Original investigation

Utility of Responsiveness Theory for Classifying Supportive Behaviors to Enhance Smokeless Tobacco Cessation

Laura Akers PhD¹, Judith S. Gordon PhD², Zoe Brady¹,
Judy A. Andrews PhD¹, Herbert H. Severson PhD¹

¹Oregon Research Institute, Eugene, OR; ²Department of Family and Community Medicine, University of Arizona, Tucson, AZ

Corresponding Author: Laura Akers, PhD, Oregon Research Institute, 1776 Millrace Drive, Eugene, OR 97403, USA.
Telephone: 541-484-2123; Fax: 541-484-1108; E-mail: lauraa@ori.org

Abstract

Introduction: Although social support is correlated with successful tobacco cessation, interventions designed to optimize social support have shown mixed results. Understanding the process of providing social support for tobacco cessation may suggest new approaches to intervention. Responsiveness theory provides a new framework for classifying supportive behaviors in the context of tobacco cessation. It proposes three main components to sustaining relationship quality when providing support to an intimate partner: showing respect, showing understanding, and showing caring.

Methods: Interviews were conducted with 35 women whose husbands or domestic partners had quit smokeless tobacco and were analyzed within a responsiveness theory framework: Positive and negative instances of the three supportive components were expressed in terms of beliefs and attitudes, interactions with the chewer, and behaviors outside of the interaction context.

Results: Positive activities included respecting the chewer's decision on whether, when, and how to quit; perspective-taking and other efforts to understand his subjective experience; and expressing warmth and affection toward the chewer. Particularly problematic for the women were the challenges of respecting the chewer's autonomy (ie, negative behaviors such as nagging him to quit or monitoring his adherence to his cessation goal) and lack of understanding the nature of addiction.

Conclusions: The findings help to confirm the potential utility of responsiveness theory for elucidating the breadth of both positive and negative forms of partner support that may be useful to guide social support interventions for tobacco cessation.

Implications: The study provides a categorization system for positive and negative social support during smokeless tobacco cessation, based on responsiveness theory and interviews with 35 partners of smokeless users.

Introduction

Smokeless tobacco (ST) use remains a significant public health issue, contributing to oral and other forms of cancer,¹ and cardiovascular disease.² In the United States, ST users (chewers) are predominantly male (at least 94%, Agaku et al.³; Table 1), and their wives/intimate partners often strongly desire for them to quit.⁴ One approach to

reducing the overall public health risk of ST use is to help these women learn how to encourage their partners to quit without promoting defensiveness or reactance,⁵ and to learn how to support the chewer most effectively if he does decide to quit.

Previous research on social support for tobacco cessation has focused on encouraging the provision of "positive" rather than

“negative” support, as measured by such instruments as the Partner Interaction Questionnaire (PIQ-20).^{6–8} In an earlier ST cessation trial,⁹ chewers’ received positive support, and the ratio of positive to negative support, predicted abstinence at 6-month follow-up (odds ratio = 1.29 for received positive support, CI = 1.03–1.61), and received positive support also predicted abstinence at 12-month follow-up (odds ratio = 1.43, CI = 1.11–1.84).⁴

Although social support is correlated with successful tobacco cessation, interventions designed to optimize social support have shown mixed results. A greater theoretical understanding of the process of providing social support for tobacco cessation may suggest new approaches to intervention.¹⁰ A more comprehensive theoretical basis for social support may be found in responsiveness theory, which addresses the types of support that can strengthen a relationship, but which has not previously been used as the basis of a support intervention. As delineated by Reis, Clark, and Holmes,¹¹ “perceived partner responsiveness” is highest when three conditions are met: (1) validation, or believing the partner esteems one’s core personal qualities, including showing respect for one’s decision-making, (2) understanding, or feeling a bond of emotional rapport and believing the partner understands one’s concerns, and (3) caring, believing the partner will respond supportively to one’s needs and make one feel cared for. Maisel and Gable¹² have confirmed this theory empirically, showing that both noticed and unnoticed support are associated with greater relationship quality and lower anxiety on the part of the recipient only when the support is “responsive.”

