "Well, how many packs did you smoke?" "She said "I smoke four a day, four or five a day." And she was an Asian. And it was so sad. That little baby was so tiny. He was so little. And his head wasn't all the way developed. I said, "That is so sad". Because of the cigarettes. And my aunt said, "See. You see that. That could be you. Even

though you almost five months that can be you." She said, "You should stop smokin' cigarettes." I said, "You know what, I am, cause that's sad. That's so sad."... Cause it's not worth my baby comin' out lookin' like no deformed alien because of some cigarettes. When I could just say I ain't gone smoke no more and just go by what I said.

Brandy, a married 25 year-old nurse, focused on behavior rather than malformation as an important outcome. She talks mostly of behavioral deficits in small children rather than newborns, implying a delayed effect of smoking. She also, like many of the other women, equates cigarettes to other drugs in the course of her explanation.

They say the baby can...I mean it can...I don't know, they say some babies come out and they have...I mean I might smoke weed sometimes, too. They say the baby comes out with the shakes. Babies come out real bad. You might have a baby that's real bad. And they say that a lot of women, their babies are comin' out where they wear diapers at five and four years old. Its just not safe. [From what?] Even the smokin' cigarettes and from smokin' weed, crack all of it. Just the smoke period. [What do you mean by they come out bad?] Like bad. You might have a baby that's real bad. He said like they're two years old and might just go up to a table and beat it. Just act real bad like breaks windows. A real bad child that won't sit down and stuff. He told us that that's from women smokin' cigarettes, weed, crack, all of it.

This quote illustrates what may be the source of the confusion for the three women discussed above. Here Brandy freely equates illicit drugs with smoking when describing the impact on the baby. This may mean that this woman is considering the symptoms of prenatal drug use, often more dramatic than those of smoking, to be potential outcomes for her baby. The same may be true for the three other women, explaining the reason behind their belief in malformation as an outcome to smoking. This issue will be revisited later in the chapter.

Three of the women in the study –Dionne, Erica and Fatima– list realistic outcomes of prenatal smoking such as asthma and prematurity. Dionne's opinion is derived from her personal history; she has several children with asthma and extrapolates her knowledge from these experiences. Dionne also directly ties her desire to quit to her knowledge of this specific risk.

I cut down cause I was pregnant cause my son had had asthma real bad. And I didn't want this one turnin' out like that and I know its from the cigarettes. Cause he had asthma attacks, couldn't hardly play and stuff. Couldn't run. That's sad, when a child can't play like they 'sposed to. With David I smoked two and a half packs, I smoked a lot with him. With Samantha too, except she don't got it that bad. She still has it, but hers flares up when she gets a cold. I'm pretty sure this baby'll have it, but I don't think'll be as bad as David's was. Cause when David came he was wheezin' and stuff. I hope not. By me cuttin' down I hope not.

The most informed woman in the study was Erica, a 25 year-old college student who had actively researched the effects of prenatal smoking before the birth of her first child. Her knowledge is clear, accurate and detailed—far more so than the other women in the study.

But, oh, and I talked to the nurses. I was like, "Where's the babies that have the nicotine, the mothers that smoke the whole time, what do they go through?" And she's like, "Oh, gosh, some of them come out so tiny. They can't breathe. They're on life support or they're in an incubator. A lot of them have asthma within the time they're a year old, and the parents smoked the whole time, and don't care enough to stop." And she's like watched babies die because they couldn't breathe. They came out, and they couldn't even breathe. Their lungs were so polluted already, and eaten away that they couldn't even survive.

And it blew my mind. I was like, "Ugh, be serious." So if they saw that kind of stuff, if they watched their babies going through this withdrawal when they come out, even with drugs, if they saw that, I would think that would convince anybody to quit. Or seeing what their lungs look like when they're newborns that the mother smoked the whole time. They don't come out with clear lungs. You know, they might as well have been smoking the whole time. They're just thinking about the fact that every time I take a drag off a cigarette, not only am I losing time off my life; the baby is not breathing the entire time you inhale that cigarette. The baby is not even breathing. They can't breathe because the smoke's coming in. And I mean no way. I'm just not going to sit there and know that information and keep doing it.

Erica, in addition to being the most educated, is notably the only woman in the study to successfully quit smoking completely. She also attributes her desire to quit to her knowledge of the risks, and assumes that other women would be similarly converted. In contrast to this view, the reality in this study was that all of the women interviewed could name a negative consequence of smoking during pregnancy. Whether their knowledge was accurate or not, they believed it to come from a source of authority: i.e., the media, doctors, their own experience. Yet, not all of these women were equally

zealous in their attempts to quit. The source of this disparity may go beyond the what they thought *could* happen, to what they thought likely *would* happen. In other words, women disagreed on the level of risk they thought they were taking by smoking during pregnancy.

2. the level of the risk

In addition to the variation in each woman's theory of smoking's impact of on the fetus, each woman also assessed the level of risk differently. Some women had experiences and information that gave them not only the idea of what could happen, but also that this outcome would happen to them. Other women had personal experiences or information that said, despite what they had heard about the outcome in general, smoking would not harm *their* baby. The conflicts between these types of information, each placing a different value on quitting, is evident in the way women discussed their personal risk. For example, Angela, who reported that smoking causes deformity, said this about her own history with smoking during pregnancy:

[*Did you smoke when you had your other kids?*] Yeah. [*And that was okay?*] Wasn't supposed to be, but didn't nothin' happen to 'em, wasn't nothin' wrong with 'em.

Although Angela has a belief that some authority has said smoking is harmful, her personal experience disagrees. Even though 'they' say smoking *should* be bad, it wasn't for her. It is interesting to note that Angela had not yet attempted to stop or reduce her smoking at the time of the interview, yet repeatedly stated her belief in the need for to do so.

Other women also experienced this conflict of information in examples given to them by friends and family about women who smoked and yet had healthy babies. Brandy states the conflict most clearly while trying to explain her reason for quitting. Here she outlines the conflict between what she has been told by doctors and the

opposing experiences of women she knows. We can also see here a reference to her own needs which are also in conflict with her doctor's advice.

[*When did you start cutting down?*] When I found out I was pregnant. Cause I know its not good. Its not easy, but I'm trying. Because I get nervous and get a lot of stress cause of our living situation cause of all those people there. And I have to have a cigarette. And I know with me having a low cervix and all I don't need it. They been gettin' on me about that, my doctors. You know when you fill things out you have to tell that you're smoking. And then I have some people that tell me "It's okay to smoke because I was pregnant and smoking and my baby came out okay." [*Who are those people?*] Well, like my friend has an auntie and she smoked cigarettes, drunk beer, smoked weed, everything. And she said it was coo', you know, "Your baby'll be fine."

These potentially reassuring statements did not only come from friends or acquaintances. Erica, who was very adamant about not smoking, lived with her mother, a smoker who advised her that there would be no problem. However, Erica saw her mother's experience not as evidence in a confusing conflict, but as a barrier to convincing her mother of the 'true' effects of smoking. Her mother's experience is only relevant in so far as it keeps her from recognizing what her daughter has learned from health professionals (see the previous section).

And my mom's like, "Well, I smoked with all of you, and you all came out fine." Except for my younger sister. She came out kinda small, like six pounds. *But the problem is* all of us were like eight pound, nine pounds...babies. So my mom's kinda like, "Smoking didn't affect my kids, it's not going to affect yours either." [Emphasis added]

Chantelle, also committed (at least in theory) to not smoking, saw this kind of statement from others as simply ignorance on their part. She was not only utterly unconvinced by it, she saw the knowledge she had gained from health professionals as more than sufficient rebuttal to any opposing information. In this quotation, Chantelle relates a conversation between herself and her brother's girlfriend in which she tries to teach the other woman the 'truth' about smoking.

I said, "That's bad. Your baby ain't gone have no lungs!" She was like, "Well, my mamma smoked cigarettes with us so I don't think it's really..." I said, "Just cause it didn't do no effect to you don't mean it won't do no effect to your baby." She like, " Well, I smoke if I want to. Don't nobody rule me." I

was like, "Well, that's your attitude. Watch when the day when you go in labor and that baby come out they say it weigh one ounce." She was like, "[sigh] Anyway, that ain't possible, that ain't possible." I was like, "Girl, what you mean that ain't possible. I go to every little class they give me to see the little babies, the little babies be in the incubator."

Unlike the other women in the study, Chantelle has an argument ready to refute her friend's anecdotal evidence. Essentially, her position is that the effect of cigarettes is variable, so that the lack of effect in one instance does not equal an assurance of safety; there is no guarantee. In fact, despite the lack of effect in her friend's mother, Chantelle is apparently sure that her friend will be effected and deliver a deformed or low birth-weight baby. She supports this position with the medical information she has learned in prenatal classes. This idea of variable effect allows her to explain accounts of good birth outcomes without invalidating the warnings that her doctors have given her. This theory of nicotine's effect was shared by Fatima, another teenager, who also seemed to deduce this idea from an analysis of her environment. Other women also offered explanations that reconciled the conflict between the reports they were given about the safety of smoking and their belief in its risks.

3. RESOLVING THE CONFLICT

Every woman interviewed reported having some information that said smoking was not harmful to the baby: personal experience or anecdotes from friends and family. In spite of this, all of the women claimed to believe the 'medical' information they were given by doctors and nurses and the media. Some women, like those quoted above, saw no conflict, and simply ignored this first kind of information. For others, the conflict was often uncomfortably apparent: How could some women smoke and have healthy children? Brandy took the question a step further to acknowledge that not only could smokers (of cigarettes or marijuana) have healthy babies, women who didn't smoke could have unhealthy babies. She sums up the dilemma in one eloquent line: you never know.

