

# LIBERATION!

## HELPING WOMEN QUIT SMOKING

### A BRIEF TOBACCO- INTERVENTION GUIDE



Prepared by Cristine Urquhart, Frances Jasiura,  
Nancy Poole, Tasnim Nathoo and Lorraine Greaves



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Centre of Excellence  
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This guide was prepared by Cristine Urquhart and Frances Jasiura with assistance from Nancy Poole, Tasnim Nathoo and Lorraine Greaves.

It is based on evidence about: women-centred care, sex- and gender-specific health impacts of tobacco, and best practices in smoking cessation, gathered by Natasha Jategaonkar, Lorraine Greaves and Nancy Poole.

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A companion piece to this guide is under development: a compendium of facts and issues related to women and smoking for local, national and global audiences. Please also see BCCEWH work on women and tobacco at [www.expectingtoquit.ca](http://www.expectingtoquit.ca) and [www.coalescing-vc.org/virtualLearning/section4/default.htm](http://www.coalescing-vc.org/virtualLearning/section4/default.htm)

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## Liberation! Women And Smoking Cessation

### liberation

noun: the act of setting someone free from imprisonment, slavery, or oppression; release

(<http://oxforddictionaries.com>)

Consider this:

- 24% of women smokers have their first cigarette within five minutes of waking up
- 50% of women smokers attempted to quit at least once in the past year
- On average, women smokers smoke 13 cigarettes a day. A pack of 25 cigarettes costs \$10 or more, so one woman spends close to \$2000 a year on cigarettes alone
- Smoking remains the number one preventable cause of death and disease for women in Canada

Quitting smoking for even a short period of time, can have profound, liberating effects on a woman's physical and psychological well-being. It can benefit her health, free up time in her daily schedule, and boost her confidence as well as her bank balance! Everyone has a story; we know that women start smoking, and continue to do so, for a reason. But we also know they have many reasons to quit and that every woman can find her own path to becoming and staying smoke-free...

This guide offers support to service providers in diverse contexts (e.g. within transition houses, community mental health teams, or primary health care) to start a conversation with women about their smoking and the possibility of quitting. Research shows that clinical interventions as brief as three minutes can increase quitting rates significantly among current smokers and recent quitters[1, 2].

So, how can you help women find liberation from smoking? Read on...

## Background

### OVERVIEW

This *Guide* was developed to help practitioners:

- Increase confidence when talking to women about quitting smoking
- Provide comprehensive support tailored for women
- Build on the recent literature review on Women-Centred Treatment for Tobacco Dependence and Relapse Prevention, by the British Columbia Centre of Excellence for Women's Health (BCCEWH) Tobacco Research Program (2011) [3]

Much of the published literature focuses on cessation interventions for those who are ready, willing and able to make changes. However, most women are not ready and able to quit, or have tried to quit smoking before with limited success. There is a lack of emphasis in the literature on how to prepare women to quit and support this decision within the larger context of their lives. In addition, there is insufficient focus on how to share tobacco-related health information with women. Most importantly, most research in this area fails to offer practitioners practical ideas on 'how' to start the conversation about quitting smoking with women.

This resource was developed as a guide, rather than a manual, to help shift away from a prescriptive approach to smoking cessation and to emphasize the collaborative and dynamic nature of real-life clinical interactions. It is meant to support brief interventions, from 5 to 30 minutes, and can be used by practitioners in various contexts and roles.

### How to Use this Guide

As a practitioner, you may use this guide to help you start the first conversation about smoking cessation with women patients. The information will support your conversations on the topic over the course of many interactions. For some women, a brief intervention may be enough to begin making changes; others may need more intensive support and follow-up.

The conversations will vary, depending on her level of readiness to quit. A woman who knows she needs to make a change but does not have the confidence to do it, has different needs than a woman who knows how important it is to stop smoking, has had some success in the past, and is now ready to try again. These conversations can be done in-person or over-the-phone. Although intended primarily as an individual approach, elements can be adapted to a group context. The choice is yours: use what you find helpful and leave the rest.

This guide offers:

- Practical ideas on how to collaboratively begin a conversation about quitting smoking with a woman
- Strategies for guiding the conversation towards making changes
- Techniques to support confidence building
- Approaches to understanding trauma and shame with ideas on how to support women on these issues
- Examples of what to say, how to pace the conversation, and how to support her readiness for change
- Tools and resources for discussion, planning and support

## A WOMEN-CENTRED APPROACH

As the evidence and understanding of sex- and gender-related influences on smoking and cessation behaviours continues to grow, so does the necessity for cessation interventions tailored specifically for women [3, 4]. A woman's experience with smoking and success at quitting is complex and influenced by numerous factors, including physiological and biological (i.e., level of dependence, menstrual cycle, genetics, mental health and substance use), as well as psychosocial (i.e., stress, race/ethnicity, lack of support, experiences of trauma) [3]. Identity, lack of confidence, and stigma (especially for pregnant women) are often core issues [4-6]. How women stop smoking may also differ in terms of method (Nicotine Replacement Therapies (NRT) or not), approach (gradual reduction versus complete cessation), and the intensity of the intervention (brief or longer-term) [3]. Despite these findings, many women-specific treatment models address only one component that is tailored for women, such as weight control [7]. A more comprehensive women-centred model of treatment for tobacco dependence will improve overall treatment engagement and retention by reaching women who may not access health services [7].

This intervention approach is built on the four women-centred principles identified in *Women-Centred Treatment for Tobacco Dependence and Relapse Prevention* [3]:

### 1) Women-centred care for tobacco is tailored specifically for women

- A tobacco-dependence program that is tailored specifically for women supports a woman's choice to quit and allows her to gain control over the intervention components, including the use of pharmacotherapy. Practitioners take into account how numerous physiological, biological, and psychosocial factors can influence individual preference and success.

### 2) Women-centred care for tobacco builds confidence and increases motivation

- Working with women to identify barriers and opportunities for change, helps build confidence and motivation, ultimately improving their chances of meeting smoking-cessation goals. It is important to see stigma reduction and social support as elements that build confidence.

### 3) Women-centred care for tobacco integrates social justice issues

- Women-centred care acknowledges other priorities such as housing, food security, and caregiving roles and how these challenges may be related to smoking behaviour.

### 4) Women-centred care for tobacco is holistic and comprehensive

- Women-centred care focuses on a woman's needs in the context of her life circumstances by acknowledging competing priorities and life experiences that influence smoking behaviours; integrating treatment for trauma, mental health recovery, substance use, or other important health concerns which the woman identifies; valuing women's health for its own sake.

## WHAT ISN'T SAID

This tobacco-intervention guide is informed by the principles of women-centred care [8]; trauma-informed practice [9]; a motivational interviewing communication style [10, 11]; and smoking cessation best practices [12]. These approaches provide us with insight into the variety of women's experiences, the key aspects of service delivery that provide women with the opportunity to succeed, and a deeper understanding of how changes are made and sustained.

The list below describes the assumptions and values embedded in this *guide to helping women quit smoking*.

It is important that:

- Women are talking about their tobacco use and cessation goals with their healthcare providers throughout health services. This conversation must be prioritized given the health consequences of smoking for women.
- Women remain in control of the pace and depth of the conversation as well as their own decisions around smoking cessation throughout every tobacco-related conversation.
- Practitioners and women work collaboratively. There needs to be a sharing of expertise, as women are the experts in their own lives, while healthcare providers have expertise on smoking cessation techniques, helpful for women.
- Practitioners make physical and emotional safety central to the interaction. The practitioner should aim to avoid triggering a flooding response that could increase the urge to smoke.

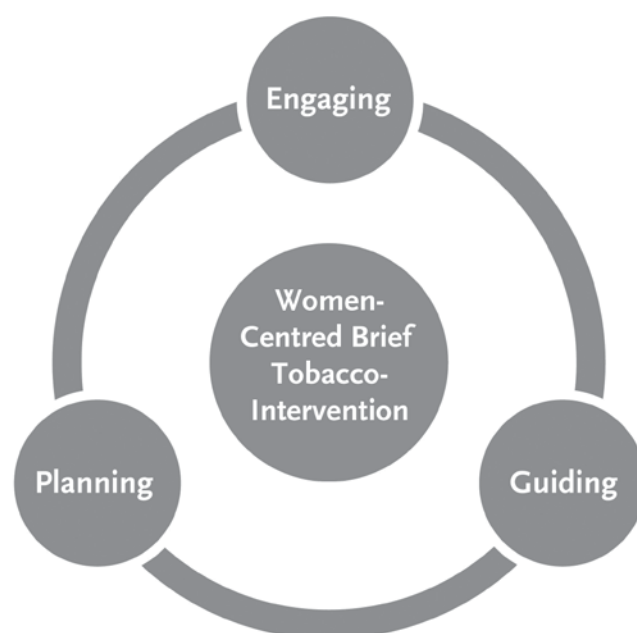


- Practitioners recognize that ambivalence about change is normal and to be expected.
- Practitioners recognize that there is no one approach that will work for all women.
- Practitioners remain curious and find out what is most important for their patient and make that the starting point. Every woman is motivated by something.
- Practitioners understand that information alone does not produce sustained change.
- Practitioners realize that sustainable change in tobacco use, must involve a shift in core values and identity, e.g., from “I am a smoker” to “I am not only a smoker,” or “I am a non-smoker.”
- Practitioners build confidence and motivation with their patients, as what women hear themselves say about change, influences whether or not the change will happen.
- The practitioner reflects on their communication style, as this affects outcomes.