The key components of responsiveness theory are consistent with other research on social aspects of behavior change (Figure 1). Self-determination theory^{13,14} has shown that events experienced as controlling are less likely to motivate behavior change, whereas those that encourage self-initiation and choice can maintain or enhance motivation. The internalization of motivation happens when three social contextual factors are present: “providing a meaningful rationale, acknowledging the behavior’s feelings, and conveying choice.”¹⁴ Conveying choice is a fundamental way of validating another’s autonomy (showing respect), and acknowledging another’s feelings presupposes that one understands what those feelings are (showing understanding).

The four forms of empathy identified by Davis^{15,16} can also fit within a responsiveness theoretical framework. For women who have themselves experienced addiction, “perspective-taking” should facilitate their ability to convey understanding to their partner. Those without this experience may also develop understanding through “imaginative projection,” provided they are given sufficient information on which to base their inferences. “Empathic concern” (associated with sympathy) has been hypothesized as associated with helping behaviors¹⁶ and would underlie a motivation to show caring to the partner. In contrast, women who tend to feel “empathic distress” may have a more difficult time coping with the chewer’s withdrawal symptoms, which could lead to lower levels of expressing warmth and affection during the cessation process. Figure 1 illustrates the relationship between responsiveness theory, self-determination theory, and Davis’s four types of empathy.

Women who want to encourage their husband or domestic partner to quit ST may be most effective if their efforts address the three responsiveness theory components. These components can also illustrate the stumbling blocks to effective support. Rather than respecting the chewer’s autonomy, women may want to figure out what they can do to “make him” quit. Without a personal experience with addiction, women may not understand why their partner cannot simply choose to stop buying and using tobacco. Although their desire to have him stop using tobacco may be motivated by caring and concern for him, a long history of friction on the topic can make it difficult to convey warmth to a tobacco-using partner who may be defensive.¹⁷

As part of our formative research to develop an intervention based on responsiveness theory for female supporters of male chewers (their wives or domestic partners), we conducted an interview study with 35 women whose husbands had quit ST to learn about their contributions to their husbands’ cessation efforts. The purpose of these interviews was to learn how the three components of responsiveness theory were reflected in the women’s internal beliefs and attitudes, verbal interactions with the ST user, and other types of supportive behaviors during the quitting process. The primary goal was to identify positive forms of support that would be operationalized and included in our intervention. A further goal was to identify forms of negative support within the responsiveness theory

Figure 1. Relationship between responsiveness theory, self-determination theory, and Davis’s four types of empathy.

framework: both attempts to be supportive that were likely perceived negatively by the ST user and other beliefs and behaviors by the women that may have undermined their partners' progress towards cessation. This interview study was thus intended to guide the creation of a coding system that would encompass a wide range of supportive behaviors. The coding system would both help to expand on our understanding of positive and negative support within the framework of responsiveness theory and to guide the development of a partner support intervention.

Methods

This study was approved by the Oregon Research Institute Institutional Review Board. We recruited 35 female participants from two previous intervention studies, one conducted with women to teach them to provide support for their husbands' cessation efforts ($n = 10$; Akers et al.¹⁸) and the second conducted with primarily male chewers who had enrolled in an ST-cessation program and who forwarded our query to their wives ($n = 25$; Danaheer et al.¹⁹). For all participants, their husband had successfully quit chewing. The key difference between the two samples was that in the first, we had intervened with the women, while the men (the chewers) were not actively seeking help with cessation, whereas in the second, the motivated male chewers participated in a cessation intervention. The first 10 participants were recruited by e-mailing a sample of 395 women who had completed the final follow-up survey in the previous supporter study. Because 10 interviews fell short of the 20–30 recommended by Cromwell²⁰ for data saturation, we also contacted the 508 men in the cessation study who had been married at baseline and reported abstinence at final follow-up, asking them to forward our e-mail to their wives; 25 of the wives agreed to the interview.