'Cause I think the problem is some women might smoke it the whole nine months and they baby come out normal. You know what I'm sayin'? It's like not everybody baby affected. Like I know some girls tell me they smoke weed they baby came out good. Then I know one girl I used to go to school with, she told me her auntie used to smoke weed all the time, her baby came out with one ear. I don't know. *You never know what your baby gone be when it come out.* (emphasis added)

Several women offered other explanations that resolve this conflict. The first example is one that was discussed briefly above. Both Chantelle and Fatima endorsed the idea of a variable effect of cigarettes on the fetus, so that some babies could be unaffected while smoking continued to be harmful *in general*. In the next quote, Chantelle explains how she arrived at this belief. Interestingly, this idea, which she uses to refute anecdotal evidence from others, is based on anecdotal evidence given to her by her mother (as is Fatima's idea of variability). Chantelle also reports that she, like other women in her opinion and in this sample, once used a strategy of comparison to determine her risk of having an effected baby, a strategy she sees as deceptive.

I think [women who smoke] thinkin' bout it like...like before, when I was smokin, I'd think about what if my baby come out like this, or what if my baby come out like that. But then I'd always compare. I used to always say my mama did smoke with me before she quit. And it didn't really do no effect on me. But then I started to get to know that difference. Everybody is not the same. Anything could happen to my baby. I don't care what it is. It's like a difference. I figured it didn't happen to them so it shouldn't happen to me, but that ain't true. That is not true. I know that for a fact that is not true.

Because, my cousin, she's deceased now, her name is Brenda. She had seven kids, one of 'em died with her. Like she smoked crack with some of her kids. Some of her kids is normal and some of them ain't. But she smoked crack with the majority of all of 'em. That's what kinda had me thinkin'. My mom brought that up to me, too. She said, "Do you think that just because Brenda smoked with all her kids, that the first ones that came out, they was normal. Did you think that all her kids was gonna be normal. No, its always different."

Other women resolve the conflict in a different way. Brandy and Erica gave examples of ways in which babies who appeared not to be affect likely were effected by cigarettes in latent or hidden ways. By including behavioral outcomes in their conception of the impact of smoking, these women saw few pregnant smokers who had

truly smoked without effect. Brandy gave the example of bedwetting as a delayed effect of smoking. She goes so far as to extrapolate that bedwetting at a late age *must* be the result of some prenatal maternal behavior.

Yeah, like sometimes you may be like my baby fine, then when your baby get up there [makes a face]. Like that dude said, that guy said that came. If your baby is four or five yeas old and they still wettin' the bed, think about that. Because they baby might come out big, seven pounds, they be like, "My baby's fine" then they be four or five still wettin' the bed. My husband said his niece is like 16 or 14 and she still wet the bed at night. It's somethin' her mama was doin'. Her mama was doin' somethin'. You know what I'm sayin. She was doin' somethin'.

Erica gives a more subtle example of a delayed effect. She sees her own smoking as the result of an addiction acquired prenatally, or perhaps through observation as a child. Yet, she also acknowledges that the effect of smoking is variable and that smoking may not have affected her or her sibling's health at birth. In spite of these explanations that seem to allow that her mother's smoking may have been benign, at least potentially, her sister's birth weight is seen as an indisputable result of smoking. While smoking may not always have an impact, when a bad outcome does occur in a smoker, smoking is certainly to blame.

Not everyone's affected. But I've also brought it to my mom's attention, "Do you ever wonder if that's why my brother and my sister smoke now?" Because they were already prone to it as infants? You know? - that example. Even seeing my mom smoking. That affected all of us. Regardless of how good a health we were when they came out. And my little sister was tiny. I was so mad at my mom. I was like, "This is because you were smoking the whole time you were pregnant."

Whatever the details, every woman had her own idea of what effect smoking would have and whether or not her baby would be effected. Some of this difference is explained by differences in information; women had different personal experiences and informants about the risks of smoking. Women also framed the information they were given in different ways. Overall, the way each woman thought about smoking during pregnancy was somewhat unique to her personal experience and perspective.

B. The Self As A Smoker

Each woman was asked about her life as a smoker. The stories they told were much the same; peer pressure lead them to try cigarettes, while addiction lead them to keep smoking. This shared story of being a smoker dissolves as the women describe their stories of being pregnant smokers. The women in the study each described her experiences and thoughts around smoking and pregnancy in a different way. Not surprisingly, the bulk of the factors reported by women in this area reflect a need to keep smoking. These factors include: cravings for cigarettes, the need for nicotine as an antidote to stress, conflict with smoking partner, and pressure from other smoker's to keep smoking.

1. DIFFICULTIES IN QUITTING

The women who had achieved the level of change they desired, whether it be quitting or reduction, talked of their cravings as an acceptable inconvenience. The cravings themselves seemed neither intense nor difficult to relieve in their descriptions. For example, Erica, the most successful quitter, described her cravings in this way: "If you weren't around it at all and you're outside at a bus stop or on the bus, I mean, you have an encounter in that sense, it's easier to deal with [than seeing it in your home]." Contrast this quote with a story told by Chantelle who depicts her experience as a struggle to avoid smoking in a world full of temptation.

Its hard to just watch people smoke. And like I seen this girl on the bus. And she had a cigarette in her hand. I guess she was waitin' till she got off the bus to smoke the cigarette. I mean I was just starin' at that cigarette for just so long.

Both of these women characterized themselves as committed to quitting, but the Chantelle's difficulty quitting seems much greater than Erica's. Is her commitment therefore weaker, because her cravings are stronger? Their behavior would suggest so;

the woman with less forceful cravings completely abstains from smoking, while the other has repeatedly slipped away from abstinence.

A second problem with quitting noted by the women was the loss of the experience of smoking: the relief of stress, the satisfaction. Brandy points to her need for cigarettes as a stress-reducer. "I can't really tell you if I'll ever just stop. I can't say. I know I want to, but I don't know if I actually could just ever stop. 'Cause I know I'll always... as long as I live I'll have stress." Erica, talked of her wish for the satisfaction of smoking. "I keep wishing there was something I could replace it with. You know? That would have the same satisfaction." This idea of quitting as the loss of something valuable is slightly different than the craving for cigarettes; these women were looking to keep the positive effects of smoking, not simply to avoid the bad effects of quitting.

For Dionne, having a method of action, a how-to strategy, was the key to quitting. She attributes her inability to quit with her earlier pregnancy because she lacked a set program.

They didn't have no smokin' class when I was pregnant with James. That was just...I was up at [the county hospital]. This time I went to the [clinic] and they have a lot of programs for me there. That's what helped me out with this baby here. Cause with James I didn't go to no smokin' class. They stayed on me but they didn't have no program. If they had had a program like that I think I probably would have cut down. But, I didn't do that with James, but with this one I did.

In Dionne's mind, the method was a *prerequisite* for action apart from her desire to act or attempts to do so. It is notable that Dionne is the woman with the most personal experience with the impact of smoking; she has several asthmatic children.

Fatima also envisioned quitting in terms of the method. Even though she had reduced her smoking from one pack to a few cigarettes or less a day, she sought help to fully quit. She planned to use nicotine replacement gum or patches to eliminate her cravings, though she seemed able to overcome them without help most of the time.

Whether she doubted her own abilities or simply equated quitting with pharmaceuticals is unclear, but the method was considered an important component of cessation.

2. REASONS FOR QUITTING

For the most part, women talked of their reasons for quitting in terms of its benefit to the baby. When quitting was discussed in relationship to the woman, the discussion focused on its difficulty rather than its advantages. Two considerations were mentioned, however: concern for personal health and the rising cost of cigarettes.

Angela and Brandy gave the rising cost of cigarettes as their main personal reason to quit and mentioned their health only in passing. A vote passed in the November 1998 state election added a 50¢ tax to each pack of cigarettes to begin in the month after these interviews. Angela specifically mentioned this tax as a reason for quitting, while giving few health reasons.

[Why do you want to quit?] 'Cause I'm tired of smokin. Plus they're goin' up fifty cents a pack, fifty cents more in January. That'll be three dollars and somethin' for a pack of cigarettes. Count up all the money you spend buyin' packs of cigarettes through the year.

Brandy agreed that price was a major personal motivation for quitting. In fact, she made the day the tax took effect as a day to start trying more seriously to quit, though she had cut down some for the baby's sake at that time. "Mmm hmmm!! I don't know, maybe in January, when they start bein' \$3, maybe I'll start...I don't know...thinkin' about it twice."

Three women in the study mentioned their health as their primary personal reason for quitting. None of these women talked about practical concerns like price. Dionne was the only woman to mention concern for her current health (perhaps because of her longer smoking history). However, Erica and Fatima shared Dionne's concern about the suffering they saw as the end result of smoking. The most striking example

comes from Erica, while volunteering in a hospital, had talked to patients in an effort to learn about the effects of smoking.

You suffer. You'll want to die. I mean, I sat down and asked one of the patients one time, "What would you say to someone who was gonna light up a cigarette, right now, in front of you?" And he said, "For God's sake, don't do it." He was like, "You think I saw myself like this 30 years ago? No way. I was cool 30 years ago. I was high, enjoying it. Look at me now, I can barely breathe. My lungs don't even work anymore. You know how horrible this is how painful this is?" It's a very painful way to die. People think you just light up a cigarette and fall over one day. No, you go to a hospital and suffer for however many years, then you die. He was like, "This is just the beginning for me. I'm not gonna die tomorrow. Everyday I have to suffer." He goes, "You know how bad my lungs burn when I go to take a breath. They burn like fire. If you want to keep smoking think about that." Forget it. I do not like pain. At least people who overdose die happy. You don't die like that when they smoke.

Fatima's fear of ending up with "a hole in my throat" shared some of this graphic quality of suffering. However, both of these women focused on the end of life rather than the present. As I mentioned above, Dionne pointed to both her future and current health as reasons for quitting. Dionne had been smoking for 20 years and had had many years of minor respiratory symptoms. Notice that her discussion of her current health is lucid and informed, while her discussion of her future death, while vivid like the description above, is less clear and is inaccurate in places.