### A BRIEF WOMAN-CENTRED TOBACCO INTERVENTION

Because every woman is unique and every conversation is different, there is no one formula, script or prescription for practitioners to follow when intervening. Instead, you can think of the flow of the conversation as having three phases: engaging, guiding and planning.

This guide describes goals for each phase of the intervention and approaches for how to translate



the women-centred principles into practice. Table 1 identifies strategies for each stage of the conversation. These phases mirror the flow of conversation for any issue you might address with women. This means that the tobacco-specific strategies described in this guide can integrate easily with your own style, the context, and the work you are already doing with women. Many of the strategies shared below are drawn from motivational interviewing, an approach to identifying strengths and supporting change. As such, you may need to adapt the examples and language to fit your context.

Table 1: Engaging-Guiding-Planning: Strategies for each stage of the conversation

Phases	Engaging	Guiding	Planning
Sample Strategies	<ul style="list-style-type: none"> <li>• Opening statement</li> <li>• Agenda setting</li> <li>• Making links with tobacco</li> <li>• Agenda setting when time is limited</li> <li>• Sharing information and providing feedback</li> </ul>	<ul style="list-style-type: none"> <li>• Decisional balance</li> <li>• Questions for change</li> <li>• Assess importance &amp; confidence</li> <li>• Build confidence</li> <li>• Identity &amp; core values</li> </ul>	<ul style="list-style-type: none"> <li>• Elicit commitment &amp; transition to planning</li> <li>• Explore previous experiences with quitting/cutting down</li> <li>• Menu of options</li> <li>• Personal plan</li> </ul>

## A Brief Women-Centred Tobacco Intervention Guide: 3 Phases

### 1. ENGAGING

Whether it is a 5-minute conversation or a 30-minute intervention, this first step is critical. As the practitioner, you have the opportunity to offer a very different experience—free of shame, guilt, judgment and pressure—and in doing so can offer a woman the respect, encouragement, and conviction to make her own decisions. It is also important to reflect on your own hopes for outcomes and to notice how they influence the approach you take. Do you move too quickly into information? Do you feel frustrated if she won't commit to quitting? Recognize the changing phases of the conversation to help balance your sense of urgency and prevent yourself from pushing the issue. The goal of engaging is that she comes back, accepts a referral, and/or continues to explore the role tobacco plays in her life.

#### GOALS FOR ENGAGING

- Establish how this conversation might be different from conversations she has had with other professionals; outline your role and what you can offer
- Begin the conversation with what is most important to her and listen for opportunities to make the link with tobacco (i.e., she is concerned about the health of her children)
- Gain an understanding of her relationship with tobacco and how it relates to other areas of her life
- Normalize the conversation around tobacco and reduce stigma
- Collaboratively find a focus and set the agenda

#### STRATEGIES FOR ENGAGING

##### Opening statement

The opening statement sets the tone for the conversation. The purpose is to clearly state how this conversation will be different from experiences she may have had with other practitioners when discussing tobacco use and to reduce any stigma and shame she might have about her smoking. The key is to convey that you will support the changes she would like to make and not tell her what she should do [13]. More often than not, and despite the best intentions of practitioners, women expect to be lectured and shamed about their tobacco use. She may have even rehearsed what she will say in the event the topic comes up and will be ready to tell you all the reasons

why she cannot quit right now. Explicitly let her know that you are there to support her in whatever way possible; this will reassure her, establish collaboration, and honour her autonomy.

##### *Example:*

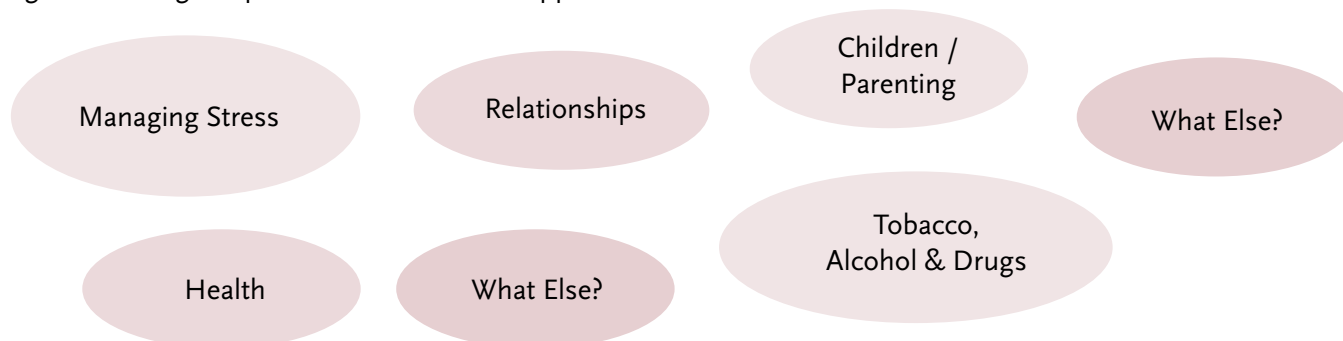
“Thank you for taking the time to speak with me. I appreciate you have a lot going on right now... (introduce self and role, how much time you have)... Our conversation today may be different than other conversations you may have had in the past. I am not here to tell you what to change or how to change, but rather to find out how I can be helpful and support you in the decisions you make.”

##### Agenda setting

Agenda setting can be done in different ways, depending on how much time you have, your role, and the context. Ultimately, the goal of agenda setting is to collaboratively find the focus of the conversation and get a sense of what is most important for her at this time [11], thereby empowering and strengthening her capacities to make a decision and be actively involved in her own care. Such an approach broadens the lens—recognizing that a woman's tobacco use falls within the larger context of her life—and encompasses the women-centred guiding principles discussed earlier. Integrated treatments that address more than one area of concern, for example depression and tobacco use, are being developed and show promise.

One way to begin is by using a visual aid such as a bubble sheet or agenda setting sheet (see appendix) [11], listing some of the topics that you have conversations with all women about (limit to 5-7 topics). In doing so, you indicate the topics you know something about, establish the parameters of your role, normalize the types of conversations you have with women, and open up the agenda to include tobacco use and related areas. Be sure to leave some circles blank and elicit other topics she might want to discuss [10]. Don't include the goal of the topic, for example use “smoking”, not “quitting smoking.” Ask her where she would like to start and try to focus on areas that she can control [14], especially related to smoking and relationships (women cannot control their partners' smoking behaviour).

As with any strategy, you want to adapt the approach depending on who you are working with by considering diversity, age, developmental stage, and cognitive abilities [13, 15, 16]. For example, use images that are age- or culturally-appropriate, instead of words, or reduce the number of topics when working with someone with cognitive challenges. A blank agenda-setting template is included in the appendix.



*Example:*

“Let’s take a look at this sheet together. These are some topics that other women have wanted to talk about and some of the areas where our program can offer support; for example, managing stress, health, relationships, parenting support, as well as tobacco, alcohol and other drug use... There may be something else that is more important to you right now that you would like to add... (Woman responds)... So looking at these topics, which would be the most helpful to start with today?”

### **Making links with tobacco**

If she chooses to start with a topic other than tobacco, remember the goal is to engage with her and gain an understanding of what is most important for her at this time. Making changes in other areas of her life may translate into increased confidence to improve her health overall. There may also be opportunities to make links between her current priorities and tobacco use. Timing and pacing are important; don’t force the conversation to shift toward tobacco usage, as she may feel pressured and stigmatized.

*Example:*

“You mentioned a few minutes ago that you are really concerned about all of the earaches your daughter has had lately. I am wondering what you have heard about the connection between second-hand smoke and earaches?”

### **Agenda setting when time is limited**

If your time is limited and you do not have the opportunity to do more comprehensive agenda setting, consider asking permission before moving too quickly into information and use an open-ended question to draw out her perspective about how things are going with her tobacco use.

*Example:*

“We only have a few minutes today, and I wanted to follow-up on the conversation we started last time about your tobacco use, wondering where that conversation may have left you. Would that be okay?... (Woman responds)... How do you feel about your smoking at this point?”

### **Sharing information and providing feedback**

An important aspect of tobacco intervention is providing information (whether it be general tobacco-related information or individualized health and biological feedback). Once the topic or focus has been identified, there may be an opportunity to share some information. However, before moving into telling the woman general facts about health implications and consequences of tobacco use and advising her to quit, or reviewing biological feedback results, it is important to ask permission to do so or be given implicit permission by the woman (e.g., she asks for more information).

The motivational interviewing approach known as *Elicit-Provide-Elicit* [11] can be helpful with this exchange. The practitioner begins by drawing out what she already knows and asking permission to provide more information, the practitioner provides the information, and then elicits the woman’s perspective on what she has heard. There is no assumption made that “she does not know” or that “if she just had the correct information, she would change.” Using this approach, women are actively involved in the information exchange and practitioners purposefully ask for their understanding

of what has been shared. Through this process, practitioners are able to provide information and feedback in a respectful and empowering way, versus becoming overly directive and potentially (re)traumatizing women by rendering them passive in the process.

*Example:*

Elicit

Find out what she already knows, what she has heard or what she would like to know most about:

- “What have you heard about... (the connection between depression and tobacco use; tobacco use during pregnancy, etc.)?”
- “What would you like to know about...?”

Ask permission to provide more information:

- “Would it be okay with you if I shared a little more about what we know...?”
- “We have your test results back, could we take a look at them together...?”

Provide

Provide the information/feedback:

- General information: “Some women experience...” Many of the women I speak with...”
- Individualized feedback: “Based on your test results...”

