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Women's Interest in Treatment to Stay Abstinent from Cigarettes Postpartum

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Abstract

PURPOSE—Most women who quit smoking during pregnancy will resume smoking in the postpartum period. Interventions to improve rates of sustained tobacco abstinence postpartum may need to address psychosocial factors during the postpartum period. However, given the multiple demands on mothers of young children, it is unclear whether women will find postpartum relapse prevention treatment acceptable. We sought to determine the acceptability of a postpartum smoking relapse prevention intervention and the appeal of strategies to address concerns about mood, stress and weight to prevent postpartum relapse.

METHODS—Women (N = 36) who had quit smoking during pregnancy and either remained abstinent or relapsed within the first year postpartum completed a survey about postpartum relapse prevention program modalities, topics and barriers to treatment. The responses of women who had and had not relapsed to smoking were compared.

MAIN FINDINGS—Both groups endorsed the opportunity to talk with a counselor about relapse prevention, and those who had and had not relapsed did not differ in their endorsement of different treatment modalities. Discussing mood, stress and weight concerns were endorsed by both groups of women, but those who had relapsed were more likely to endorse stress management as an intervention topic. Those who had relapsed also were more likely to endorse the use of pharmacologic aids than were those who had remained abstinent.

CONCLUSIONS—These data suggest that postpartum women would find a smoking relapse prevention program that includes group and individual counseling and the use of strategies to address mood, stress and weight concerns to be acceptable.

Introduction and Background

The majority of women who quit smoking during pregnancy will resume smoking within the first six months of the postpartum period (Fingerhut et al., 1990; McBride et al., 1990; Mullen et al., 1990). Smoking relapse in the postpartum period exposes children to tobacco smoke, which has been linked to sudden infant death syndrome, ear infections, respiratory illness and asthma (Dybing et al., 1999; Ey et al., 1995) as well as to deficits in cognitive and behavioral performance among children (Cornelius et al., 2000; Kahn, Zuckerman et al., 2002; Maughan et al., 2001). Smoking during the postpartum also has numerous consequences for the mother's health (Kure et al., 1996; Zang et al., 1996; Castela et al., 2001; Langhammer et al., 2000;

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Castle et al., 2002; Baron et al., 1990). Thus, the development of efficacious interventions to prevent postpartum smoking will have clear implications for improving the health of mothers and children.

To date, interventions to prevent postpartum smoking have been modestly successful in delaying relapse to smoking (for review, see Mullen, 2004). However, with few exceptions (Higgins et al., 2004; Valanis et al., 2001), these interventions have not substantially decreased the overall rate of relapse postpartum. Moreover, with the possible exception of pilot data supporting the use of contingent vouchers to reinforce abstinence (Higgins et al., 2004), no specific intervention strategies have been shown to significantly reduce rates of postpartum smoking relapse. Therefore, novel approaches to improving rates of sustained abstinence postpartum are needed.

There are also several ways in which previous postpartum interventions might be improved to increase their efficacy. First, most previous postpartum relapse prevention interventions have provided the bulk of information about postpartum abstinence during pregnancy, with little or no continued contact postpartum. However, the salience of the information provided late in pregnancy may be limited as a result of increased anxiety at the end of pregnancy compared to the earlier stages of pregnancy (Da Costa et al., 1999). Second, some of the factors that may affect postpartum smoking, such as method of infant feeding (McBride & Pirie, 1990) and partner's smoking (McBride & Pirie, 1990; McBride et al. 1992), may lack relevance at the end of pregnancy when women may not be experiencing strong urges to smoke. Third, stress, depressed mood and weight concerns, which increase vulnerability to smoking relapse (Levine & Marcus, 2004), also become more relevant during the postpartum period. Thus, a more intensive intervention, delivered during the postpartum period, when women are experiencing stronger urges to smoke and when factors that increase vulnerability to smoking relapse are most salient may improve rates of sustained abstinence.

However, there are many demands on mothers of infants and young children, and it is not clear whether intensive relapse prevention counseling would appeal to women postpartum. Moreover, postpartum tobacco use occurs in the context of social and environmental factors, such as the presence of a partner or friends that smokes, couple dynamics around tobacco use and socioeconomic pressures (Bottorff et al., 2006; Greaves, et al., 2007) that may also affect her ability or desire to remain abstinent postpartum. Nonetheless, given the potential relevance of depressive symptoms, stress and weight concerns to postpartum smoking (Levine & Marcus, 2004; Levine et al., 2006), and their ability to be addressed within an individual regardless of her social context, it is important to determine whether intervention strategies designed to target these psychosocial factors will appeal to women.