I sure wish I hadn't started smokin' cigarettes. Just for my own health and stuff. Cause all this coughin'. They keep thinkin' I got TB but I don't. I had that TB test you know. I got a shot, a little needle. It came up okay, so. I just know I got a lot of phlegm from that coughin' and that's from those cigarettes since I don't have a cold. They told me it was nothin' but the cigarettes doin' that...I don't wanna die from it I know that. I'm scared of it; I don't know why, but I am. I don't wanna die in that kinda...You suffer. That's sufferin' when you die with cigarettes and your lungs and stuff? I know I gotta go some time and I wanna die in my sleep, but that's better than anything, dyin' in your sleep, huh? I think that's the worstest though, other than cancer, is smokin' those cigarettes. But that leads to cancer, huh? Come to think of it I can't have cancer, I could be the first though I guess. Most everybody in my family die from heart attacks.

Interestingly, *which* of these two motivations was cited, price or health, seemed to relate to the mother's confidence in quitting. Neither of the women who focused on price, Angela and Brandy, expressed much concern for their own health as smokers.

Each mentioned cancer, but only as a possible outcome, not as a reason to quit. These same women both gave noncommittal responses when asked about their attempts to quit. They could “try” to quit, but with no real assurance of success, as Angela illustrates here: “I’m just gonna hafta see what I can do. Try to wean myself down, then just wean myself off. All I can do is try. And hope nothin’ is wrong with the baby.”

Contrast this attitude to Erica and Dionne who focused on their health and didn’t discuss cost at all. Both of these women spoke vividly and at length about their fears for their health. This fear is what set these women apart; while other women talked dispassionately about the risk of premature death from cancer, these women painted emotional pictures of suffering leading up to death. Fatima fell somewhere between these two groups, showing some emotion about her health but not having a great deal of commitment. Overall, however, concern about the personal health effects of smoking was more intense and emotional than concern for the practical costs of smoking.

3. INTERACTIONS WITH OTHER SMOKERS

Another influence that encouraged smoking, from the perspective of these women, was pressure from other smokers to continue smoking. All of these women are surrounded by smokers in their daily lives; all or nearly all of their friends and family smoke. Those women who were actively trying to stop smoking reported encountering three types of opposition or even sabotage from the smokers around them: 1) others actively try to tempt the woman to smoke, 2) others smoke around them in spite of being asked to stop, 3) other smokers insist that the woman support their smoking (e.g. helping to buy cigarettes for underage acquaintances). The example of the first behavior below, while not the most commonly reported, illustrates the possible roots of all such behaviors.

Several women pointed to specific instances when other smokers tried to tempt them to smoke. The most common form of this behavior were the assurance that smoking would not harm the baby. This type of pressure was discussed earlier as a factor in determining the baby's needs. However, there were also examples of "tempting" directed at the mother herself. Chantelle talked of her struggle to resist such temptation. "Cause like my cousins be like, 'You want a cigarette?...You know you want this cigarette.' And I be like, 'No, I don't want none!...' And I just keep telling myself, 'No I don't'. But sometimes I be saying to myself, 'Yes I do, I do want that cigarette.'" Chantelle offered an explanation for this behavior later in the interview.

They want you to be the same person you was from jump to now. And they be like, "You actin' funny style. Just because you pregnant don't mean you gotta act like that." That's the type of person they are. They want you to stay the same type of person you have been. Like when they be like that I'll be like, "Y'all just want me to smoke. That's y'all's problem. Y'all just mad cause I can quit and you cain't." They be like, "You only stopped smokin' for a week, and that's just the beginnin'." I said, "Yeah, you right. It's the beginnin'. I'ma make it the end too."

Chantelle sees these statements as an attempt to keep her from changing. A broader explanation of this behavior is that it may be an attempt to maintain the relationship of the smokers to this new non-smoker. Several of the women, including this one, give examples of their difficulty being with friends and family, who are mostly smokers, due to their need to avoid cigarette smoke or to convince others to quit.

Another type of interaction with other smokers was the exchange of cigarettes between smokers. An unspoken agreement seemed to exist in which cigarettes would be given any smoker in need of one. Several women reported this behavior as conventional between their peers; a kind of cooperative atmosphere seemed to be the expectation, as we can see in Angela's statement below.

[*You give everybody cigarettes?*] Mmmm-hmmm. 'Cause I don't be trippin' off these cigarettes. I'll be saying, shoot, well less cancer for me to get. And then sometimes I'll be out of cigarettes and I may ask somebody, can I get a cigarette from you? [*Do you get it?*] Yeah! The majority of the time.

Brandy even saw this open exchange as a barrier to her attempt to quit. The easy access made it harder for her to resist smoking in the face of temptation; others were smoking and she was tacitly invited to join in.

Say, I don't want to, it's still gonna be in my face and somebody's gonna have a cigarette. So if I don't have a cigarette I just ask somebody else for one. I can just borrow one so it doesn't make it easy.

This exchange was disrupted by pregnancy for some women. They recount being denied cigarettes by other smokers because of their pregnancy. They took these refusals as an offense, at least partly. Rather than seeing this as supportive (these women are reportedly trying to quit) Brandy saw it as rudeness.

I mean now they might ask me when I ask for a cigarette, "Aren't you pregnant?" Cause I didn't have one the other day and this lady that lives by me and she knows I'm pregnant. I asked her for a cigarette and she was like "Aren't you pregnant? Should you be doin' that while you're pregnant?" I was like "I was doin' it before I got pregnant!" Still, she gave it to me though. Even though she said that. "Aren't you pregnant?" [laughing] But she still handed it to me. And she shook her head afterward, but she gave it to me.

Dionne was different in that, though initially angry, she did come to see this behavior as supportive of her and her baby. People denied her cigarettes, in her opinion, out of concern for her child's health.

And when I used to ask [for a cigarette] they say, "Well, I ain't gonna give you no cigarette cause you pregnant." That used to make me mad! They didn't want to give me no cigarette cause I'm pregnant. Like when I didn't have one and didn't want to go all the way to the store and get some. After a while I just stopped askin' and took myself to the store and got some cigarettes. A lot of people would give me some, but some wouldn't. I understand that though. That's what's good for the baby. I couldn't get too mad. I was mad, but I understand it, too. But then a lot of time, out of like five people I'd ask for a cigarette, two of 'em wouldn't give it to me. "I can't give you one. You shouldn't be smokin with that baby." Oohhh!

Dionne saw these refusals as a change in the way people had behaved with her past pregnancies. There is a new concern in the community at large in her opinion. She thought the change was a result of media attention on the effects of smoking that informed people of the need for pregnant smokers to quit.

A lot of people sayin', "Oooh, you shouldn't be smokin with that baby." Years ago you wouldn't be hearin' that. A lot more people found out about it now, I guess that's why. 'Cause everybody's concerned about it now. It seemed like a long time ago you ask for a cigarette, they didn't even bother with you. You bein' pregnant, it didn't even bother 'em...You see it in posters and stuff, I guess that's why a lot of people is concerned about it nowadays. People say things, "Think about that baby." But that's good. Let you know that they care about your baby. Even though they don't know you they still care about the kid.

The women interviewed consistently reported hearing the opinions of other smokers about their attempt to quit, both supportive and discouraging. This may be a reflection of the fact that every woman in the study had a social circle composed mainly, or even entirely of smokers. This means, for most of these women, that their social support came from smokers who were not universally supportive of their decision to quit.

4. INTERACTIONS WITH PARTNERS

Only some of the women I spoke to were still involved with the father of their baby. Those who were had different expectations and experiences with their partners as they attempted to quit smoking. Dionne, an older woman with grown children, did not mention any problems with her partner. Three of the younger women with partners, Chantelle, Fatima and Brandy, both mentioned frustration, though for different reasons.

Chantelle described conflicts with her partner over her boyfriend's continued smoking, which she considers a threat to her own attempt to quit (a situation shared by Fatima). Yet, Chantelle also recognizes his attempts to help her quit in other ways.

He still smokes cigarettes. He don't smoke marijuana no more. He don't drink alcohol no more. But he still smokes cigarettes. And I told him, I said, "I ain't gonna quit smokin' till you quit smokin'." Now when I see him sometimes, when he come over, he don't smoke. Cause he knows that I'm tempted a little bit to smoke. So he be like, "I'm not gonna put it in your face cause that be like teasin' you. Tellin' you...(like what my cousins do) that'd be like teasin' you. But I'm not gonna lie to you, I haven't stopped." So I know that much that he haven't stopped smokin'. And he said, "I'm not gonna smoke this cigarette in front of you." And he like go outside. But I still know that he's smokin' and that's what just makes me more tempted. I'm like, "Don't smoke it then." And he'll put it out and he'll come sit with me.

While some conflict exists in this relationship over smoking, Chantelle still sees her partner as an important support for her during her pregnancy.

But he's a supportive person. He always wanna come to my doctor's appointments. I told 'em he could come to my classes that they gonna be given me where they teach you the breathin' and stuff. I said, "You can come to those." He said, "I wanna come to the fun stuff, too." I said, "What fun stuff?" He said, "You know, where you watch the videos where the babies come out. You know. Where they tell the stories about the babies and the mamas and stuff. I wanna know that too. You know they be givin' y'all cookies and stuff and milk. I wanna do that too." I said, "Nah, you cain't do that." He like, "I wanna go. Can I go?" I said, "No you cain't go." I told him he could go see the ultrasound. You could see the pictures. He said "I'm gonna put it in my wallet and show everybody. This is my baby on the way."

Brandy, a 25 year-old married woman, was also upset at her husbands refusal to stop smoking. She considered his smoking as one source of her failure to quit, and as a sign of disrespect for her.