Elicit

Draw out what the information means to the woman and how it fits for her:

- “I appreciate that some of this may be new information and I am wondering how it might fit for you?”
- “What’s staying with you?”
- “What do you make of it?”

Information sharing can happen at any time throughout the brief intervention, not only in the initial engagement. This approach could also be used to find out what she has done in the past to quit smoking and then, with permission, offering some more suggestions and finding out which ideas fit best for her.

There may also be times when it is ethically or medically required to share information or feedback. How you approach the conversation is critical to maintaining rapport and her sense of safety in the relationship. Focus on offering choice wherever possible and respecting autonomy using statements like: “This may or may not concern you...” or “There is something that I need to discuss with you today, and before I begin, I am wondering if there is anything else that you would like to address first...”

**REMEMBER:** The goal of engaging is that she comes back for a follow-up, accepts a referral, and/or continues to explore the role tobacco plays in her life.



## 2. GUIDING

Many practitioners are skilled at building relationships and creating plans. When a woman doesn't follow through with the plan, doesn't make the referral appointment, or doesn't come back for a second visit, reactions vary from surprise, frustration, annoyance, and questions about what could have been done differently. Often, the missing piece is skillful *guiding*—the ability to encourage dialogue about the possibility of change without demanding change. The practitioner must create the space to work through ambivalence, free of shame, and draw out the woman's own change talk—her desires and abilities, as well as her reasons and needs for change—statements that help her move towards commitment and taking the first steps [11]. Commitment statements, like “I will,” predict change [17].

Having mixed feelings or ambivalence about change is a common human experience, yet practitioners are often surprised, frustrated and impatient when it arises—especially in the face of medical research and facts related to the consequences of tobacco use for women. Such life-altering decisions are much more complex than just having the ‘right’ information and being told to quit smoking. The challenge for practitioners, especially when feeling pressured by genuine concern, time and program expectations, is not to become directive and overtly persuasive. If a practitioner begins to tell a woman all the reasons she needs to change and how to do it, chances are the response will be a variation of “yes, but...” because she still has mixed feelings about it and now needs to defend her position. It's not that she doesn't have any concerns; the “yes but” is a natural response to persuasion and being directed by the practitioner. Practitioners must understand that it is critical for women to hear their own voices and talk themselves into change.

Skillful guiding is also essential to building confidence. A common experience shared by many women who smoke is that it isn't so much about whether quitting smoking is important—most women have thought about or even tried quitting on numerous occasions—it is more about having the confidence and belief in their own self-efficacy to actually be able to do it. Previous failed attempts and the multitude of barriers that can get in the way (lack of support, financial limitations, experiences

of trauma, stigma, etc.) undermine a woman's confidence and belief that she can actually quit smoking. Although ensuring that women have accurate information is important, it may not be enough.

### GOALS FOR GUIDING

- Discuss the possibility of change without demanding it
- Help women explore their mixed feelings about change
- Purposefully draw out change talk
- Heighten discrepancy between smoking and core values
- Strengthen confidence and increase motivation

### STRATEGIES FOR GUIDING

#### Decisional balance

This strategy can be helpful to explore the costs and benefits of smoking or any health behaviour without influencing the direction of change or pressuring the woman to make a decision [10]. The goal is to deepen the understanding of the woman's ambivalence to change, weigh the multiple benefits that smoking may offer her, and address the very real barriers to change (the survival pressures—poverty, low education, etc.) [4]. Through this process, women are able to identify the downsides to smoking, especially since they don't have to defend themselves. Again, they find out what they believe by hearing themselves speak. Practical strategies to address barriers to change may then become a planning focus.

#### Example:

The following decisional balance in Table 2 represents collective responses from women who participated in an empowerment group. These women demonstrate a depth of understanding of the costs and benefits of smoking and their own ambivalence. Through this exploration of ambivalence, the tension increases and ultimately begins to resolve. The completed decisional balance below is not a resource to hand out to women. Please use this example to inform your practice and think through some of the topics women might bring up. There are no right or wrong answers, and women are encouraged to reflect on their own experience. A blank decisional balance is included in the appendix.



Table 2: Decisional Balance: Sample responses from women

	Benefits / Pros	Costs / Cons
<b>No change</b> Continue to smoke	<ul style="list-style-type: none"> <li>• to cope with my emotions - anxiety, stress, boredom, upsetting memories</li> <li>• smoke with my partner</li> <li>• helps me relax</li> <li>• partner does not support quitting; avoid conflict</li> <li>• keep everything the same</li> <li>• weight management</li> <li>• smoking is like an old friend</li> <li>• reward myself</li> <li>• social; fit in</li> <li>• prevent withdrawal and cravings</li> <li>• time out from crying infant</li> </ul>	<ul style="list-style-type: none"> <li>• sick more often</li> <li>• increased chances of lung cancer, heart trouble, emphysema, HBP</li> <li>• harder to get pregnant, bring to term, low birth weight</li> <li>• breath! cough! smell! stained teeth!</li> <li>• bury feelings</li> <li>• decreased energy</li> <li>• low self-esteem</li> </ul>
<b>Change</b> Quit smoking	<ul style="list-style-type: none"> <li>• more \$\$\$</li> <li>• escape powerful addiction</li> <li>• dirty habit</li> <li>• no longer cool</li> <li>• improve my health &amp; my baby's health</li> <li>• more energy</li> <li>• self-confidence, control</li> <li>• what do I do with my hands?</li> </ul>	<ul style="list-style-type: none"> <li>• withdrawal; bitchy</li> <li>• tried too many times before</li> <li>• totally surrounded by smokers</li> <li>• I can't right now</li> <li>• weight gain</li> <li>• loss of intimacy</li> </ul>

The strategy can be adapted depending on who you are working with, the context, and the amount of time you have. Women could complete it on their own or it could be done with the practitioner either written or verbally. You may even explore only two of the four quadrants. Another variation would be to verbally ask about the good and the not so good things about smoking, beginning with what smoking offers her.

### Questions for Change

Even in the briefest conversation, it is possible to ask a question that plants the seed of change. Rollnick and colleagues (2008) suggest that "If your consultation time is limited, you are better off asking patients why they would want to change and how they might do it rather than telling them that they should" (pg9).

#### Examples:

What are you already doing to take care of yourself (and your family)?

Why might you consider making this change?

If you decided to make this change, how do you imagine you would start?

What makes you think that you need to do something about \_\_\_\_\_?

In what ways does this concern you, if at all?

What worries you about your current situation, if anything?

What do you want to be happening in your life a year from now, 5 yrs, 10 yrs?

If nothing changes, what do you imagine might happen?

What is the best outcome you could envision if you make this change?

What are some of the benefits that you see in making this change?

### Assess importance and confidence

Using a scale from 0-10 and key follow-up questions, this strategy helps practitioners gain a better

understanding of a woman's readiness to change in terms of how important it is and her confidence to succeed in making the change [18]. Assessing readiness in this way informs practitioners how they can best guide the intervention and be the most supportive. For example, when working with a woman who states that she is at a "9" for importance to quit smoking, and a "2" for her confidence to be able to do it, a practitioner would focus on building confidence, not necessarily reviewing all of the health consequences of tobacco. Another scenario might be that she indicates she is low on importance and confidence. This could be because she needs more information on the effects of tobacco and cessation strategies and the conversation might focus on providing this information to increase its importance to her. It might also mean that, given her life circumstances, multiple stressors and competing priorities, she can't imagine adding one more thing to her list. Or possibly, it is a reflection of a sense of lack of safety in the relationship and fear of trying and failing one more time and thus being judged by others. To avoid shame, she is not going to tell you that quitting smoking is important to her.

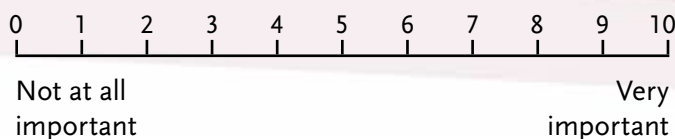
Understanding readiness in this way helps practitioners shift away from the belief that some women are just unmotivated and puts more emphasis on the practitioner's communication style in increasing or decreasing motivation. The focus turns to finding out what motivates her.

#### *Example:*

The questions are used as a guide rather than a fixed sequence. Some practitioners find it helpful to use a visual aid of a 10-point ruler. Asking the follow-up questions draws out her reasons for change.

#### **Importance**

Question 1: Considering the change you are thinking about, on a scale of 0-10, 0 is not important and 10 is very important, how important is it for you to make the change?

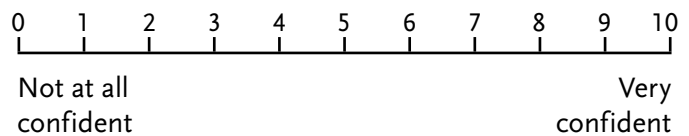


Question 2: Why did you give yourself a (number provided) and not a zero (or a lower number)?  
Question 3: What would have to happen to

move up 1 number (or to a higher number)? (Remember small steps are important. Do not jump all the way to a 10—go slowly!)

#### **Confidence**

Question 1: If you did decide to make this change, how confident are you that you would succeed? If 0 is not at all confident and 10 is very confident, what number would you give yourself?



Question 2: Why did you give yourself a (number provided) and not a zero (or a lower number)?

Question 3: What would it take to move up 1 number (or to a higher number)? (Remember small steps are important. Do not jump all the way to a 10—go slowly!)

The rulers could be adapted in many ways to fit your context, including using a 1-10 scale rather than 0-10, using culturally appropriate images instead of numbers [15] or having the conversation verbally without visual aids.