We obtained demographic data, history of tobacco use, and relationship information from 31 of the 35 participants (89%). The mean age of the women at the time of the interview was 42.4 years (range 29–66 years). Twenty-seven were non-Hispanic white, three were Hispanic (two multiracial and one white), and one was non-Hispanic and multiracial. All but one of the 31 women had attended college, and 21 had completed a 4-year degree. Two were current smokers, eight were ex-smokers, and one of the ex-smokers was also an ex-chewer. One of the marriages had ended after 2 years, and for the other 30 women, the mean relationship length was 14.1 years (range 3–46 years). The sample was similar to the overall sample from the previous supporter intervention¹⁸ but somewhat better educated; in that study, about 68% had attended college and 26% had earned a 4-year degree.

Interview Script and Process

The first and third authors developed draft scripts for the structured interview based on our previous work with this population (National Cancer Institute Grant No. R21-CA131461). The second author, who has expertise in qualitative methods, reviewed and revised the scripts, which were then integrated into a single script. No problems or issues were identified regarding the process during the first interviews. Therefore, subsequent interviews were conducted using the same script and procedures.

Each of the 35 women provided online informed consent and completed an audio-recorded structured phone interview with the third author (ZB), an experienced telephone counselor for ST cessation who had had no previous contact with either the women or their partners. Each participant received \$20 as compensation for

her time. The 35 interviews averaged 21.9 minutes (range 11.5–41.2 minutes); interviews from the first sample tended to be slightly longer than those from the second sample (mean 25.5 minutes vs. 20.6 minutes, $P = .105$). Transcriptions were reviewed by the interviewer while listening to the recordings to ensure their accuracy. The interviews were then coded by the first three authors.

The Coding Process

Coding of the interview was based on the presence of showing respect/autonomy (R), the presence of showing understanding (U), the presence of showing caring (C), whether the activity described cessation-related behavior outside of verbal interaction with the partner ("instrumental," I), and whether the activity was negative (counter to one of the three components, or expressing hostility or conflict, N). For example, a woman who described spending time going through her husband's truck looking for evidence of ST use would have the relevant block of text coded as R (she was not respecting the husband's autonomy), I (she was engaging in a behavior outside of verbal interaction with her partner), and N (the behavior was undesirable because it was counter to the respect theme).

The coding process was iterative, focusing on building consensus among the coders. The three coders manually coded the instances in small batches and resolved discrepancies through discussion until a full consensus was achieved. After all blocks had been coded for R, U, C, I, and N, the instrumental and negative examples were recoded, with the instrumental examples coded to RI (ie, instrumental examples of respect/autonomy), UI, CI, and other I, then the same was done with the negative examples: RN, UN, CN, and other N. Two of the coders then looked for conceptual themes within each of the 11 categories, and the examples were sorted within themes, then reviewed and discussed by all three coders. Finally, the classification system was reviewed holistically to ensure that superficially similar themes across categories were actually conceptually distinct.

Nuances of Coding Decision-Making

Across categories, a distinction was made between attitudinal/verbal support and instrumental support, and between positive and negative support (Negative support may also be attitudinal/verbal or instrumental, but we did not examine this distinction.)

Attitudinal/verbal support refers to (1) the woman's attitudes, beliefs, and ways of thinking about things, which are probably foundational to her other behaviors, and (2) her interactions with the chewer: the way she talks to him and the things she says to him.

Instrumental support refers to the woman's behaviors beyond her verbal interactions with the chewer. Decisions about how to interact with him also fit in this category (deciding when and how to talk to him about his tobacco use, choosing to stay out of his way when he is irritable, and making time to listen to him when he is stressed), because they affect her time outside of her usual interactions with the chewer. We based the meaning of "instrumental" on the social support literature,^{21,22} where the term refers to (often tangible) "actions" supporting a person, as contrasted with either "attitudes and beliefs" or "social interactions" supporting a person (This contrasts with the conventional and philosophical meaning of "instrumental" as any action taken as a means toward an end, rather than for its own sake; in this usage, even conversations intended to encourage someone to quit tobacco would be instrumental conversations.). In general, direct interactions between the supporter and the chewer were not classified as instrumental, unless the interactions involved doing something beyond having a conversation, such as

going with him to the doctor or looking at quitting materials with him, or if they involved extra time and were focused entirely on his well-being, such as helping him problem-solve.