It's like when you have somebody real close to you, and how close can you get but a husband, and they're doin' somethin' wrong you wanna fit in. You wanna do what your husband's doin'. You know. I mean, if he's in the room smokin', if he gonna sit there and roll up a joint and smoke weed right in my face. Shoot I'ma wanna hit it. See, at my house what my mom does, she makes my dad go outside. He knows do not smoke in front of her - they're gonna argue. I told my husband that. I said "I think I'ma start makin' you go out." "You can't make me go outside."

Unlike Chantelle or Fatima, Brandy did not experience this conflict in an atmosphere of support. She considered her husband to be involved in the pregnancy, but not actively in some areas. Specifically, he did not participate in her medical care (certainly not in the way the Chantelle describes above), something she saw as a negative reflection on herself.

He's involved. But like my doctor's appointments, he don't really feel like he gotta go. "But I want you to come." But he said when I go hear the heartbeat he'll go. I just say that he should just automatically get up, get dressed, and go with me... Just because I want him there. It looks good for you. You know. That's one of the first things I noticed they ask you lately when you go to the doctor - how much is the father involved? Cause they know a lot of us black girls are alone.

Despite their differing desires for support, all three of these women agreed that it would be much easier to quit *with* their partner than without him. Even with other types of support available, this particular form of participation was seen as the most important.

5. SMOKING EQUATED WITH DRUG USE

Five of the six women in the study included many illegal drugs in their discussion of the dangers of smoking during pregnancy. Marijuana was mentioned by most of the women in one way or another. For some women, illegal drugs served only as a measuring stick against which to judge their own smoking. Other women were fighting the cessation battle on two fronts, trying to quit smoking marijuana and tobacco. In both cases, illegal drugs (particularly marijuana) were equated with cigarettes. The dangers of smoking might be less severe, or its benefits less desirable, but smoking and other drugs were seen to be different sides of the same coin—addiction.

Several women mentioned that smoking during pregnancy was not as harmful as taking other drugs. Some examples have already been given above, but this quote from Angela demonstrates it most succinctly: “But I’m doing good cause some people be smoking weed with theirs. But then again weed might not be as bad as cigarettes.” Women seemed at once to use marijuana use as a comforting example of a worse behavior; yes, I smoke, but look how much worse I could be doing. Yet, at the same time they seemed unsure of its effects. Crack cocaine was used in this same way by several women, though their conception of its effects and their seriousness was certain. When I asked Fatima for an example of a bad outcome she had seen due to smoking during pregnancy, she gave this response:

Yeah. Oh, yeah. My cousin's baby - my uncle's wife's baby had a baby, and she was smokin' crack. That baby, the baby came out shaking and wanting crack. How can I say? With... Addicted to it, I guess it needed it. I heard most babies come out, they need that nicotine. So I look at that and say fuck that, that ain't me.

Fatima sees cocaine and nicotine addiction as the same. She seems to expand that analogy to equate the outcome of smoking cigarettes during pregnancy with smoking cocaine. For her, women who smoke cocaine are not a worse example but a frightening prediction of her own future as a pregnant smoker.

Three women in the study linked smoking marijuana to smoking cigarettes. Angela mentioned marijuana as something her peers did. Brandy and Fatima were themselves marijuana smokers and both were unsuccessfully trying to quit or cut back. In fact, both women focused more on the difficulties of quitting marijuana than they did their problems with cigarettes. Both women also equated the two drugs repeatedly in their discussions. Brandy equated smoking tobacco, marijuana and cocaine. She seemed to consider the act of smoking, or the smoke itself, to be the source of harm rather than the drugs. To explain what could cause the physical and behavioral problems she listed in the interview, Brandy said, "[The problems come] from smokin' cigarettes and from smokin' weed, crack all of it. Just the smoke period." Brandy reported that this idea of equivalence had come from a health educator who taught her about the risks of smoking.

Fatima seemed more confused than confident of the connection between marijuana and cigarettes. She reported being told by her doctor to cut back on cigarettes, but to stop smoking marijuana all together. She apparently took this emphasis on marijuana to mean that marijuana was more dangerous. Yet, its effects seem tied to cigarettes in her mind.

I think nicotine and marijuana is two different drugs. I think - nicotine, it's for your nerves. Weed is for your nerves also stress. When you smoke weed and you can't get no weed, you stress a lot. You know, you get angry. Nicotine, it does - both of them's basically the same, but - well, my main thing is that marijuana 'cause I don't want my baby to come out retarded. But nicotine, I don't think it will really mess up the brain on the baby. It could, but then it might can't.

Why women made this connection between cigarette smoking and the use of other drugs is not explicit in the data. Perhaps the similarity between the act of smoking a cigarette or a 'joint' was seductively obvious to them. Alternatively, media emphasis on dramatic 'drug baby' stories as the height of fetal risk may have placed these drugs as models of all risks during pregnancy. Whatever the source, illegal drugs were used by many women as an analogy for the effects of cigarettes during pregnancy.

C. The Self As A Mother

As related above, the women in the study thought about their smoking in terms of the needs of their child. They saw themselves as acting (or needing to act) to protect their unborn child from harm. This self-sacrificing attitude between a woman and her child is not surprising; our social conception of motherhood requires that the mother forfeit her desires in favor of the needs of her child. There may even be a biological imperative to maternal self-sacrifice that creates this attitude, though philosophical and sociological debate on that question is still unresolved. Whatever the source of the inclination to put baby first, one might expect that the concept of motherhood would be a salient issue for women being interviewed about a undesired behavior change on behalf of their child. This was only partially the case here.

The older women interviewed (Angela and Dionne), both of whom had five or more children, talked little of themselves as mothers and mentioned their relationships with their children only briefly. Angela only mentioned her children once and referred to them as siblings: "We laugh and talk like we're sisters and brothers, instead of more like mothers and sons." These comfortable relationships with adult children did not seem to involve any examination of themselves as parents. Dionne, describing her relationship

with her children, illustrates this point. She acknowledges some criticism of her children, but without any self-criticism.

All my kids is spoiled. And they still spoiled and they grown. I told Alandria she still spoiled. She ask me for stuff and I still give it to her. If I have it I give it to her. But Malika is lazy. I don't mind. I don't mind at all. She too old to be tryin' to break her of somethin'.

The image of the self as a mother was a greater preoccupation of the four younger women in the study. These women had complex associations with the idea of motherhood, from their relationships with their own mothers to negative societal constructions of mothering in poverty. Their discussion of motherhood can be divided into two basic issues: 1.) What does it mean to be a good mother? 2.) What does it mean to be a bad mother? The characteristics that make up each of these pictures of motherhood were largely shared by these women. What is particular to each woman is how she places herself between these two images. Is she *herself* a good mother or a bad mother? We will examine the third question by looking at how each woman's judgment of her own capacities in this area, and through her comparisons of herself with other mother images, both personal and societal.

1. THE GOOD MOTHER

What are the characteristics of a good mother? The answer to this question must be inferred from the way women described mothers they admired, usually their own mother. The basic traits that were attributed to these 'model mothers' were those one might expect: responsibility, nurturing, open communication, unconditional support. Other traits were mentioned by particular women that were more individual to them, such as fostering independence, or having high expectations. Before we discuss these characteristics, I will first illustrate the close relationships between the women in the study and their mothers (as in most cases it was the mother that served as the model) that makes their descriptions of their mothers apt models for good mothering.

Many of the women felt that their close relationship with their mother was unique among their friends, and even among their siblings. Brandy, quoted here, even felt that those around her were jealous of this closeness: "Cause like I know me and [my mother] have like a best friend relationship. And I notice a lot of my friends always didn't like that. You know, I be like 'I got my mom'. [And they would say] 'I'm not close to my mom at all.'" Other women simply described their mother-daughter relationship as "close" or "good" in broader terms. The feeling of intimacy was similar in all of these statements. Several women went beyond this surface to relate what about their mother created this closeness, or in other words, what about their mother made her a good mother.

Each woman described some important characteristic of her mother. For Chantelle this pivotal trait was communication. She and her mother had a relationship that included open communication on any subject, even subjects on which they disagreed. In this story, Chantelle describes telling her mother about having sex even though she had been previously forbidden to date boys. In spite of that prohibition, Chantelle felt no fear of telling her mother anything on her mind.

And the first time I had sex I told her. I mean it's just somethin I just can't...it's in my blood, I just talk to my mama. I just tell her. And I said, "Mama, I had sex." She said, "You what?!" I said, "I had sex." And she said, "What is sex to you? What that mean to you?" I said, "You know when you humpin' and you do it and stuff." She was like, "Did he stick his thing in there?" I was like, "No. No." And she said, oh, that was the first time I had come close to it. She said, "Tell me everything that happened." And I told her everything from A to Z. I told her everything.

This communication is later described as a parenting strategy on the part of the mother, rather than as a natural byproduct of these personalities. The mother talks instead of punishing or hitting because she sees this as a way to prevent rebellion. The mother is understood by the daughter to be aware of her daughter's feelings, to know her in a truly intimate way.

And sometimes she'll get upset cause I don't tell her something. She'll be like, "Why didn't you come tell me? You know I'm not gonna whoop you or nothin'. I never did whoop you for stuff you did. I always talked to you. 'Cause I felt like beatin' you was gonna make you do it more. If I hit you it was gonna make you wanna do it. Like if you sneak out the house, like when you snuck out the house that night and I hit you in the back of the head. You did it again because I hit you and you was tryin' to intimidate me and make me madder." And what was on my mind that second time was, "Oh she wanna hit me, I'm gonna leave again." That's how I understand my mom.

Erica pointed to unconditional support as an important quality in her mother. She relates being allowed to make her own choices and mistakes as a crucial part of her upbringing and a source of personal growth. The fact that her mother was supportive in spite of those mistakes gave her daughter the belief that her mother was a safe refuge that would always be available.