#### **Build confidence**

Lack of confidence is a central concern for women trying to quit smoking or make changes in related health areas. A woman-centred approach to quitting smoking purposefully aims to build confidence and reduce shame and stigma. Practitioners should look for opportunities to genuinely affirm steps that women are already taking and reframe their attempts to cope from a strengths perspective ("You are doing the best you can in what feels like an impossible situation.") There are also a number of questions that can help to build confidence and inner strength, without having to commit to change.

#### *Examples:*

Thinking about another time in your life when you made up your mind to do something or you got through a challenging time... What helped you get through?

What strengths do you have that could help you succeed in making this change?

What would someone close to you, that you trust, describe as your strengths?

Who else could help with the change?

If you were to consider making a change, not saying you're going to, what do you imagine could be a first step?

What gives you some confidence that you might be able to do this?

Suppose you did succeed and are looking back in time now: What most likely is it that worked? How did it happen?

### **Identity and core values**

A shift in identity is commonly reported as women transform from smokers to non-smokers [5, 6]. Their way of being in the world changes: their relationships with others (friends, partners, children) as well as how they work and spend their leisure time [6]. Many emotions arise as dissonance increases between their self-image as smokers and what is most important to them, their core values, and how they would prefer to see themselves. Although this level of work is often beyond a brief intervention, as it requires a high level of safety and trust, it is important that practitioners

honour and affirm the role that identity plays in women's experience of smoking. Once safety is established, the following questions may help deepen the conversation.

#### *Examples:*

What values matters most to you? (i.e., freedom, independence, family, etc.)

What does being a 'smoker' mean to you? What are some of the other ways you would describe yourself? (i.e., artist, sister, mother, etc.)

How would someone close to you, that you trust, describe you?

How do you see yourself in relation to smoking?

How does smoking affect your life?

Tell me a bit about how and where smoking fits into your life.

What would your life have to be like to consider yourself a non-smoker? How would you describe that woman?

What might have to change in your life for you to consider making a change in your smoking?

**REMEMBER:** Guiding is the ability to encourage dialogue about the possibility of change without demanding change.





### 3. PLANNING

It is critical to approach planning carefully in order to avoid getting ahead of a woman's readiness and ending up in "yes, but..." conversations. What's a "yes, but..." conversation? Here is an example:

Practitioner: "There are a number of aids to help you stop smoking, including nicotine patches, medication, help lines, and smoking cessation support groups.

Woman: "That all sounds good, *but* I just have too much going on right now and I don't know how I would pay for medication or anything else."

"Yes, but..." is a sign of ambivalence and often resurfaces during cessation planning. For those who have managed to stop, these feelings can be a precursor to lapse and relapse. The planning phase requires a balance between the need to move at her pace and moving forward with the next step. Each plan needs to be individualized and tailored, focusing on a woman's specific needs and what works in the context of her life. To stop smoking, women may choose different methods (NRT or not), approaches (gradual reduction versus complete cessation), and intensity of intervention (brief or longer-term) [3]. Choice and flexibility are paramount. Further, if a woman is not ready to take action regarding her tobacco use, it is critical to keep the door open, remain non-judgmental and supportive, and take a holistic approach to her health.

#### GOALS FOR PLANNING

- Remain connected and do not get ahead of the woman's readiness
- Elicit commitment for next step
- Offer choice and options
- Build relapse prevention into the plan
- Prepare for referral if the woman is interested

#### STRATEGIES FOR PLANNING

##### Transition to planning and elicit commitment

A common sticky spot for practitioners is the transition between talking about the possibility of change and moving into planning. One way to shift the conversation forward is to begin with a summary of the conversation, followed by a key question to elicit commitment [11]. The summary might include a re-cap of her mixed feelings about changing, some of the reasons to stay the same and reasons for change, as well as her hopes, values, strengths, abilities and anything she is already doing to take care of herself.

##### Example:

"Let me tell you what I have heard so far: you have a lot of competing priorities in your life right now, and keeping your family together is at the top of the list. Smoking helps you take a break from the chaos and is "your time." It's hard to imagine yourself as a non-smoker, especially how you would manage your anxiety. At the same time, you've mentioned that your energy just isn't the same as it used to be and having a few more dollars every month would sure help. You're getting tired of being controlled by smoking and have started to wonder what life might be like without it. You're just not sure where to start. So where do we go from here?"

##### Examples of key questions:

So where does this conversation leave you?

Where do we go from here?

What is the next step, if anything?

What would be the smallest first step?

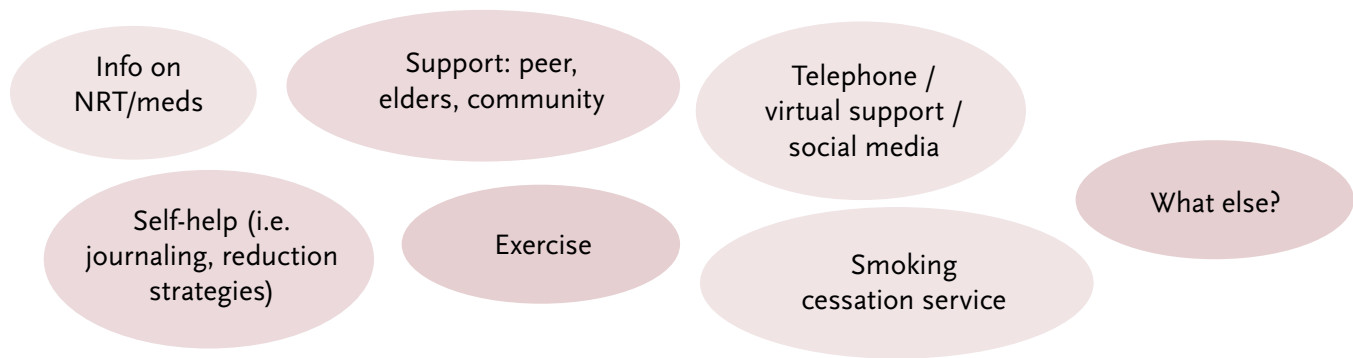
What, if anything, do you plan to do?

##### Explore previous experiences with quitting/cutting down

Before moving into advice and offering strategies and solutions, pause and find out first what she has already tried (refer back to E-P-E strategy above). What was helpful? Not helpful? The outcome of the intervention may be that she commits to thinking about what you have discussed or perhaps journaling about her smoking patterns in preparation for your next meeting. It may not be that she will make a change in her smoking at this time, however the value of her commitment to stay engaged should not be overlooked.

##### Menu of options

Once a woman commits to making changes to her smoking, there are a number of options noted in the literature to support the smoking cessation process: information on NRT and medication; smoking cessation services; telephone and virtual support; self-help; exercise. Similar to the agenda setting strategy, practitioners can develop a menu of options for planning and next steps. She can then decide which option would be the most helpful to start with and what she would like more information about. This strategy helps to contain and focus the conversation and avoid overwhelming her with too much information.



*Example:*

Practitioners are encouraged to use this as a template and identify local area resources under these categories and tailor the menu (a template sheet can be found in the appendix). Questions to consider:

- Who is the contact person for a referral to the community smoking cessation service?
- Are there support groups available?
- What information do you have available on NRT and other medications?
- Who would you contact to get that information?
- What cessation aids are available for free?

Some self-help resources for women are listed in the appendix.

### Personal plan

There are many levels of planning and ways to develop a personalized plan. The result of an initial brief intervention may be to keep thinking about what was discussed and come back for a follow-up visit. Depending on the level of readiness and commitment to move forward, the plan may be much more involved and formal. A template for a personal plan is included in the appendix. Some of the key components to consider in a more detailed plan are:

- Clearly establish the change to be made (cutting down, quitting completely?)
- Identify the reasons why the change is important and strengths she brings to help her make the change
- Specify the steps and timeline
- Identify the supports she has and how they can assist her

- Identify barriers that might come up and brainstorm ideas for responding (relapse prevention)
- Decide how she will know that her plan is working [10]

Once the plan is complete, it is important to reassess her confidence in succeeding, as ambivalence may re-emerge or intensify as the plan takes shape. Further, it is critical to explicitly address her fear of failure. Making a statement like, “No matter what, please come back in—we may have missed something in the plan and we can figure it out together,” communicates collaboration and unconditional support.

### Preparation for referral

In this phase of the conversation, practitioners play an important role in inviting consideration of a referral. Questions like “What would support look like for you? What would you need from the next person you speak with in order to feel safe and supported?” will elicit considerations that will help guide the referral process and assist her in envisioning the next step. You may also want to explore the reality that the next practitioner she has this conversation with may not take the same approach and or have the same understanding. Brainstorming ideas on how she would handle this and take care of herself can help her prepare.

Practitioners can also support engagement by making the referral call with the woman before she leaves the appointment, providing a hand written reminder, following-up with a phone call after the initial visit and introducing her to the person she will be speaking or meeting with.

**REMEMBER:** A plan needs to be individualized and tailored, focusing on a woman’s needs and what works in the context of her life. If a woman is not ready to take action specific to her smoking, it is critical to keep the door open, remain non-judgemental and supportive, and take a holistic approach to her health.

## Wrapping Up And Getting Started

### THE CONVERSATION IS THE INTERVENTION

You have the skills and, more importantly, the opportunity to support women in taking their first steps towards liberating themselves from smoking. While the strategies described in this guide vary in

terms of the length and time required to incorporate them into practice, they are intended to provide you with a variety of ways to start a conversation about quitting smoking.