Negative forms of support included all activities that were counter to showing respect, understanding, or caring. Expressing negative affect towards him also qualified as negative support. Having negative feelings about ST and his use of ST were not considered intrinsically negative, nor was expressing these feelings to him, as long as she took care to make a distinction between her feelings about ST and her feelings about him. A good example was a woman who said that smokeless is disgusting, but that does not mean she thinks her husband is disgusting. Further, if the woman was doing something otherwise considered negative (such as monitoring his use), and he explicitly told her that he wanted her to do it (either by asking her to do it or by telling her or others that he appreciates it), then it was not coded as negative. For example, if he asked her or the children to check in with him every day to make sure he was still abstinent, this would be considered a positive respect activity (following his wishes on how to support him, in this case providing “supportive accountability”²³) rather than “monitoring” (a negative respect activity).

Results

The 35 women who completed interviews represented a range of supporters and support contexts. Most of the women knew about their husband's ST use when their relationship began, but at least one of the men did not start using ST until after many years of marriage. At least one of the women had previously quit smoking, and one quit smoking at the same time as her husband quit chewing. Many of the women were very involved in helping their partner quit—including several who tried to manage the whole process for him—but many others let him take full responsibility for his quitting, with some finding it had little impact on their own lives.

Roughly 70% of the interview content was coded as reflecting positive or negative support, with the other 30% typically presenting anecdotes about the chewer, the supporter, and others they know, in the context of tobacco cessation. About 52.1% of the interview content was coded within the respect-understanding-caring framework (46.6% positive and 5.5% negative). Another 16.1% described other positive supportive activities, especially instrumental actions such as purchasing quitting aids or providing snacks. A further 2.0% of the material was coded as negative behavior outside the respect-understanding-caring framework, such as general conflict or expressing hostility toward the partner.

Altogether, 965 instances were coded within 11 final categories, and the coding by category is summarized in Table 1. Many of the instances of “pure” instrumental coding were also coded elsewhere, for example, “He asked me to buy him some gum” would be coded as both respect (taking direction from him) and instrumental (buying him gum); likewise buying gum because she inferred he would like some would be coded as both instrumental and understanding (perspective-taking).

All of the women reported at least one instance of showing respect or understanding, but 14 of the 35 women did not report an instance of showing care (as defined by warmth, affection, or concern). Negative instances were much less prevalent, with only 27 of the 35 women reporting negative respect, 12 of the women reporting negative understanding, and 10 of the women reporting negative care.

Table 1. Supportive Instances ($n = 965$) by Coding Category

	Positive		Negative
	Attitudinal/verbal	Instrumental	
Respect	209	72	79
Understanding	161	192	18
Caring	37	11	14
Other	—	128	44

This study was not designed to compare the two samples, but minor differences were found between the groups. Although they did not differ in terms of total instances or total positive instances, the 10 women who had received a support intervention were more likely than those who did not to report positive caring behaviors (attitudinal/verbal and instrumental combined; mean = 2.50 vs. 1.00, $t(33) = 2.369$, $P < .05$), respect-related behaviors (attitudinal/verbal, instrumental, and negative combined; mean = 13.40 vs. 9.04, $t(33) = 2.485$, $P < .05$), care-related behaviors (attitudinal/verbal, instrumental, and negative combined; mean = 3.20 vs. 1.28, $t(33) = 3.063$, $P < .01$), and total negative behaviors (negative respect, negative understanding, negative care, and general negative combined; mean = 6.90 vs. 26.44, $t(33) = 2.208$, $P < .05$).

Categories of Positive and Negative Supportive Behaviors

The 11 categories were R, RI, RN, U, UI, UN, C, CI, CN, other I, and other N, as described above. Here we present the resulting classification scheme, describing the range of topics coded within each of the 11 categories.

Showing Respect (Attitudinal/Verbal; R)

Examples of supportive behaviors showing respect for the chewer's autonomy included respecting that quitting (or not) is his decision, trusting his judgment on the appropriate methods and process for quitting, and respecting his reasons (rather than trying to impose her own).