She's really good about...she taught me everything growing up. She really encouraged me to get my education. Wasn't really hard on me expectation wise. But she's been so supportive over the whole thing, even with my decisions and my personal life and never downed me or anything. She's real supportive, there for me when things didn't work out this way or that and so - and I knew I could always come home if things got really bad.

In this relationship the key issue is responsibility and the fostering of that trait by the mother. Rather than being directive, Erica's mother is accepting of whatever her children do. By not giving direction, Erica felt that her mother had instilled her with a sense of responsibility that she would otherwise not have had.

She always was the kind of - she's the kind of mother that's like, "Whatever choices you make, I'll support, so I'll try to give advice, I'll try to deter you if it's not - if I don't think it's the right choice, I'll give you my input, but I won't tell you don't do it." So she's never been real dominating in that sense of saying no. At least when I was older. When I was younger, of course, she was like, you know. But as soon as we got to the age where we were making choices like that, 18, after that it was our choice, and "Here's my input but I'm not going to stop you." Yeah, she's - I mean in some ways it's really bad to have a mom that is like that, but for us I think it's been good. You know? That way we - really it puts the responsibility on us, you know? She didn't tell us not to. She didn't tell us to do it. We decided. Therefore, it's our responsibility.

Brandy describes a different mother than those the others describe. This mother is directive rather than unconditionally supportive. In fact, Brandy ties her own troubles to failures to head her mothers rules. In this case, the notable characteristic is nurturing

instead of freedom. Brandy refers to her mother's affection and physical presence as the tie that binds them.

My mom loved me and took good care of me. And she babies me now still. And my husband his mom passed last year in May of '97. So he got jealous of me and my mom's relationship. 'Cause we'll get into it and I be like "I'll go call my mama" and he hates that. "What you gonna do when your mama's not here?" I say "I don't know but she's here now." We'll get into it and I'll be like, "I don't need you I got my mama." (laughing) 'Cause she babies all of us like that.

Two women mentioned a mother-model other than their own as an ideal. The first is Dionne, an older mother, who spoke of her grown daughter as a good mother. Dionne talks of her admiration for her daughter, as well as the admiration of others toward this young woman. The characteristic that is highlighted in her description of her daughter is responsibility. This daughter works (unlike her mother Dionne) and raises both her own children and younger siblings. In this quote Dionne talks of how her daughter took responsibility for the family after the death of the mother's youngest son.

Everybody gives her a lot of credit 'cause she do a lot. 'Cause when my son died, she just got my little girl and she been keepin' her and stuff. 'Cause you know that's my second child died. She did a lot for me. She even took care of the funeral. She did everything. I'm proud of her for doin' all that stuff for me. She even took over for this visit. I'm proud of her. To be so young and take all that responsibility. Takin' care of kids and stuff. That's a lot of responsibility.

Fatima also talks about a 'substitute' mother role model. She has a history of conflict with her cocaine-using mother and identified her as a bad mother. Her aunt serves as her model for good mothering. This aunt lives in a suburb, does recreational activities, and has children doing well in school; she is the 'recreation' mom that Fatima wants to be. The basis of her good mothering stem from her ability to give her children hope and direction for the future.

I mean she does a lot of things with them. She shows them - she shows her kids that it's another way than being out there on the streets and doing bad things. It's another way, where you can get the things you want by doing right, not doing wrong.

These images of 'good mothers' are varied in the types of women they describe. Some are strict, others liberal. Some are affectionate, others more stoic. However, all of these women describe mothers who place their children at the center of their lives. These mothers are aware and skilled parents who, according to their daughters (or mother or niece), are creating good children. In the next section we will look at how these women envision mothering that is harmful and outline their images of 'bad mothers'.

2. THE BAD MOTHER

As you might expect the image of the 'bad mother' is in many ways simply a negative reflection of the image of the 'good mother'. Where the good mother is responsible, caring and supportive, the bad mother is selfish, distant and critical. Yet the difference goes beyond this simple polarity to define whole persons that these women felt existed in their world. This perception of reality was then used as a standard against which to measure the mothers they planned to be.

The negative mother was discussed in depth by three women. Brandy, Erica and Fatima each portrayed the 'bad mother' as a norm that separated themselves and their motherhood role model from other mothers they knew or saw. It was this norm that made their own plans for motherhood and, in Chantelle's and Brandy's cases, their own experience of being mothered unique.

Brandy emphasized her mother's nurturing as the key to good mothering. Being 'babied' and cared for as she was is not the norm in her perspective; other women appear distant and neglectful in comparison. This more usual withholding of affection is seen as inappropriate or even harmful. Physical, tangible love is viewed as an important part of mothering and failure to provide it as a sign of selfishness or vanity. Brandy saw this bad mothering as especially prevalent among African American mothers, at least when compared to Mexican mothers. She noted several times that Mexican men and women were more loving to their children than the African American

mothers she saw. Race, class, and mothering behavior are all involved in this comparison.

What do [Mexican women] do that makes you think they love their babies more?

You can just tell. I don't know. They hold 'em, they kiss 'em. Like I know some girls that don't even hold their kids that much. I think a baby at one and 2, you should still hold a baby at one and two. You know. I know some girls - "get off of me" - cause they wanna look all nice, you know. I know when I was still one and two I was still under my mommy.

Erica also described a complex melding of issues in her discussion of bad mothering. Erica's image of herself as a good mother is directly tied to her ability to be self-sufficient: "Well, actually I feel pretty good about being a mom right now. Because, you know, I got my education done as a mom." In her discussion of the bad mother we find concerns about single motherhood again, but this time within the context of Welfare and dependence. The bad mothers who are the norm again create the backdrop which makes Erica and her mother uniquely good mothers. In particular, Erica explicitly judges herself as a mother in terms of her differences from 'Welfare mothers'. In this quote she is describing how she felt while being on public assistance with her first child.

And so I looked at myself when I had my son, and I said, "OK, I'm not going to be like that." I went ahead and I got my education, did three years of college and raised him, and I felt really good about it. It seems like the more difficult it was, the more I felt good about it. You know? Because I felt like nobody could ever look at me and say, "You are a lazy da da da. Someone like you." They could never say that because I wasn't like them. You know, I felt like it separated me.

In contrast to her own apparent willingness to stereotype other women on public assistance, Erica complained of being judged as a mother by this standard. She felt unfairly stigmatized by others who saw her situation as a sign of irresponsibility or laziness, the qualities she herself attributes to other women "in the system". She acknowledges this conflict in this quote.

They've looked at me, said, "You're on welfare. You're just like them." And they don't know anything about me. They don't know that I have a degree. They don't know that I'm trying. They don't know that I'm planning to continue getting more education or get that job. They don't even know. They just look at you and say, "Damn, make a decision." So I don't want to be like that.

Fatima was unique in that her image of the bad mother centered on her own mother. Fatima's mother is a cocaine addict who Fatima saw as unconcerned about her daughter's welfare. In particular, Fatima seems to have felt that her mother was inattentive and failed to provide the structure that children need. The connection between limit setting and poor mothering is evident in this quote from Fatima. Here she was describing how she was raised after first saying that her mother was a 'dope fiend'.

Basically, my mom, she wasn't really - she didn't really trip off of things I do because I went to school and I cut school, and she... she wouldn't ask me, you know, "Did you do your homework?" or "Did you wash the dishes?" She wouldn't ask me nothing like that. She'll, she'll just come and be like, "Titi, I'm going out for the night," and go be with her boyfriend.

Other mothers who fail to provide this structure are also considered bad mothers. Here Fatima explains what is wrong with 'welfare mothers'. "Some of them don't know how to be a mother. Some of them do learn it though. But mostly, from what I've seen, no, they let their kids do what the fuck they want to do." You can see in this quote a second idea that Fatima held about mothering that was also shared by other women. Bad mothering, in her mind, is learned; these mothers that do the wrong thing have learned to be that way. In the same vein, good mothering can be learned as well. Fatima herself consciously looks to her aunt as a model in order to 'break the chain' of bad mothering in her family that stretches back to her great grandmother. She seems to forgive her mother's disinterest based on this explanation.

The definition of the bad mother in all of these cases seems heavily invested with social commentary. Both women see bad mothering as a pervasive problem, with their own experience as confirmation of a widespread phenomenon. Good mothering is far less common in their view. The examples of this type of mother are few and intimate. In modeling themselves after the latter, they distinguish themselves from their peers and from larger social portrayals of women who, on the surface, would seem to be much like them.

3. THE ROLE OF FATHERS

This belief that African American women were especially poor mothers extended to African American fathers as well. Here, Brandy describes how African American women are without husbands more often than women in other groups. Earlier in the interview, Brandy had described the good mother role in terms of her own mother's life as the head of a family, a wife-mother rather than a mother alone. In light of that, and the way in which the lack of fathers is discussed in terms of single mothers, one could imply from this quote that this lack of fathers is in fact a deficiency of the mothers as well.

And I also think like Mexican men and Chinese men they stick better with their wives than black men do. 'Cause like when you go to the doctor, it be like all us black girls sittin' there by ourselves. But the Mexican girls always have their men with them. I noticed that too.

This implication is made clearer as the discussion progresses. When asked about the reason for the distance she saw in African American mothers, Brandy gives an answer that melds mothering with father abandonment with mothering again. The interrelation is so dense that the two issues cannot be disentangled and assumed to be truly separate.

That might be how their mother's raised them. 'Cause see my mama raised me the way she was raised. I think it starts like that. More and more babies are bein' born and they're not loved. I mean what makes a black guy get you pregnant and once you tell him you're pregnant he leaves? I say a black guy because, most like I said, when we go to the health...to like the doctors for appointments, the Mexican women have their men with them. Even my husband. Sometimes he wants to go. But he's not really that much into goin' with me. You know, "Why I gotta go. You ain't gone be in there that long." "It's just the fact I want you there."