Accordingly, we administered a series of surveys to determine the acceptability of an intensive postpartum smoking relapse prevention intervention and to evaluate the appeal of different modalities through which a postpartum smoking relapse prevention program would be implemented and to explore the face validity of strategies to address stress, mood and weight concerns among women who had and had not maintained abstinence postpartum. We expected both women who had and had not relapsed to smoking to find telephone and in person treatment acceptable postpartum. We further hypothesized that women who had relapsed to smoking would be more likely to endorse the need for strategies addressing stress, mood problems and weight concerns than would women who had maintained smoking abstinence postpartum.

Methods

Participants

Women (N = 36) were recruited through flyers, mailings to agencies serving women and children, advertisements in community magazines geared toward pregnant women and letters announcing the study sent from coordinators of a local prenatal smoking cessation program. On average, women were 26.6 (± 6.2) years old, 8.0 (± 3.9) months postpartum and had a BMI of 30.4 (± 7.3). Approximately half of the women (52.8%) were married or living as married and 38.9% were African American. Additional participant characteristics are shown in Table 1.

Procedure

Two groups of women, those who had remained abstinent (n = 15) and those who had relapsed within the first year postpartum (n = 21), participated in a study designed to determine the acceptability of different postpartum intervention strategies. Women who telephoned the study and were interested in participating were asked a series of brief questions to ascertain eligibility. To be eligible for this study, women had to: 1) have delivered a baby within the past 9 months; 2) self-report having quit smoking during their most recent pregnancy or within three months of becoming pregnant; 3) self-report smoking for at least one month prior to quitting; and 4) be at least 18 years of age.

Eligible women who agreed to participate were scheduled for a group discussion session. Sessions were held separately for women who had and had not relapsed to smoking, and if too few women presented to engage in a group discussion, an individual interview was conducted. Thus, discussion sessions consisted of between 1 and 7 women. The discussion session facilitated by the author using a facilitator guide designed for this study. Open-ended questions about treatment modalities, topics and formats were asked, and sessions were recorded and transcribed. At the conclusion of the discussion session, women were presented with a paper and pencil survey about postpartum intervention strategies. Women also completed a brief demographic form and a questionnaire assessing current depressive symptoms and received \$50 for participating.

Measures

Demographic information: Participants were asked to self-report body weight prior to pregnancy. Current postpartum weight and height were measured at the completion of the moderated discussion. Current body mass index (BMI) was computed as weight in kilograms divided by the square of height in meters.

Survey of treatment modality, format and barriers: A 28 item survey developed for this study was administered. The survey consisted of a series of yes/no question divided into three categories: treatment modalities, treatment topics and barriers to treatment. The text of each question is reproduced in Table 2.

Depressive symptoms: Women completed the Center for Epidemiological Studies-Depression Scale (CES-D; Radloff, 1977) to assess current depressive symptomatology.

Analyses—Means, frequencies, variances and ranges for demographic and yes-no questions were computed. The demographic information, BMI and depressive symptomatology of women who had and had not relapsed were compared using t-tests and chi-square tests for continuous and categorical data, respectively. Responses to questions on the survey of treatment formats, topics and barriers of women who had and had not relapsed were compared using chi-square tests.

Results

Program Modality

Table 2 contains the proportion of women endorsing each potential treatment modality. In general, women who had and had not resumed smoking postpartum did not differ in their endorsement of the different modalities for a postpartum relapse prevention program. Specifically, 92% (n = 33) endorsed both a desire to participate in a postpartum relapse prevention program with other women and the opportunity to talk with a coach or counselor postpartum. Women also rated highly the chance to talk with a counselor at their doctors office (86.1%; n = 31) or without leaving their homes (80.6%, n = 29). Receiving support to remain abstinent via phone (63.9%, n = 23) or the internet (52.8%, n = 19) received less endorsement than the other modalities. As one woman who had started smoking within a week of her baby's birth stated: *"It would have been nice to have something and I probably wouldn't have started again if I had somewhere to go, even if it was once a week."*

Program Topics

The most commonly endorsed program topics were discussion of urges to smoke and relaxation skills, with 91.7% (n = 33) of women who had and had not resumed smoking endorsing these topics. Both groups of women also rated information on managing stress and healthy eating as desirable (86.1%; n = 31), although a larger proportion of women who had resumed smoking endorsed wanting information about stress management than did those who had not relapsed (100% vs. 66.7%; $\chi^2 = 8.1$, $p = .01$). For example, in one discussion group, a woman who had relapsed explained: *"There are other ways I could cope with stress but I think a lot of anxiousness worries you. You think smoking cigarettes takes away your worries but it's really not."* There also were differences between women who had and had not relapsed in desire for information about the relationship between eating and smoking and between feelings and smoking, although these differences did not reach the level of statistical significance (p 's = .06).