## Appendices

- 1) Information sheets
  - a. Women and Smoking: An Overview
  - b. Women and Smoking: In Numbers
  - c. Your Body Will Forgive You
- 2) Intervention tools
  - a. Agenda Setting
  - b. Decisional Balance
  - c. Menu Of Options To Support Planning
  - d. Personal Plan
- 3) Resources for women
  - a. AWARE Self-Help Worksheets
  - b. Smoking and Pregnancy: Getting Ready to Quit
- 4) Resources for practitioners
  - a. Conversation Examples for Practitioners
  - b. Women, Trauma, and Smoking:  
Tips for Service Providers

## Women And Smoking: An Overview

Smoking continues to be the number one preventable cause of death and disease.

### HOW MANY WOMEN SMOKE IN CANADA?

- Overall, 18% of women (15 and older) smoke (about 2.2 million women)
- While overall rates of smoking are declining in Canada, young women and Aboriginal women are not following this trend.
  - 13% of teen girls (ages 15-19) smoke and 22% of young women (ages 20-24) smoke
  - 61% of First Nations girls (ages 15-17) smoke (<http://www.tobaccowise.com/common/pages/UserFile.aspx?fileId=76661>)

### ON QUITTING

- More than 75% of women say they want to quit smoking.
- Almost half report having tried to quit in the past year.
- More than 50% of former smokers report they are able to become smoke-free after one or two serious attempts. (CTUMS, 2003)
- Quitting has health benefits that begin almost immediately:
  - 30 minutes after quitting:** blood pressure, heart rate, and the temperature of hands and feet become normal.
  - 1 week after quitting:** nicotine is flushed from the body.
  - 2 years after quitting:** the risk of heart attack drops to that of a woman who has never smoked.
- It's never too late to quit smoking. Quitting smoking at any age can have enormous health benefits.

### SMOKING AND WOMEN'S HEALTH

**Heart Disease and Stroke:** Smoking increases risk of heart disease and stroke. Heart disease is the leading cause of death for women.

**Cancer:** Tobacco use accounts for nearly 1 in 3 cancer deaths. Enough said.

**Birth Control Pill and Other Hormonal Methods:** Women smokers who use hormonal methods of contraception face increased risk of complications such as blood clots, heart attacks, and strokes. Because this risk increases with age, health care providers advise women over 35 who smoke to use alternate methods.

**Pregnancy:** About 13-27% of women smoke during pregnancy (Greaves et al., 2011). Women who smoke may have a more difficult time getting pregnant. Smoking during pregnancy can increase the chance of complications for mother and baby. Complications include premature birth, miscarriage, stillbirths, low birth weight, and sudden infant death syndrome (SIDS).

**Menopause:** Women who smoke may go through menopause earlier and experience more symptoms associated with menopause.

**Ageing:** After menopause, women who smoke often have lower bone density (thinner bones) and are at higher risk for broken bones, including hip fractures. They may also be at higher risk for getting rheumatoid arthritis and cataracts (clouding of the lenses of the eyes), as well as age-related macular degeneration, which can cause blindness.

## SECOND HAND SMOKE

- 600 000 non-smokers die each year due to exposure to second hand smoke

## MARKETING, ADVERTISING, AND PROMOTION

- These days, women are the main targets of the tobacco industry's efforts to win new consumers and rates of smoking in women are continuing to increase in women while peaking or declining in men.

## INTERNATIONAL FACTS

- Approximately one person dies every six seconds due to tobacco (<http://www.who.int/mediacentre/factsheets/fs339/en/index.html>)
- Globally, tobacco use kills more than five million people every year, about 1.5 million of whom are women.
- Women comprise about 20% of the world's more than 1 billion smokers (*Bulletin of the World Health Organization* 2010;88:563-563. doi: 10.2471/BLT.10.080747)
- The International Network of Women Against Tobacco is an official non-governmental organization of the World Health Organization and the only international organization dedicated to reducing the global impact of tobacco on women. [www.inwat.org](http://www.inwat.org)

### Sources

Greaves, L., Poole, N., Okoli, C. T. C., Hemsing, N., Qu, A., Bialystok, L., & O'Leary, R. (2011). *Expecting to Quit: A best practices review of smoking cessation interventions for pregnant and post-partum women* (2nd ed.). Vancouver: British Columbia Centre of Excellence for Women's Health.

Statistics Canada. (2007). Canadian Tobacco Use Monitoring Survey (CTUMS) 2007: Health Canada. Health Promotion Directorate, Ottawa. Table: [http://hc-sc.gc.ca/hc-ps/alt\\_formats/hecs-sesc/pdf/tobac-tabac/research-recherche/stat/\\_ctums-esutc\\_2008/sup-table-ann-eng.pdf](http://hc-sc.gc.ca/hc-ps/alt_formats/hecs-sesc/pdf/tobac-tabac/research-recherche/stat/_ctums-esutc_2008/sup-table-ann-eng.pdf)

U.S. Department of Health and Human Services. (2004) *The Health Consequences of Smoking: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.)

U.S. Department of Health and Human Services. *Women and Smoking: A Report of the Surgeon General*. Rockville (MD): U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General, 2001.

## Women And Smoking: In Numbers

<b>1</b>	The number one preventable cause of death and disease for women is smoking.
<b>13</b>	Percentage of women in Canada who smoke during pregnancy. Complications from smoking during pregnancy include premature birth, miscarriage, stillbirths, low birth weight, and sudden infant death syndrome (SIDS).
<b>13</b>	Average number of cigarettes smoked daily by women smokers in Canada.
<b>20</b>	Percentage of all cancers worldwide attributable to smoking. Women who smoke have higher risks for many cancers, including cancers of the lung, mouth, pharynx, oesophagus, larynx, bladder, pancreas, kidney, and cervix.
<b>24</b>	Percentage of women smokers who have their first cigarette within 5 minutes of waking up.
<b>35</b>	Age at which health care providers encourage women who smoke to use non-hormonal methods of birth control due to concerns about increased risk of complications such as blood clots, heart attacks, and strokes.
<b>50</b>	Percentage of former smokers who report they are able to become smoke-free after one or two serious attempts at quitting.
<b>75</b>	Percentage of women who say they want to quit smoking.
<b>1919</b>	The year in which the American Lorillard Company was the first to use images of women smoking in advertisements. Public outcry ensued.
<b>600 000</b>	Number of non-smokers globally who die each year due to exposure to second hand smoke.
<b>1.5 million</b>	Number of women globally who die every year from tobacco use.
<b>2.2 million</b>	Number of women (over the age of 15) who smoke in Canada.
<b>33 million</b>	Number of people worldwide engaged in tobacco farming - many of whom are women.
<b>200 million</b>	Number of women who smoke globally.

### Sources

Greaves, L., Poole, N., Okoli, C. T. C., Hemsing, N., Qu, A., Bialystok, L., & O'Leary, R. (2011). *Expecting to Quit: A best practices review of smoking cessation interventions for pregnant and post-partum women* (2nd ed.). Vancouver: British Columbia Centre of Excellence for Women's Health.

Samet, J.M. and Yoon, Soon-Young. (2010). *Gender, women, and the tobacco epidemic*. Geneva, Switzerland: World Health Organization. ISBN 978 92 4 159951 1. [http://www.who.int/tobacco/publications/gender/women\\_tob\\_epidemic/en/index.html](http://www.who.int/tobacco/publications/gender/women_tob_epidemic/en/index.html)

Statistics Canada. (2007). Canadian Tobacco Use Monitoring Survey (CTUMS) 2007: Health Canada. Health Promotion Directorate, Ottawa. Table: [http://hc-sc.gc.ca/hc-ps/alt\\_formats/hecs-sesc/pdf/tobac-tabac/research-recherche/stat/\\_ctums-esutc\\_2008/sup-table-ann-eng.pdf](http://hc-sc.gc.ca/hc-ps/alt_formats/hecs-sesc/pdf/tobac-tabac/research-recherche/stat/_ctums-esutc_2008/sup-table-ann-eng.pdf)



## Your Body Will Forgive You

**Don't ever think it's too late to quit smoking. Remember, your body will forgive you no matter how long you've been at it.**