Fatima also talked about abandonment by men. She portrays the abandonment during pregnancy as the result of male irresponsibility and their desire for sex instead of relationships.

But some [men] don't give a fuck. Some of them do. Some of them just bang you up, don't care. Like as soon as the baby come out, "That ain't mine."

Don't want to take responsibility. Don't want to take responsibility, or it never was meant to be.

While Fatima doesn't specify the race of these men she does refer to them as 'niggers' in another part of the interview which may or may not mean African American men. "Some women just get banged up, get pregnant, get tossed away. Some niggers, some niggers don't care." In this quote we also see some of what we saw with Brandy. While the woman is not at fault for being abandoned, women become inconsequential once this happens. Without a man to stay with them, the pregnant woman alone is just someone else's debris. Having or not having a man is part of what makes a real mother in the eyes of these women.

The themes that emerged from these interviews touched on multiple aspects of women's lives beyond pregnancy or smoking alone. The emotional adjustment to pregnancy and motherhood colored the meaning women gave to the risks of smoking; the risks are to the baby and the baby's importance is viewed through the lens of motherhood. Smoking during pregnancy takes on new meaning that it did not have before, but also retains old meanings that made it useful to women before pregnancy. Finally, cultural conceptions of motherhood (particularly young, poor, or single mothers such as these) shape how women judge their own actions as mothers, and their decisions on behalf of their baby.

Chapter VI. DISCUSSION

The stories told by the women in this sample reveal smoking during pregnancy to be more than a risky health behavior, but a symbolic behavior that both defines and challenges the image of self. Pregnant smokers are subject to demands on multiple fronts; pregnancy, their lifestyles as smokers, and their own expectations of themselves as mothers. The meaning that these women attached to their decision to quit (or not quit) derived from the conflict between these demands. In this chapter, we will discuss the meaning women gave to the decision to quit and the process they went through in making that decision. Finally, we will compare the approach these women took to their decision to the model of health behavior change that underly health education strategies. For that exercise we will use the Health Belief Model as a representative for the psychology-based theories that are most commonly used in the field. To begin I will briefly describe the factors that seemed to be related to quitting in this sample of women.

A. The Determinants of Quitting

With a small sample the ability to draw causal relationships is lost as the depth of knowledge about experience and perception increases. For that reason it is not possible to say what factors lead to smoking cessation based on these data. However, women did hold perceptions about what was necessary for successful cessation, which I will outline here.

The environment was seen as essential to quitting. Women cited support from family, usually mothers, as key to their decision to quit and their ability to maintain that decision. Support from partners was an unattained ideal for many women, especially for women who considered not smoking the only truly supportive action her smoking

partner could take. Similar support from friends (fellow smokers) was also desired but not found. Overall, these findings reveal that smoking cessation is at best a social activity, one in which participation of significant others is seen as important for success.

This finding of the importance of significant others is supported by other studies. Qualitative studies have reported that friends and family are named as both resources and barriers by pregnant smokers attempting to quit (Pletsch & Johnson 1996, Lawson 1994). Prospective studies on smoking cessation during pregnancy has found that partner smoking is one of the most significant predictors of continued smoking during pregnancy (Haslam et al., 1997; McBride et al., 1998). Other people, such as friends and extended family, have been less often reported as influences though they were important to the women in this study.

At the same time that women desired their loved ones to support their efforts to change, and were influenced by others in the decision to quit, the decision itself was almost entirely personal. In spite of the fact women considered success to be partially dependent on others, quitting was seen as a personally defined and defining act that was internal rather than externally focused.

B. The Meaning of Quitting: a conflict of interests

The women in this sample quit smoking because they thought smoking would hurt their babies. That is what most of us would have intuitively expected. Yet, that expectation is different than the one we have for non-pregnant people. In general, we expect people to change their behavior for their own benefit. So why do we take as a given that pregnant women will depart from this general rule and act on the benefit of another, a faceless other that they have not even met? What seems to lie behind that expectation for the women in this sample (and perhaps in our culture) is a belief that quitting during pregnancy is an act of mothering.

To quit smoking was a defining act that declared to these women that they were capable and willing to fulfill the motherhood role. That role was defined differently by different women but each had a shared belief in responsibility and protection as central to motherhood. To be a good mother implied strength of character and righteousness that is lacking bad mothers (who were defined by their continued smoking among other things). This inclusion of the decision to quit within the definition of good mothering explains why the discussions of this choice have a moral and emotional tone, rather than the dispassionate rationality of most health decisions. The act of quitting was almost never spoken of as a matter of belief or knowledge, but as a test of will and generosity; strong, decent women quit and weak, selfish women keep smoking.

That smoking, a normal activity for these women, could now be defined as selfish shows how dramatically its meaning was altered. Much of the social function of smoking was lost as relationships between these women and other smokers became sources of stressful new emotions, such as: anger at censure from other smokers about smoking while pregnant, resentment of smoking friends who now served as unwitting seducers or outright saboteurs of the effort to quit, and frustration with smoking partners who now seemed disrespectful in their refusal to join in that effort. Yet, smoking also retained its old role as a stress-reliever in the midst of these new stresses. These changes in the function of smoking derived from its role as part of the definition of bad mothering.

Why women made this connection between good mothering and smoking cessation at all may lie in both their own experience of pregnancy and the social construction of pregnancy and motherhood. Pregnant women are thought to go through an emotional transition in pregnancy that includes the adoption of a mother role (Lederman, 1984). We could see this adoption process occurring in the women in this sample as they judged the mothering of the women around them, whether idealizing or

condemning them. Some women even stated explicitly their intention to pattern their own mothering after their role model. The extension of this process of self-definition into pregnancy may lie in our cultural emphasis on the fetus as a whole person in prenatal care or the media (Kitzinger 1992, Kaplan 1992). Or, it may simply be that the demand that women stop smoking implies this conception of the fetus (otherwise who are we protecting), and in considering that demand women are induced to adopt the same premise. Whatever the source, the decision to quit smoking was conceptualized by these women as a conflict of interests. However, the relevant interests were not those of the baby versus the woman, but of the woman as a smoker against her own conception of herself as a mother. One might better call it a conflict of self-interests.

For African American women like those in this study, the interest in the self-concept as a good mother may be especially strong. Unlike the mainstream mother image (which resembles the good mother described in this study), the representation of the African American mother is not an ideal that women strive for and fail to achieve. The 'black mother' stereotype includes a broad range of vices and weaknesses that combine classist, racist, and sexist prejudices (Geiger, 1995) that go beyond a simple lack of virtues (like the 'pathological mother' Phoenix and Woolette (1991) describe). The representation is so broadly negative that it is difficult for African American women not to see something of themselves reflected in it: poverty, unemployment, out-of-wedlock births (read promiscuity), etc. The women in this study defined motherhood in their community, though not in themselves, in ways that echo this stereotype. Even if similarities exist demographically between women in Oakland and in the stereotype, the disapproval and contempt these women had for these 'other' mothers suggests that their assessments were not purely objective. Becoming a good mother (which included not smoking) may have been more than just a way to attain the social status of motherhood, but also a way to avoid the 'black mother' label. The need to avoid this label may have

encouraged the use of tangible evidence, like smoking cessation, to define good mothering.

C. Deciding to Quit: a conflict of informants

Even though quitting offered personal benefits as a evidence of good mothering, the perceived size of the benefit was not the same for each woman. The source of difference seems to lay in the personal assessment of risk each woman made. If a woman assessed the risk of smoking to be high, she also judged smoking as reckless endangerment of her child. By contrast, a woman who did not feel personally at risk saw no certain benefit to her child from quitting. Most of the women in this study fell somewhere between these two positions: uncertain of the necessity of quitting, but also unable to fully deny that there was a risk. The reason for all of this confusion was that women were getting opposing information from various sources about smoking during pregnancy. In order to make a decision, women had to endorse one set of information over the other. The resolution of this conflict was related both to personal strategies used by each woman and to the type of information women had.

The overall pattern of information used by the women in this sample was a dependence on anecdotal and experiential knowledge rather than the formal statistical data given by health professionals. Individual examples of poor outcomes due to smoking that came from personal experience, friends, coworkers and even television were described in emotional detail by women who were motivated to quit smoking. Women who were less motivated gave only vague and cursory explanations of the dangers of smoking. These same women, however, gave their own individual and immediate examples of good birth outcomes to pregnant smokers. Whatever the opinion of these personal informants, their opinion seemed invariably to outweigh the warnings

of health care providers or health education campaigns, even when the two sets of information agreed.

Some data suggest this phenomenon occurs beyond this sample of women. Other qualitative studies of urban teenagers and Latinas have mentioned that women cite the healthy babies of fellow smokers as reason not to quit (Pletsch & Johnson 1996, Lawson 1994). Haslam and colleagues (1997) describe a sense of 'personal immunity' to the risks of smoking that pregnant smokers used to justify their continued smoking. From the results of this study I would argue that this sense of immunity is more than simply a justification. Even the women who did quit or reduce their smoking struggled with this conflict of informants in making their decision. The women who quit were not simply more logical or informed; they actually had a different set of data than the women who did not quit. Experiential information was a powerful motivation for quitting as well as a powerful rational for not quitting.

D. Comparison to Theoretical Models

Considering the type of information women had brings us to a discussion of how health education, intended to inform women about the risk of smoking, had an impact on the decision to quit. To assess that impact we will compare the way education was used by women in this sample to the influence education is intended to have based on theoretical models, specifically the Health Belief Model (HBM; described in Chapter 2, Figure 2.1).