As shown in Table 2, the use of nicotine replacement therapies (38.9%; n = 14), Zyban® (50%, n = 18) or other pharmacologic approaches (47.2%, n = 17) were less likely to be endorsed as potential tools to help maintain smoking abstinence postpartum. However, a greater proportion of women who had returned to smoking relative to those who had not indicated that they would be interested in a medication to help them quit smoking postpartum, (66.7% vs. 20.0%, $\chi^2 = 7.7$, $p = .01$). Thus, although postpartum women were not likely to endorse the use of medications for smoking relapse prevention, women who had resumed smoking were more likely than those who had not to indicate that they would want to use a pharmacologic approach.

Barriers to Treatment

Table 2 illustrates women reactions to potential barriers to participating in a postpartum relapse prevention program. A majority of women (72.2%; n = 26) indicated that a lack of childcare would make it hard to participate in a program about smoking. However, women who had and had not resumed smoking did not differ in the frequency with which they endorsed barriers to participating in a postpartum relapse prevention program (p 's > .47; See Table 2). Indeed, most women agreed that participating in a program that was flexible would be welcome. As one woman in a discussion group explained: *"You have so much going on, it's very difficult ... that was one of the things I liked about the [prenatal smoking cessation project] because whenever it was time for me to meet with them, they met me at [local women's hospital] so I didn't have to make another appointment. You know, it was like I could stay an extra few minutes so it wasn't a big deal 'cause I was already there and I planned it as part of my schedule."*

Conclusions and Discussion

The development of a smoking relapse prevention program designed to address factors that may increase women's vulnerability to smoking relapse and delivered during the period of highest risk for relapse can help to increase rates of sustained smoking cessation for women. Data from this study indicate that postpartum women would find a smoking relapse prevention program acceptable. Women who have and have not successfully maintained abstinence postpartum were largely similar in their endorsement of treatment modalities, treatment strategies and the potential barriers to participating in a postpartum relapse prevention program.

Specifically, women appear to be interested in a postpartum treatment that includes both group and individual counseling. This study also suggests that treatment strategies designed to target women's concerns about mood, stress and weight are relevant to postpartum women. Although women who relapsed were more likely to endorse the need for help managing stress, both groups of women rated information on stress management and relaxation highly. Stress and negative affect are commonly cited relapse triggers for smoking in general (Kenford et al., 2002; Shiffman et al., 2007) and may be particularly relevant to women smokers postpartum (Solomon et al., 2007). The data from this investigation suggest that strategies to manage stress and negative moods are not only salient but would be acceptable treatment targets for women postpartum. The use of cognitive-behavioral strategies to address issues related to women's postcessation weight concerns (Levine, Marcus, Perkins 2003; Perkins et al., 2001) and mood management (e.g., Hall et al., 1994, 1996; Brown et al., 2001) have been developed. The application of principles from these treatment approaches may help increase rates of sustained smoking cessation postpartum.

A majority of women who had relapsed to smoking postpartum also were interested in pharmacologic approaches to smoking cessation. However medications to aid in staying quit were not endorsed highly by women who had remained abstinent, and pharmacologic approaches were not rated as highly as some other treatment topics by women overall. Given that particular pharmacologic approaches appear to be most appealing to women who have already resumed smoking, education about the efficacy of pharmacotherapy for smoking cessation may be a useful component of a comprehensive postpartum relapse prevention intervention. Thus, additional data on the acceptability of medications to postpartum women who may be nursing and their perceptions of safety and tolerability to these approaches are needed.

Although these data provide direction for the development of postpartum smoking relapse prevention program, there are several limitations to this report. First, this study was designed to query women about certain strategies. It is possible that there are other factors that may be important to address in a postpartum relapse prevention programs or additional barriers to treatment about which we did not inquire. For example, social and environmental issues such as a couple dynamics related to smoking (Bottorff et al., 2006; Greaves et al., 2007), individual differences in cessation experiences during pregnancy and the larger social context in which smoking occurs of women, were not considered in this study. Second, women self selected for participation in this study and their responses about treatments can not be assumed to represent the interest of a wider group of postpartum women who had quit smoking during pregnancy. The majority of women in this study were lower-income urban and women from other racial, ethnic or geographic backgrounds may be different from those in this sample. Finally, these data are cross-sectional and differences between women who did and did not relapse to smoking postpartum may be obscured by individual differences in the characteristics of these women.

