Identifying and Eliminating Stigmatization of Pregnant Smokers

Ways to Enhance My Smoking Cessation Practice

Helping pregnant women to quit or reduce smoking requires special knowledge, skills—and even a heightened degree of personal awareness. These clients face unique cessation issues, such as high rates of relapse, physiological changes, and social pressure. They also experience stigmatization in their communities, and, in some cases, bias from health-care practitioners. If you apply woman-centred care best practice values and beliefs, you'll be better poised to identify and eliminate these harmful barriers, including personal bias, from your own smoking cessation practice.

Why Health-Care Practitioners' Bias Hurts Pregnant Smokers

Bias is the intentional or unintentional negative evaluation of one group and its members relative to another. Health-care practitioners may believe pregnant smokers or new moms should take every reasonable step to ensure their babies are born with healthy prospects, including overcoming nicotine dependency—regardless of circumstances. This attitude is rooted in a fetus-only focus, and can negatively affect quality and process of care, including clinical judgments and decisions, and even client use of treatments. It may trickle down into the self-image and consciousness of the pregnant smoker or new mom.

3 Steps to Help You Address Bias

1 Be Sensitive to the Stigmas of Tobacco Use

Today's promotion of healthy smoke-free living and restrictive smoking legislation creates a negative social and legal atmosphere for women who smoke during pregnancy or with their infants or children. Partners, family members and society at large place intense pressure on pregnant women to quit smoking.

Recognize: Stigmatization is not a useful deterrent if it results in your pregnant client feeling pressured or coerced. Such a response may lead her to hide her tobacco use from you or create a barrier to cessation support. Stigmatization may also result in negative health consequences such as raised blood pressure for some women.

2 Mitigate the Tendency to Blame Smokers

Evidence suggests that many cessation interventions are not tailored to pregnant smokers, whose readiness to quit may not match stages of change. Furthermore, interventions may not be adequately tailored to the social and economic situations of subpopulations of pregnant smokers. Bottom line: there are a host of reasons why a woman smokes when pregnant, including organizing social relationships, to feel in control and to control emotions.

Recognize: Incorporating a holistic approach in your smoking cessation practice is vital to avoid victim blaming. Namely, this entails considering a woman's needs in the context of her life circumstances, including focusing on the woman's health before, during and after pregnancy versus solely on the health of her fetus. The latter diminishes the value of the mother, and fails to address the need for long-term motivations to quit smoking.

3 Build Up Your Empathy

Unemployment, poverty, multiple roles and stress reduce the importance pregnant smokers place on quitting or cutting back. Survival issues are very real to pregnant smokers; in fact, smoking can be perceived as a benefit or way to mediate circumstances. At the very least, women in disadvantaged or marginalized circumstances are poorly positioned to even begin considering quitting smoking when facing other pressures.

Recognize: One of the cornerstones of motivational interviewing is expressing empathy. Identifying with the client's emotions through active listening is critical to a successful cessation intervention: otherwise it is difficult to identify and understand resistance and reasons for unhealthy behaviours.

Before your next smoking cessation intervention, engage in reflective practice. Examine past experiences with pregnant and postpartum smokers, review your practice and aim to place it in the context of woman-centred care.

*Citations for this document are available at TobaccoFreeRNAO.ca

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