The HBM conceives the impact of education on behavior to be the perception of threat. The more people are educated about a given outcome, in this case the risk of low-birth weight births due to smoking, the more they will feel threatened by this outcome. At some level, that threat becomes an impetus to take action to prevent the outcome from ensuing. This progression did appear to occur in a modified form in the

lives of the women interviewed. Women did appear to feel more or less threatened by the risks of smoking depending on what they knew. However, unlike the HBM, the information that was most important was not education about the dangers of smoking. Women were most motivated by information about susceptibility, a kind of information that seemed to come primarily from personal experience and informal sources. These sources are not generally recognized by interventions or research in this area, in spite of the fact that susceptibility has been shown to be a powerful predictor of other preventive actions (Strecher & Rosenstock 1997). In light of this, it might be more effective for interventions with pregnant smokers to direct education toward increasing perceptions of susceptibility than to increasing knowledge of risk generally.

A second HBM construct, perceived severity, did not seem to be important to the women in this study. Every woman gave examples of severe health consequences of smoking during pregnancy, many so severe as to be unrealistic. This may be why these women did not perceived themselves to be threatened by this outcome. The outcomes they attribute to smoking were so severe that they are unlikely to occur in their community often, if ever. In the HBM, perceived severity and susceptibility are sometimes presented separately and sometimes treated in combination. From these data, the combination would seem most accurate, with perceived susceptibility being the greater influence. This result is congruent with prospective evaluations of the HBM which showed that perceived severity was not a strong predictor of preventive health action (Strecher & Rosenstock 1997).

The HBM construct that has been deemed the most predictive of behavior is the perception of barriers. In this case, the corollary in this specific case would be that women who judged that quitting would cause problems (e.g. withdrawal symptoms, conflict with friends) would be less likely to quit. That was not perceived to be the case by the women in this study. Rather than a matter of costs and benefits, women saw the

decision to quit as a test of will. That quitting would be beneficial (to the baby) was taken as a given. Just as quitting was assumed to be difficult and problematic (for the mother). However, the two were not seen to be in opposition. The act of quitting was not a matter of net benefit, but an act of will. Women who were strong willed quit, those who were weak did not quit. The 'will' described here is somewhat like the concept of self-efficacy that some would advocate be added to the HBM (Strecher & Rosenstock 1997). Yet, there is a slight difference. Self-efficacy was defined by Bandura as the conviction that one is able to take an action. In this study, women assumed that everyone was able to quit smoking, but that some people failed to do so out of selfishness, or laziness, or moral weakness. The moral tone to this description makes inaction more a choice than a lack of capacity, as in the self-efficacy construct.

This concept of will is also somewhat different than the cost-benefit analysis implied in barriers to change construct of the HBM. Women seemed to disregard external influences such as the barriers to quitting, and consider the central factor to be strength of character, an internal influence. This elevation of internal forces over external influences may have to do with the mother role women connected to the decision; society places responsibility for the welfare of children with their mothers, and assumes her ability to control those forces is a function of her devotion (think of adrenaline-filled mothers lifting overturned cars from their children's backs, or not eating so that their children would not starve. The mother is the fortress that prevents the cruelties of the outside world from harming her children. For these women, the desire to smoke is the result of just such an external force, in this case an addictive drug acting on their bodies and minds.

Both the way in which women conceptualize the decision to quit and way in which they assess the risk of not quitting are somewhat incongruous with the way they are portrayed in public health practice. For these women, relevant information was not

something that was given by formal educators, but absorbed from the world at large. Also, the constructs that pregnant smokers saw as most influential in their behavior were not the same as those found to be most predictive in the HBM generally. In the next chapter I will suggest how interventions for pregnant smokers might be look with these differences in mind.

Chapter VII. CONCLUSIONS & RECOMMENDATIONS

Women conceptualized the decision to quit as a conflict between multiple images of the self as a smoker, a pregnant body, and a mother. Conflict between these self-images lead to behavior change; when beliefs about the risk of smoking put the personal desire to smoke in conflict with the mother self-concept as a protector, the desire to quit emerged. However, the belief that smoking was personally risky was not universally shared due to inconsistencies in information. Personal and vicarious experience suggested that smoking during pregnancy was less harmful than doctors had predicted. Women used various strategies to resolve these conflicts, including: attributing hidden deficits to infants of smokers who appeared unaffected by smoking, or acknowledging the uncertainty of outcome and quitting in spite of the lack of guaranteed benefit.

Other barriers to quitting included partner smoking, low assessment of personal susceptibility and interactions with smokers. Two important theoretical conclusions can be drawn from these findings: 1.) The use of personal and familiar sources of information over the opinions of professionals lead women to feel invulnerable to the risks of smoking; 2.) Acceptance of a motherhood role was an important inducement for smoking cessation.

These two main points have potential implication for public health practice. First, the fact that these pregnant women used personal contacts and experiences as important sources of information might also be addressed in ways to promote smoking cessation. To that end, health education would need to be personalized and include opportunities for women to have personal experiences that demonstrate the need to quit smoking. The second point is the importance of the mother role. The centrality of the identity of mother in the decision to quit make this identity one worth fostering and supporting in pregnant smokers.

A. Recommendation 1: Support The Mother Identity

The African American women in this study related quitting smoking to mothering. Other studies suggest women in other cultural groups made similar connections. Yet, health education does not address this connection explicitly. Statement like "Quit for the baby" may refer to mothering, but they do not directly address the mother identity that would generate such behavior. Women who have not yet adjusted to pregnancy and their impending motherhood may not relate to this message. A more effective approach might be to help women accept their pregnancy and develop expectations of themselves as mothers. Early and interactive ultrasound exams, liberal use of monitors that would allow the mother to hear the fetal heartbeat, or even simply asking about names for the baby are some examples of activities that might explicitly encourage the mother identity. Involvement of the patient's mother (when she is available) is also suggested as a useful tool by this study. Women in the process of reevaluating their relationships with their own mothers may be more receptive to suggestions from their mother than from health care providers. In short, treating the pregnant woman as a mother and the fetus as real person capable of being mothered may encourage women to act as if they were mothers, including giving up cigarettes for the sake of their child.

This suggestion may be more relevant for African American women than women generally. The women in this study included negative social constructions of poor and African American mothers in their concept of motherhood. Being acknowledged as mothers and having the need for smoking cessation framed as responsible mothering might serve as a support for women who have internalized these negative images. In particular, women seem likely to respond to the idea that health is an advantage that African American and poor women can give their children in spite of other disadvantages that may be out of their control.

B. Recommendation 2: Address Opposing Information

Currently, health education (the main form of intervention in this area) does not generally address misconceptions or differing experiences of pregnant smokers. Rather, interventions focus on giving research-based assessments of risk. The assumption here is that a lack of information rather than incorrect information is what prevents smoking cessation. Essentially, if women knew better they would do better. Yet, in this study we saw that women were not burdened with ignorance but confusion. They had information, but it was not consistent or uniform in its content. This implies that women would find it easier to decide to quit if they could reconcile their conflicting sources to endorse this single message. So, what do we know about those sources that might help us to reconcile them.

The pregnant women in this study used information from personal contacts more than professional advice to support their decision about smoking, even when that information said that it was safe to smoke. Health professionals who want women to believe that smoking is harmful must re-frame risk information to reflect this reliance on experience and relationships. What shape that information finally takes depends on the answers to two questions: 1.) Why does personal experience and anecdotal evidence generally show smoking to be harmless?; 2.) What experiential data is available that shows smoking to be harmful?

The first question is easy to answer if we understand the true scope of the risk we are considering here. The incidence of low birth weight births (the primary effect of smoking) is only 12.3 percent for smokers (Bureau of the Census, 1997). While this is much higher than the rate for non-smokers (6.7 percent), it still means that roughly one smoker in ten will have a low birth weight infant. The ratio for non-smokers is one in fifteen. On an individual level this difference is so small that a smoker is nearly as likely to see small babies born to her non-smoking acquaintances as to her fellow smokers.

That is considering that any woman's circle of acquaintances is unlikely to hold more than one or two examples of poor birth outcomes in total, even if everyone she knows is a smoker and most of them are young mothers; a woman would need twenty pregnant smoking friends to see two bad results at any one time. Inevitably the number of rumors and eyewitness accounts about women who've evaded the effects of smoking abound.

That brings us to our second question: How do we intervene in this reality in ways that make it more consistent with our conception of risk? Two methods are suggested by this study. Women were greatly effected by examples of poor outcomes, even when they were singular. The fear of having a sick or deformed baby seemed to be easily triggered without much evidence to support it. However, the examples that served as triggers were individual rather than hypothetical. Where doctors and educators speak of aggregate outcomes like decreases in birth weight, these women responded to pictures of premature babies and the trauma of seeing one's own asthmatic child. This suggests that rather than statistical data, pregnant smokers would be more responsive to real-life examples of poor outcomes. Possible examples include visits from smokers with effected children, video rather than written descriptions of potential outcomes, and warnings about more prosaic and common effects of smoking. This last suggestion is an important one.

Health professionals and academics tend to focus on the most dangerous potential outcome when allocating resources and designing educational interventions. In the case of smoking during pregnancy the focus is on prematurity and low birth weight. However, as explained above, experience of these outcomes is uncommon. To compound this limitation, public health work in this area has focused on pregnancy as an isolated event so that experience with smoking before or after birth is ignored. This study suggests that conditions like asthma, ear infections, or extra days spent in the hospital after birth that are more likely to be experienced by smokers than extreme poor birth outcomes are potential sources of motivation for quitting during pregnancy. Rather than

waiting until a pregnancy to begin education, women should be told about effects on themselves and their children that are potentially due to smoking. These bits of experiential data will then be available as motivation during subsequent pregnancies.