**30 minutes after you quit:** blood pressure, heart rate and temperature of hands and feet become normal.

**12 hours after you quit:** carbon monoxide and oxygen levels in the blood return to normal.

**48 hours after you quit:** your sense of taste and smell start to return to normal levels.

**72 hours after you quit:** bronchial tubes relax and breathing is easier.

**1 week after you quit:** nicotine is flushed from your body.

**2 weeks after you quit:** circulation, breathing, and lung function improve.

**1 month after you quit:** coughing, sinus congestion and shortness of breath decrease.

**2 years after you quit:** risk of heart attack drops to that of a woman who has never smoked.

**5 years after you quit:** risk of stroke drops to normal; risk of lung cancer decreases by half.

**10 years after you quit:** risk of most types of cancer drops to normal.

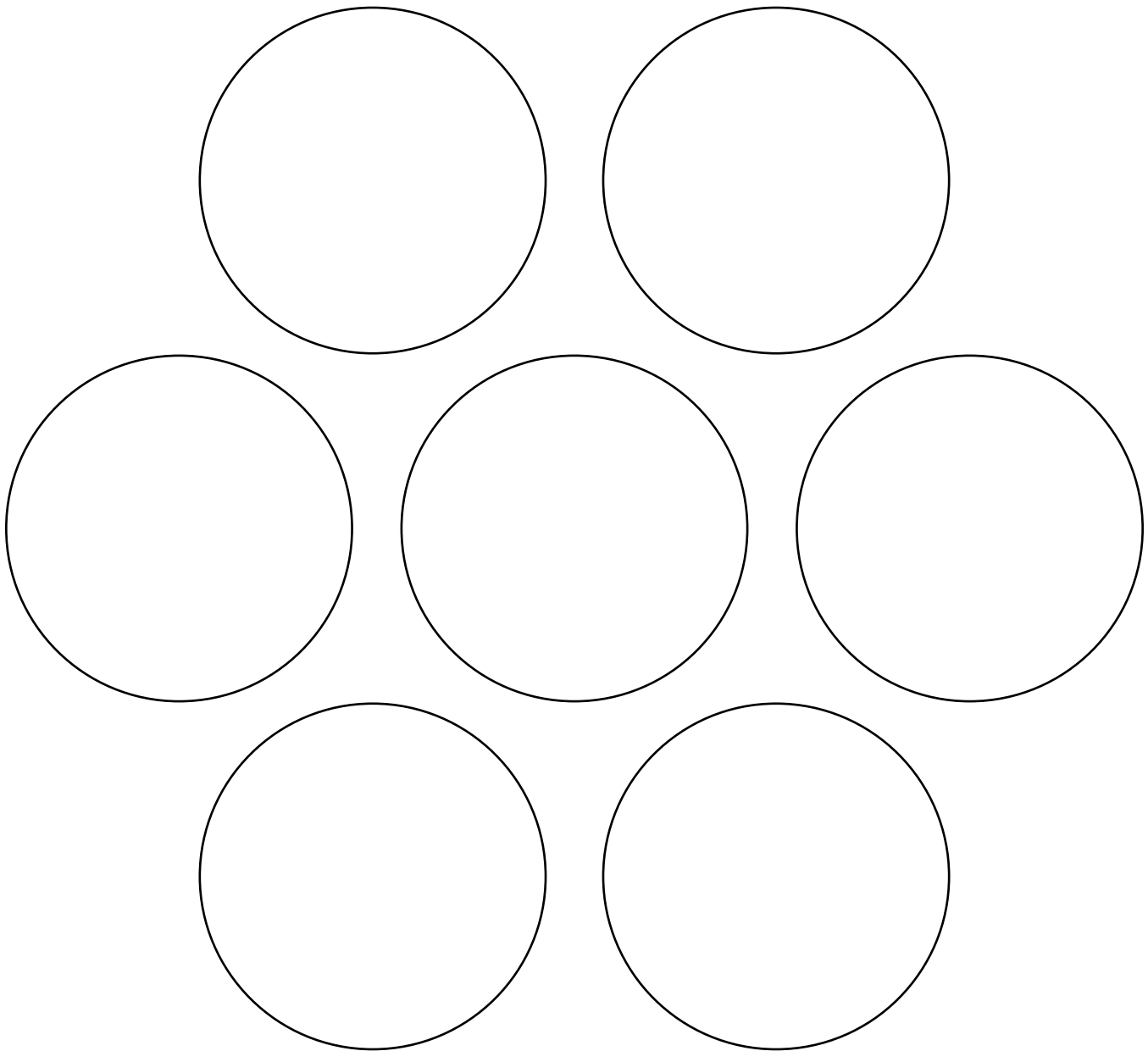
**20 years after you quit:** risk of dying due to smoking-related causes is similar to that of women who have never smoked!

Adapted from *Catching Our Breath: A Journal About Change for Women Who Smoke* by Deborah Holmberg-Schwartz (1997) and *The Health Consequences of Smoking: A Report of the Surgeon General* by the U.S. Department of Health and Human Services, 2004.

PDF version available from [www.expectingtoquit.ca](http://www.expectingtoquit.ca)



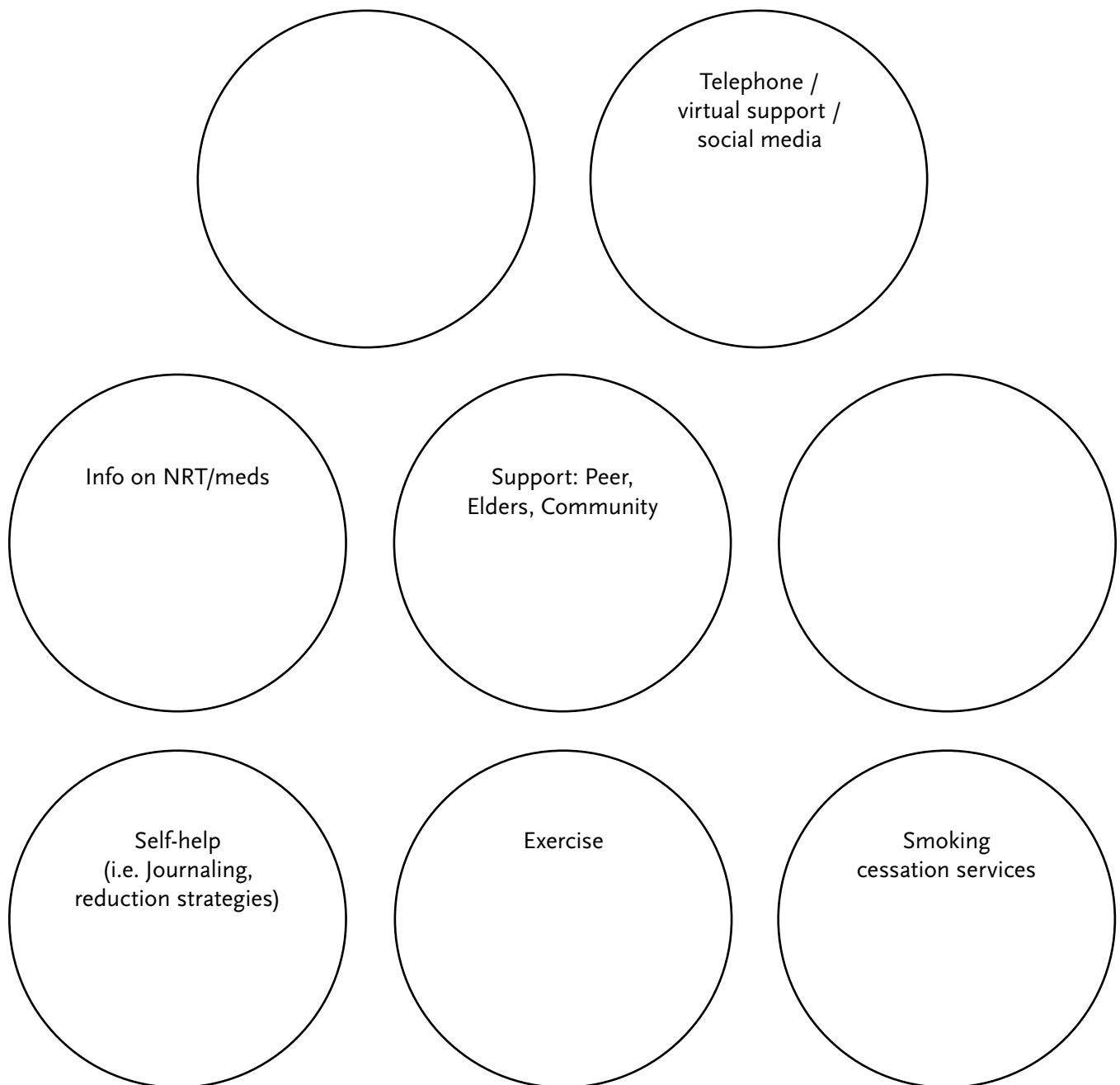
## Agenda Setting



## Decisional Balance

	Benefits / Pros	Costs / Cons
No change		
Change		

## Menu Of Options To Support Planning



## Personal Plan

The changes I want to make are:

The reasons I want to make these changes are:

The strengths/skills I bring to these changes are:

The steps I plan to take in changing are:

Other people can help me by:

Some things that could get in the way:

I will know that my plan is working when:

My level of confidence in succeeding at my plan: \_\_\_\_\_ (using a scale of 0 to 10, 0=not confident at all and 10=completely confident)

## Resources For Women

- 1) Expecting to Quit [www.expectingtoquit.ca/resources](http://www.expectingtoquit.ca/resources)
- 2) Couples and Smoking: What You Need to Know When You are Pregnant  
[www.hcip-bc.org/resources-for-women/documents/TripsBookletNov509forweb\\_000.pdf](http://www.hcip-bc.org/resources-for-women/documents/TripsBookletNov509forweb_000.pdf)
- 3) AWARE [www.aware.on.ca](http://www.aware.on.ca)
- 4) Pregnets [www.pregnets.org](http://www.pregnets.org)
- 5) Quit Now [www.quitnow.ca](http://www.quitnow.ca)
- 6) Smokefree Women [www.women.smokefree.gov](http://www.women.smokefree.gov)
- 7) Holmberg-Schwartz, D., *Catching our Breath: A journal about change for women who smoke*. 1997: Winnipeg.

## Self-Help Worksheets For Women

The following worksheets are drawn from the STARSS (Start Thinking About Reducing Second-hand Smoke) resource developed by AWARE <http://www.aware.on.ca/starss/starss-resources> and can be shared with women.



### Worksheet #2: Cigarette Fading and DEEDS

Two ideas or strategies to cope with cravings are **Cigarette Fading** and **DEEDS**. These ideas help moms who want to protect their children from secondhand smoke. Or they also help if you're trying to quit smoking. The ideas help you delay smoking until you can go outside, get away from your children, or go to your smoking space. Both strategies are also great for single moms who can't always go outside to smoke.