Another facet of respect for autonomy is supportive attitudes and activities that promote his sense of self and his value as a person. Related behaviors included promoting his confidence and self-efficacy, encouraging him towards meeting his goals (which may happen to include quitting), and expressing pride and admiration of him.

Showing Respect (Instrumental; RI)

This category covers behaviors that convey respect but also require some effort from the woman when not interacting with the chewer. Activities include showing the self-restraint involved in avoiding or stopping her nagging of him before he decided to quit, refraining from monitoring him while he was quitting, and minimizing her reaction to slips or relapse. It also includes taking direction from him on how to support him (eg, “[I always had] gum with me whenever he asked so that he had something in his mouth”). Further, expressing praise or admiration for his quitting beyond her verbal interactions with him (such as leaving him congratulatory notes) also fit in this category.

Negative Respect (RN)

Negative examples of respect included nagging him to decide to quit, monitoring his purchasing decisions or his use (eg, looking for signs

that he was still using), imposing her own will and making decisions for him, lecturing him, dismissing his ideas or his efficacy, and going behind his back to enlist his friends or coworkers in his quitting (although not his family members, as they have a personal stake in his quitting, and talking with them was less likely to feel like a violation or betrayal of his privacy).

Issuing ultimatums and other threats was coded as a violation of autonomy, as was the use of scare tactics (showing him graphic photos or warning him he's going to "lose his mouth" or "his face will melt off"). Expressing a lack of trust in him qualified as not showing respect, as did any attempt to shame him or expressing contempt of him (calling him ridiculous or stupid). Treating him like a child (making decisions on his behalf and talking to him as if he were incompetent) usually fit several of the above descriptors.

Showing Understanding (Attitudinal/Verbal; U)

Examples of this category focused on showing that that she understood the chewer's perspective, including that quitting is difficult. The key distinction between respect and understanding was that the former involved supporting his decisions and his values; the latter involved attentiveness to his subjective experience (how he is feeling during the process and needs that might follow from that).

Understanding was often expressed by saying it is important to understand what he is going through, by trying to think what he might be feeling, and by relating it to her own experiences or offering examples of when he has to extend the same understanding to her (eg, one woman mentioned a parallel with her PMS irritability). Any time she attributed thoughts or feelings to him qualified as an attempt at understanding.

Showing Understanding (Instrumental; UI)

Four main sub-categories fit within the category of instrumental understanding. Practicing perspective-taking included asking him for his perspective on tobacco and addiction, trying to imagine his perspective and his subjective experiences during quitting, and spending time thinking about his views and likely reactions, especially when deciding how to talk to him about quitting. The second sub-category was to try to be the kind of supporter he needs, such as making herself available to listen to him talk about his feelings and experiences, asking him (or not asking him) how things were going based on what she thought he would appreciate, and making inferences about the type of support he might want. The third sub-category concerned being patient and tolerant of his irritability. If she left him alone to "let him have his space" during withdrawal and thereby avoided conflict with him, this qualified as an instrumental form of understanding; if instead she expressed exasperation to him about it, then it was coded as negative. Some women explained withdrawal to their children, helping them feel empathy for their dad. Finally, the fourth sub-category focused on reducing his exposure to stress—deflecting potential stressors from him, avoiding conflict with him and criticizing him, and being easy to get along with.

Negative Understanding (UN)

This category included expressing exasperation about the difficulty of quitting, frustration and impatience with his decision-making and pace of quitting, and intolerance of the withdrawal symptoms.

Showing Care (Attitudinal/Verbal; C)

All supportiveness implies care for another, but within the context of the study we operationalized "showing care" as expressing warmth, affection, and loving concern for the chewer. The four types of care that were most commonly described were care as a motive for wanting him to quit (concern about his health, expressions of wanting a long life together), affection as a method of support during planning and quitting, expressions of affection after quitting, and general expressions of care and love.

Showing Care (Instrumental; CI)

Classified here were actions taken to express affection, tenderness, and romantic sentiments beyond the content of their conversations. Bodily expressions of care included massage and backrubs, and visual reminders of care included affectionate greeting cards and homemade stickers.