The fundamental message of this study is that health educators and physicians must directly acknowledge the experiences of pregnant smokers before they suggest that they change their behavior. Stories of how smoking is used by the smoker, or accounts of fellow smokers with healthy babies, should be recognized as powerful ingredients in the decision to quit, probably more powerful than any advice a near-stranger can give. Rather than simply adding information to the confusion about risk and how to understand it, health care providers should be helping to guide women to resolving the conflict. Whether women find that resolution in accepting the uncertainty of risk, through debunking examples that deny the risk, or from simply ignoring their doctors, the conflict will be resolved in some way. If professionals want to control the decision that results, they must participate in that resolution process.

REFERENCES

- Barnett, E. (1995) Race differences in the proportion of low birth weight attributable to maternal cigarette smoking in a low-income population. *American Journal of Health Promotion*, 10(2): 105-10.
- Bureau of the Census. (1996) *Statistical abstract of the United States: 1996*. (116th ed.). United States Department of Commerce, Washington, DC.
- Bureau of the Census. (1997) *Statistical abstract of the United States: 1997*. (117th ed.). United States Department of Commerce, Washington, DC.
- California Department of Health Services [CDHS] (1991) *Vital statistics of California, 1994*. Department of Health Services, Health and Welfare Agency, Sacramento, Calif.
- Campbell, S., Reading, A. & Cox, O. (1982) Ultrasound scanning in pregnancy: the short term psychological effects of early real time scans. *Journal of Psychosomatic Obstetrics and Gynecology*, 1: 57-61.
- Dollan-Mullen, P., Ramirez, G., and Groff, J.Y. (1994) A meta-analysis of randomized trials of prenatal smoking cessation interventions. *American Journal of Obstetrics and Gynecology*, 171(5), 1328-1334.
- Feinhandler, S. (1986) The social role of smoking. In R. Tollison (ed.), *Smoking and society: toward a more balanced assessment*. (pp. 167-188) Lexington Book, Lexington, Mass.
- Geiger, S. (1995) African American single mothers: public perceptions and public policies. In Vaz, K. (ed.), *Black women in America*. (pp. 244-260) Sage Publications, Thousand Oaks, Calif.
- Glaser, B. & Strauss, A. (1967) *The discovery of grounded theory: strategies for qualitative research*. Aldine, Chicago.
- Hartman, K. et al. (1996) A randomized controlled trial of smoking cessation intervention in pregnancy in an academic clinic. *Obstetrics and Gynecology*, 87(4): 621-626.
- Haslam, C., Draper, E.S., & Goyder, E. (1997) The pregnant smoker: a preliminary investigation of the social and psychological influences. *Journal of Public Health Medicine*, 19(2): 187-92.
- Horner, E. (Ed) (1998) *California cities, towns, and counties: basic data profiles for all municipalities and counties*. Information Publications, Palo Alto, Calif.
- Institute of Medicine. *Preventing Low Birth weight*. National Academy of Science, Washington, DC.

- Kaplan, E.A. (1992) *Motherhood and representation: the mother in popular culture and melodrama*. Routledge, New York.
- Kendrick, JS and Merrit, R.K. (1996) Women and smoking: an update for the 1990's. *American Journal of Obstetrics and Gynecology*, 175(2), 528-35.
- Kitzinger, S. (1995) *Ourselves as mothers: the universal experience of motherhood*. Addison-Wesley, Reading, Mass.
- Krough, D. (1991) *Smoking: the artificial passion*. W.H. Freeman and Company, New York.
- Lawson, E.J. (1994) The role of smoking in the lives of low-income pregnant adolescents: a field study. *Adolescence*, 29(113): 61-80.
- LeClere, F. & Wilson, J. (1997) Smoking behavior of recent mothers, 18-44 years of age, before and after pregnancy: United States, 1990. *Advance Data*, 25(288): 1-11. Center for Disease Control and Prevention, United States Department of Health and Human Services.
- Lederman, R. (1984) *Psychosocial adaptation in pregnancy: assessment of seven dimensions of maternal development*. Prentice Hall, Englewood Cliffs, NJ.
- Lofland, J. & Lofland, L. (1995) *Analyzing social settings: A guide to qualitative observation and analysis*. Wadsworth, San Francisco.
- Marshall, H. (1991) The social construction of motherhood: an analysis of childcare and parenting manuals. In Phoenix, A., Woollette, A. and Lloyd, E. (eds.), *Motherhood: meanings, practices and ideologies*. (pp. 66-85) Sage Publications, London.
- McAdoo, H. (1986) Strategies used by black single mothers against stress. In Simms, M. & Malveaux, J. (eds.), *Slipping through the cracks: the status of black women*. (pp. 153-166) Transaction Books, New Brunswick.
- McBride, C., Curry, S., Grothaus, L., Nelson, J., Lando, H. & Pirie, P. (1998) Partner smoking status and pregnant smoker's perceptions of support for and likelihood of smoking cessation. *Health Psychology*, 17(1): 63-9.
- National Center for Health Statistics [NCHS]. (1995) Births to unmarried mothers: United States, 1980-1992. *Vital and Health Statistics, Series 21, No. 53*. PHS publ. No. 95-1931. United States Department of Health and Human Services, Hyattsville, Maryland.
- National Institute on Drug Abuse [NIDA]. (1992) *National pregnancy and health survey: drug use among women delivering live births 1992*. United States Department of Health and Human Services, Rockville, MD.
- Parsons, T. (1951) Illness and the role of the physician: a sociological perspective. In Stoeckle, J. (ed.) (1987) *Encounters between patients and doctors: An anthology*. (pp. 147-156) MIT Press, Cambridge, Mass.

- Phoenix, A & Woolette, A. (1991) Motherhood: social, construction, politics and psychology. In Phoenix, A., Woolette, A. and Lloyd, E. (eds.), *Motherhood: meanings, practices and ideologies* (pp. 13-27). Sage Publications, London.
- Pletsch, P. & Johnson, M. (1996) The cigarette smoking experience of pregnant Latinas in the United States. *Health Care for Women International*, 17: 549-562.
- Shughart, W. & Tollison, R. (1985) Smokers versus nonsmokers. In R. Tollison (ed.), *Smoking and society: toward a more balanced assessment*. (pp. 217-224) Lexington Book, Lexington, Mass.
- Simms, M.(1986) Black women who head families: An economic struggle. In Simms, M. & Malveaux, J. (eds.), *Slipping through the cracks: The status of black women*. (pp. 141-152) Transaction Books, New Brunswick.
- Stretcher, V. & Rosenstock, I. (1997) The Health Belief Model. In Glanz, K., Lewis, F. & Rimer, B. (eds.), *Health Behavior and Health Education: Theory, Research, and Practice*. (2nd ed.) (pp. 41-59) Jossey-Bass, San Francisco.
- University of California, San Diego [UCSD] (1990) *Tobacco use in California 1990: a preliminary report documenting the decline of tobacco use*. California Department of Health Services.
- Valbo, A & Eide, T. (1996) Smoking cessation in pregnancy: the effect of hypnosis in randomized study. *Addictive Behavior*, 21(1): 29-35.
- Viscusi, W. (1992) *Smoking: making the risky decision*. Oxford University Press, New York.
- Wilcox, AJ. (1993) Birth weight and perinatal mortality: the effect of maternal smoking. *American Journal of Epidemiology*, 137(10): 1098-104.
- Windsor, R., Boyd, N., & Orleans, T. (1998) A meta-evaluation of smoking cessation intervention research among pregnant women: Improving the science and art. *Health Education Research*, 13(3): 419-438.
- Wolkind, S. (1981) Nausea and vomiting in pregnancy. In Wolkind, S. & Zajicek (eds.), *Pregnancy: a psychological and social study*. (pp. 75-88) Grune & Stratton, San Francisco.
- Woolette, A & Phoenix, A. (1991) Psychological views of mothering. In Phoenix, A., Woolette, A. and Lloyd, E. (eds.), *Motherhood: meanings, practices and ideologies* (pp. 28-46). Sage Publications, London.
- Zajicek, E. (1981) The experience of being pregnant. In Wolkind, S. & Zajicek (eds.), *Pregnancy: a psychological and social study*. (pp. 31-56) Grune & Stratton, San Francisco.

UNIVERSITY OF CALIFORNIA, BERKELEY

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO



SANTA BARBARA • SANTA CRUZ

COMMITTEE FOR PROTECTION
OF HUMAN SUBJECTS
THE A & E BUILDING #1340
BERKELEY, CALIFORNIA 94720-1340

(510) 642-7461 • FAX: (510) 643-6272
e-mail: subjects@uclink.berkeley.edu

April 10, 1998

Ayanna Bennett
1238 Martin Luther King, Jr. Way
Berkeley, California 94709

RE: "A Study of Attitudes and Beliefs of Pregnant Smokers" - Joint Medical Program Research -
Department of Health & Medical Sciences

Dear Ms. Bennett:

Thank you for sending your revised materials relating to the protocol referred to above. They satisfy the conditions in our letter to you of March 13, 1998, and we are pleased to grant full approval. The number of this project remains 98-3-53. Please continue to refer to this number in all future correspondence about the project.

The expiration date of this approval is March 12, 1999. Approximately six weeks before the expiration date, we will send you a continuation/renewal request form. Please fill out the form and return it to the Committee, according to the instructions.

Attached is a copy of the consent materials reviewed by the Committee; the expiration date of the Committee's review is noted in the bottom right hand corner. Please copy and use this stamped consent form for the coming year and destroy any unsigned, out of date consent forms in your file.

Please note that even though the Committee has approved your project, you must bring promptly to our attention any changes in the design or conduct of your research that affect human subjects. If you have any questions about this matter, please be in touch with the CPHS staff at 642-7461; FAX 643-6272; Email subjects@uclink.berkeley.edu.

Sincerely,

Richard Steinhardt
Professor of Molecular and Cell Biology
Chair, CPHS

RS:nan

Attachment

cc: Professor Henrik L. Blum
Graduate Assistant
Graduate Division (SID #11219647)