#### Cigarette Fading

Cigarette fading means gradually cutting down on the number of cigarettes you smoke each day. Start by figuring out the number of cigarettes you will allow yourself each day. Then only carry that number with you or give them to a non-smoking friend to keep for you. Put the rest of the package in the freezer or another place that's difficult to reach. Try this schedule:

- Figure out the average number of minutes between each cigarette you smoke.
- Gradually increase the time between each cigarette by 10 to 15 minutes.
- Keep increasing the time between each cigarette.
- Stick to your schedule or the strategy won't work. It's OK to wait longer if you can. But don't smoke more than your schedule allows.
- If you find it too difficult to stick to your schedule, it's OK to go back to smoking more frequently until you're ready to increase the minutes again. ***Just don't go back to smoking whenever you feel like it.***

#### The DEEDS Strategy

**Delay:** A cigarette craving fades in 10 to 15 minutes even if you don't smoke. Talk to yourself. Say "this urge will pass" or "I'd like a cigarette but I don't need this one." When you have a craving, delay smoking for 15 minutes. This gives you a sense of control over smoking. And it shows that cravings don't last forever. Delaying gets easier with practice. Gradually, you can delay for longer and longer periods of time. This means you smoke fewer cigarettes each day. Try these ideas:

- Delay your first cigarette of the day - eat breakfast before you smoke or wait until you get the children off to school.
- Set certain hours that are smoke free. For example, try not smoking between 9PM and 9AM.
- Put ashtrays and lighters in different places so smoking is less convenient.

**Escape:** Leave the situation that causes the craving, if you can. But this isn't always easy, especially if you're a single mom because you can't leave your children alone. Also sometimes it's your children's behaviour that causes cravings! Try these ideas to escape, instead of smoking:

- Occupy your children with a DVD. Or listen to an MP3 player or radio.
- Keep a treasure box of things from the dollar store handy - if you need a little break, a new toy can distract your children for a while.
- Make a list of cool crafts they can work on when you need a break - try to keep the materials on hand.
- Act "as if" - pretend that you're a non-smoker for 15 minutes.
- Be realistic - take a 5 minute break instead of wishing for the afternoon off.
- Take a mental vacation - imagine the place you would most like to be. Include your children. Ask them where they would most like to be and why.
- Put on headphones and listen to your favourite music or the radio - you can still see your children without hearing them.

**Evade:** If you can, avoid situations where you know there will be smoking. When you're more able to resist cravings, you can slowly get back to a normal routine. Set non-smoking rules for your home and stick to them. Try these ideas:

- Set up a comfortable smoking place outside for your guests to use. Also, ask them to watch your children while you go outside to smoke.
- Go places where smoking isn't allowed, like playgroups or the library.
- Hang out with friends who are non-smokers or who are trying to protect their children from secondhand smoke. Visit friends who also have a non-smoking home.

**Distract:** Think of things to do that will keep your mind off smoking. Think of a list of things that you can't smoke and do at the same time. For example:

- Wash dishes, your hair, or give the dog a bath.
- Play cards, knit, sew, or hammer nails.
- Chew gum or hard candy.

**Substitute:** When you have a craving, substitute something you like that keeps your hands and mouth busy. ***The substitute must be something you can do quickly and have on hand.***

- Chew a hard candy, a straw, or fennel seeds.
- Chew regular or nicotine gum.
- Brush your teeth or have a drink of cold water.





## Worksheet #7: Coping With Cravings

It's very common to have cravings for cigarettes when you try to make a change in your smoking. Try to wait out the craving. Tell yourself it will pass after a few minutes. Get busy, drink water, or chomp on some ice. There are many things you can do to cope with cravings. A good first step is to plan ahead. Figure out situations or feelings that are likely to cause a craving. These situations or feelings are called triggers. After you've figured out your triggers, plan ways to deal with them when they happen. Here are some ideas:

### Things I can DO

- Do something that you can't do and smoke at the same time (see **Worksheet #6**).
- Talk to a supportive friend.
- Take your children to the park or for a quick walk outside.
- Hide ashtrays and put your cigarettes out of sight.
- Take deep breaths.
- Have a drink of water.
- Chew gum, breath mints, or hard candy.
- Chew fennel seeds or anise seeds.
- Try using a cinnamon stick or a Smoke Free Cig-rette (a plastic tube flavoured with herbs, menthol, or lemon).
- Try relaxation exercises.
- Take a shower.
- Clean your house.
- Do a craft or colour with your children.
- Do something with a non-smoker.
- If you don't like spicy food, dip your filters in hot sauce or Tabasco sauce so you will only smoke the cigarettes you really crave.
- Reward yourself for delaying your smoking or changing your thinking about smoking.



Make up your own list of things that you can do to help you cope with cravings.

### Things I can DO

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

It isn't always easy for moms to find time to **do** some of the things on the list above. Instead, it might be easier to talk to yourself and change the way you **think** about smoking. Here are some things you can try:

### Things I can THINK

- Tell yourself to delay having this cigarette.
- Try to figure out why you're craving a cigarette.
- Remind yourself the craving will be over soon.
- Figure out what else you can do besides having this cigarette.
- Remember the changes you've made already.
- Remind yourself what a good job you're doing protecting your children from secondhand smoke.
- Remember that not smoking around your children means their health will improve.
- Think positive - remember the benefits to you and your children, pets, and home.
- Think of something you want to buy and put a quarter in a smoking jar every time you delay having a cigarette.
- Don't think of a cigarette as a reward - learn to reward yourself in other ways.

Make up your own list of things that you can think to help you cope with cravings.

### Things I can THINK

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_



## Pregnancy And Smoking: Getting Ready To Quit

Women often feel intense pressure to stop smoking when they become pregnant. This pressure comes from partners, family members, the media, etc. Pregnant women who are unable to reduce or stop smoking often feel guilty and ashamed about their smoking.

Remember, it's your decision to smoke, reduce, or quit. There are lots of paths to quitting smoking—you can find yours in your own time. In the meantime, here are some ideas on what to do until you're ready to take that first step.

### Ways to reduce the harmful effects of smoking:

- Get into the habit of smoking outside. Then, when the baby comes home, you'll be used to smoking outdoors, not inside.
- Talk with your doctor about using nicotine replacement therapy.
- Try smoking only part of each cigarette—such as three-quarters of it— instead of the whole cigarette.
- Work towards reducing or quitting smoking in the last three months of your pregnancy.

### What to say if people tell you that you shouldn't be smoking because you are pregnant:

You can remind them that there are many things you do for your health in general and for a healthy pregnancy in particular. Some of the healthy things that women do while because they are pregnant include:

- getting enough rest
- eating regularly
- learning how to better deal with stress
- exercising
- going for regular health check-ups
- beginning to prepare the home for baby
- staying emotionally healthy

Adapted from Bottorff, J. L., Carey, J., Poole, N., Greaves, L., & Urquhart, C. (2008). *Couples and smoking: What you need to know when you are pregnant*. Vancouver, BC: Jointly published by the British Columbia Centre of Excellence for Women's Health, the Institute for Health Living and Chronic Disease Prevention, University of British Columbia Okanagan, and NEXUS, University of British Columbia Vancouver. ISBN 978-1-894356-61-9.

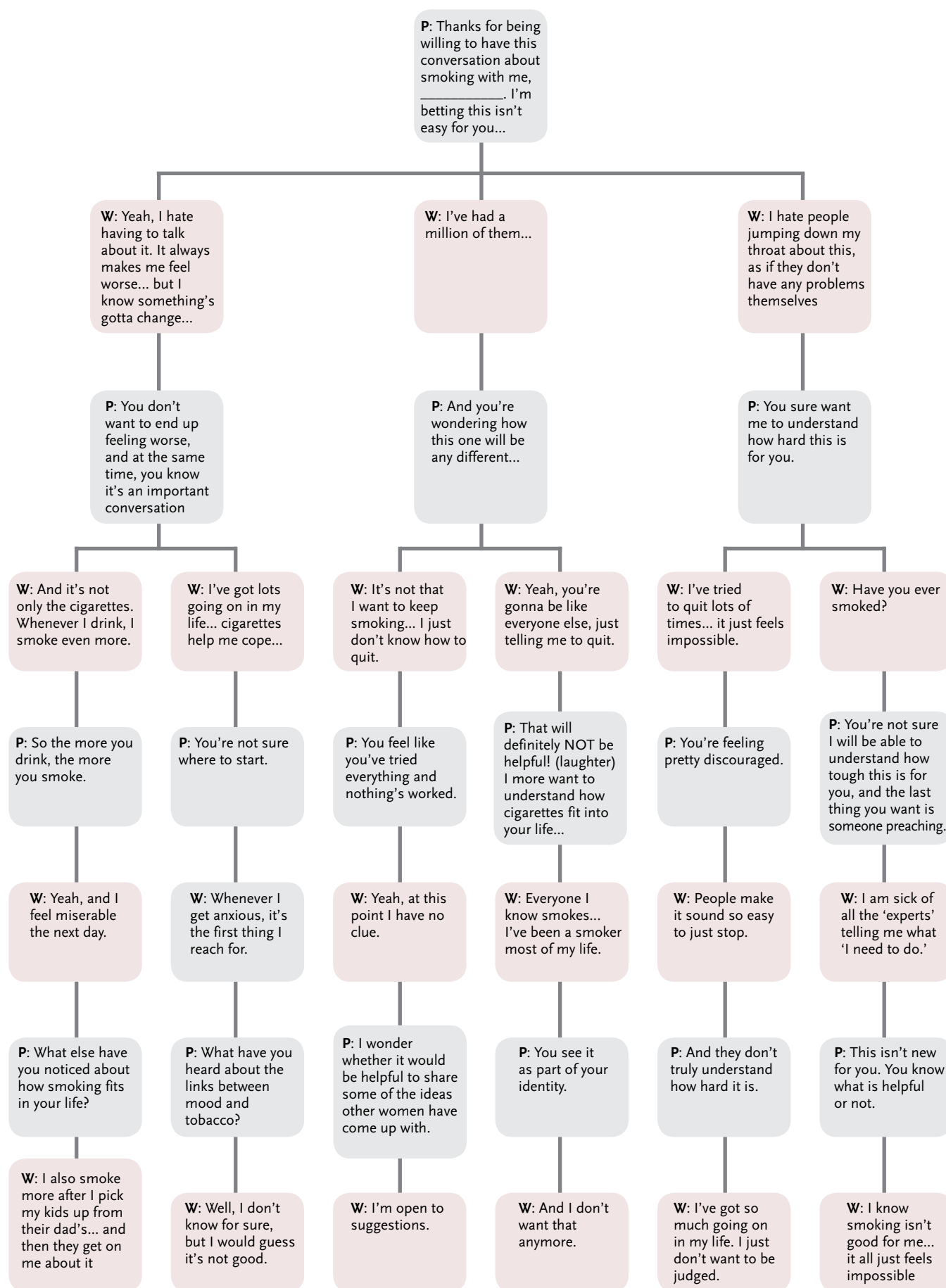
PDF version available from [www.expectingtoquit.ca](http://www.expectingtoquit.ca)