Despite these limitations, these results support the development, implementation and testing of a postpartum smoking relapse prevention program that adopts some of the strategies and

topics that women found salient. In particular, a program that is flexible to the demands of women postpartum and addresses psychosocial issues that are modifiable may help to increase rates of sustained smoking cessation postpartum. Our research group is beginning a clinical trial to determine whether strategies to address women's perception of stress, concerns about weight and negative moods will decrease relapse to smoking relative to a supportive treatment postpartum. Data from this trial also will inform theories about the psychosocial factors that affect postpartum smoking relapse.

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Table 1

Participant characteristics.

	Abstinent (n = 15)		Relapsed (n = 21)		Total (N = 36)	
	M	SD	M	SD	M	SD
Age	27.3		26.2		26.6	6.2
% College graduate	33.3%	5.1	19.0%	6.9	25%	
% African American	26.7%		47.6%		38.9%	
% Married/living as married	53.3%		52.4%		52.8%	
Months Postpartum	6.7	3.8	9.0	3.7	8.0	3.9
Current BMI	31.9	7.2	29.3	7.3	30.4	7.3
CES-D	15.7	12.2	19.4	11.1	17.9	11.6

Note. There are no statistically significant differences between abstinent and relapsed women.

Table 2

Questions and responses on survey of postpartum women who had remained abstinent or relapsed to smoking (N = 36).

Question	RELAPSED (N = 21) % yes	ABSTINENT (N = 15) % yes	χ^2	P-value
PROGRAM MODALITY				
Would you participate in a group with other women designed to help you quit smoking/stay quit (from cigarettes) after your baby is born?	95.24%	86.67%	0.84	0.56
Would you participate in a program where you talked with a coach or counselor about issues related to quitting/staying quit after your baby is born?	90.48%	93.33%	0.09	1.00
Would you want to discuss quitting/staying quit with a coach/counselor while you were at your doctor's (e.g., OB, PCP) office or clinic?	90.48%	80.00%	0.80	0.63
Would you want to discuss quitting/staying quit with a coach counselor at the baby's doctor's (i.e., pediatrician, family doctor) office or clinic?	80.95%	60.00%	1.92	0.26
Would you find it helpful to talk about issues related to quitting/staying quit without having to leave your home?	80.95%	80.00%	0.01	1.00
Would you find it helpful to discuss issues related to quitting/staying quit over the phone?	61.90%	66.67%	0.09	1.00
Would you find it helpful to discuss issues related to quitting/staying quit over the internet on a secure website? A	47.62%	64.29%	0.33	0.49
Would you find written information about quitting/staying quit helpful?	76.19%	66.67%	0.40	0.71
PROGRAM TOPICS				
Would you like to discuss urges to smoke?	90.48%	93.33%	0.09	1.00
Would you like to receive information on the effects of smoking on your baby's health?	85.71%	80.00%	0.21	0.68
Would you like to receive information on the effects of smoking on your health?	85.71%	60.00%	3.09	0.12
Would you like information on managing stress?	100.00%	66.67%	8.13	0.01
Would you like to learn skills to help you relax?	95.24%	86.67%	0.84	0.56
Would you like information on healthy eating?	85.71%	86.67%	0.01	1.00
Would you like to talk about how to lose weight?	76.19%	80.00%	0.07	1.00
Would you like help returning to your pre-pregnancy weight?	80.95%	73.33%	0.29	0.69
Would you like help managing your negative feelings?	76.19%	73.33%	0.04	1.00
Would you like information about the relationship between eating and smoking?	85.71%	53.33%	4.57	0.06
Would you like information about the relationship between feelings and smoking?	95.24%	66.67%	5.14	0.06
Would you be interested in a program designed to help you quit smoking/stay quit after your baby is born?	90.48%	73.33%	1.85	0.21
Would you be interested in taking a medication to help you quit smoking/stay quit after having a baby?	66.67%	20.00%	7.65	0.01
Would you be interested in nicotine replacement therapy (e.g., nicotine gum, nicotine patch)?	57.14%	13.33%	7.07	0.01
Would you be interested in taking Zyban®, an FDA-approved medication for smoking cessation?	66.67%	26.67%	5.60	0.04
BARRIERS TO TREATMENT				
Lack of childcare	66.67%	80.00%	0.78	0.47
Lack of transportation	52.38%	40.00%	0.58	0.52
Lack of money for transportation	57.14%	46.67%	0.39	0.74
Time of day	57.14%	60.00%	0.03	1.00
Schedule conflicts	57.14%	60.00%	0.03	1.00
Lack of motivation to stay quit	52.38%	20.00%	3.86	0.08
Pressure from others to keep smoking ^a	30.0%	26.67%	0.05	1.00

^aTotal N for this question is 35. One individual failed to answer this question.