## Resources For Practitioners

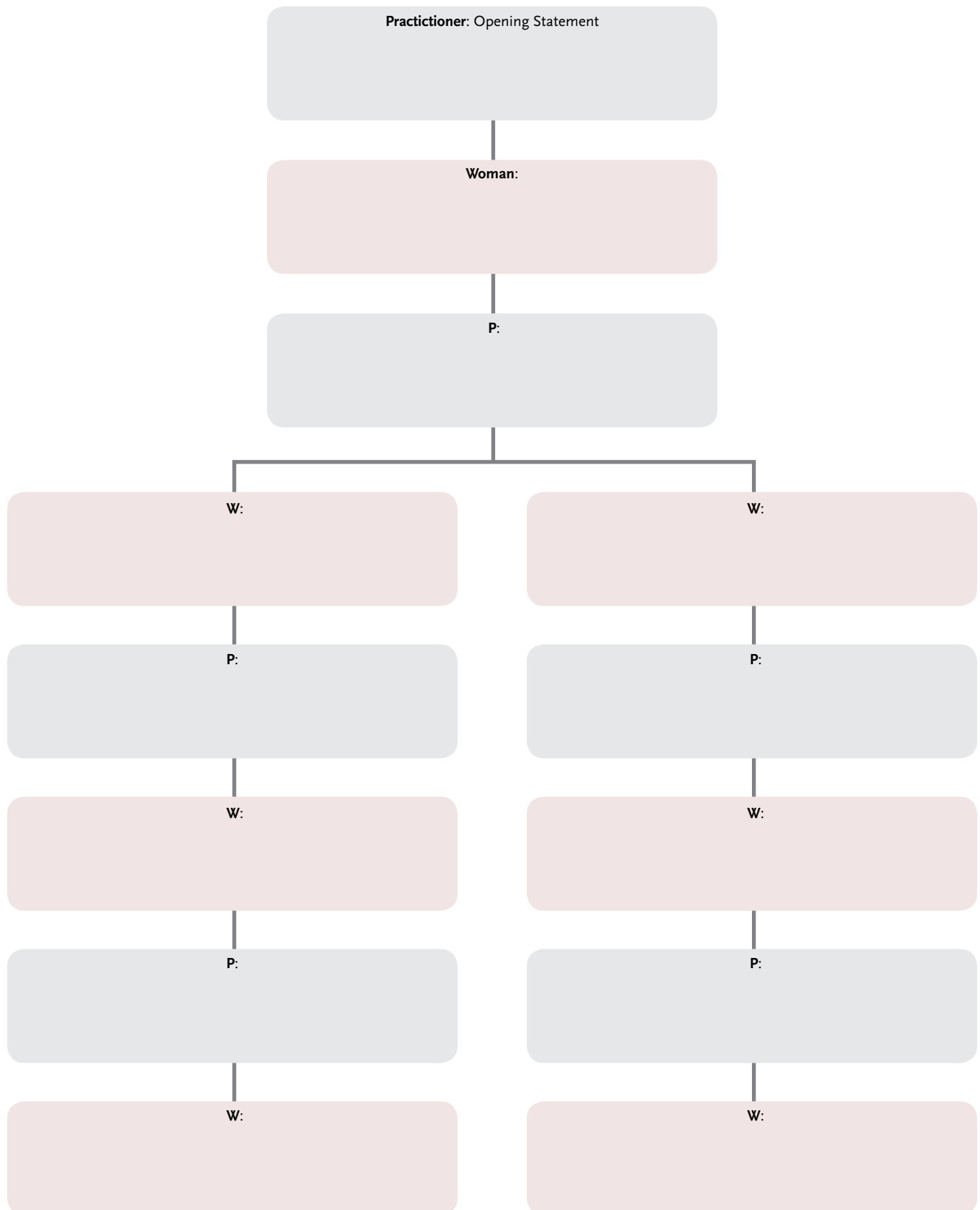
- 1) Expecting to Quit [www.expectingtoquit.ca/approaches](http://www.expectingtoquit.ca/approaches)
- 2) Merlo Lab clip – Effective & Ineffective Physician with Mother  
[www.youtube.com/user/MerloLab#p/u/3/URiKA7CKtfc](http://www.youtube.com/user/MerloLab#p/u/3/URiKA7CKtfc)
- 3) Pregnets [www.pregnets.org](http://www.pregnets.org)
- 4) CAMH TEACH Project [www.youtube.com/user/teachproject#p/u](http://www.youtube.com/user/teachproject#p/u)
- 5) Conversation examples (see attached)

## Conversation Examples For Practitioners

The following dialogue demonstrates the many different directions a conversation could take in the form of a branching script [19]. Each vertical line represents a different conversation and should be read from top to bottom. The examples stress the importance of staying in tune with the woman and not getting ahead of her. The relationship between what the practitioner says and how the woman responds is also evident – whether she moves closer to change, stays neutral or is resistant. Note that reflective listening is the most common response and helps to build the relationship and reduce resistance.



This template can be used to practice conversations that you may have with women about tobacco and related concerns.



## Women, Smoking, And Trauma: Tips For Service Providers

Despite a decrease in the smoking prevalence of the Canadian population from 50% in the 1960s to about 19% today, many cigarette smokers remain unable to quit (Health Canada, 2009). Among those who continue to smoke are women with trauma and violence-related concerns. These concerns often overlap with mental health issues and other substance misuse.

The higher than average smoking rates for women with trauma and violence-related concerns provide a strong rationale for integrated support for smoking cessation in trauma treatment programming. They also suggest a need for all service providers who work with women to have an understanding of the links between trauma and violence and smoking so that they can provide women with information and practical support.

**Help women make the connection between their smoking and experiences of trauma and violence.** While every woman has her own reasons for smoking, it may be helpful for some women to have a better understanding of how their smoking may be related to past experiences or current symptoms of trauma. Service providers can create space for discussing how common smoking is for women who have experienced trauma and suggest ways of learning more about their symptoms and possible avenues for healing. Download a brochure on recognizing the effects of abuse-related trauma in women from the Centre for Addiction and Mental Health [http://www.camh.net/about\\_addiction\\_mental\\_health/mental\\_health\\_information/women\\_signs\\_abusetrauma.pdf](http://www.camh.net/about_addiction_mental_health/mental_health_information/women_signs_abusetrauma.pdf)

**Teach women new coping skills for managing stress and/or helping to regulate emotions.** For many women, smoking is one way of coping with emotional distress. You may want check out Lisa Najavits book *Seeking Safety: A Treatment Manual for PTSD and Substance Use*. It includes a list of over 80 “safe coping skills” that have been used in individual and group programming for women. Visit <http://www.seekingsafety.org>

**Promote physical activity.** Physical activity can improve smoking cessation outcomes by reducing withdrawal symptoms and cravings and addressing concerns about weight gain. Physical activity can also be effective in alleviating symptoms of trauma such as anxiety and panic attacks, cravings for other substances, and sleeping problems. Running, hiking, aerobics, dancing, cycling, swimming.... there are lots of possibilities to explore with women.

**Learn more about the connections between substance use, mental health and addictions for women.** Research is growing quickly in this area and many organizations across Canada are developing innovative programming and policies that incorporate principles of women-centred care, trauma-informed practice, and harm reduction activities. Visit the Coalescing on Women and Substance Use from BC Centre of Excellence for Women's Health. <http://www.coalescing-vc.org>

**Learn more about services that offer treatment for trauma in your organization and community.** Research is beginning to show that many women benefit from addressing trauma before smoking and other addictions or by addressing trauma and addictions concurrently. Be prepared to answer questions or provide information about available services to women who indicate that they might be ready or interested in formal treatment for trauma.

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Additional BCCEWH resources on women and  
tobacco available at: [www.expectingtoquit.ca](http://www.expectingtoquit.ca)  
and  
[www.coalescing-vc.org/](http://www.coalescing-vc.org/)



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