Negative Care (CN)

The negative side of care included anything that would hurt his feelings or otherwise feels hostile toward him. Some women described emotional withdrawal (indifference), and some described physical withdrawal (sleeping in a different room because he would not quit or while he was quitting).

Other Instrumental Support (I)

This category applied when the woman supplied practical support for the chewer's quitting, including tangible support, and it also included anything else she did of a practical nature that she believed would make it easier for him to quit or for her to support him more effectively.

One broad category of instrumental support involved information—she may have provided him with practical information on quitting (eg, quitting resources or descriptions of others' experiences); she may have provided information to motivate his quitting; she may have functioned as a gatekeeper to see the doctor or dentist about quitting or tobacco-related health issues; and she may have educated herself about the quitting process. A common way to provide tangible support was by buying him quitting aids such as nicotine replacement or herbal snuff, and by facilitating their use. Redirecting his attention may be helpful, either by helping him avoid social and visual triggers to use, or by providing distracting activities during cravings and withdrawal. She may provide positive feedback, for example, reminding him about benefits he had realized by quitting, encouraging him to celebrate or acquire tangible rewards of quitting, and indulging him during cessation (a combination of rewards and reducing stress). Finally, she may have engaged in self-care to make herself a more effective supporter, especially by managing her own stress and by attending to her own health issues.

Other Negative (N)

The two main types of other negative behavior included expressing disgust to him about his ST use (which was often accompanied by physical withdrawal, such as refusal to kiss him), and general open conflict between them that did not fit into another category.

Discussion

Responsiveness theory provides a framework for identifying both positive and negative types of social support that is novel as applied

in the context of tobacco cessation. The interviews we conducted with women whose husbands/domestic partners had quit ST yielded a rich data set illustrating a wide variety of supportive acts. Responsiveness theory provided a useful way of mapping the women's self-reported supportive behavior, and helps to resolve some of the ambiguities in the valence of previous support items from widely used measures—for example, the PIQ-20 support item “ask him to quit” is coded as negative because it can be perceived as overstepping the boundaries of his autonomy, whereas “ask him to consider quitting” could be positive if framed in terms of respecting his choices and reflecting her care for him.

Through the use of responsiveness theory, we were able to identify many positive, supportive behaviors described by the women in our study. These behaviors included learning and respecting the chewer's own reasons for quitting, trusting the chewer's judgment and when and how to quit, shielding the chewer from stress during the early stages of cessation, explaining the process to their children, and expressing confidence in the chewer during the process and pride in his achievement.

Conversely, even though all of the participants were women whose partners had quit ST successfully, most of them had engaged in behaviors coded as negative. Some women described learning to replace their negative behaviors over the course of the chewer's cessation. In other cases, the chewers were able to quit despite the negativity.

The two biggest challenges faced by the women appeared to be respecting the chewer's autonomy and judgment, and understanding addiction. Autonomy within an intimate relationship may be counterintuitive for people who think of marriage as making them into a single unit that faces all challenges together. Many women described a process of realizing that they had to let go and allow the chewer to make his own decisions. Although many women found analogies to addiction within their own lives, such as weight control and motivating themselves to exercise, there appeared to be a lack of understanding overall regarding the nature of addiction to tobacco. Providing more information about addiction might help them be more patient with the chewer's cessation process.

Relevance for Intervention Design

In general, the categories identified in our study could be useful for educating supporters about the range of helpful activities to consider and behaviors that may be counterproductive. The tallies by category revealed several opportunities for strengthening supportive behaviors among women whose partners are trying to quit ST. In particular, most of the women reported negative activities in the “respect” category, such as nagging and monitoring, and previous research has indicated that such behaviors may not support abstinence.^{6–9}

Further, our findings have implications on the timing of provision of support. Numerous positively coded activities that the women inferred to be helpful (such as asking or not asking their chewer “how's it going” during cessation, or buying him quitting aids) would be better discussed with the chewer in advance (showing respect). For example, some men would find it very helpful to have their wives buy them quitting aids, whereas others may experience more investment in the quitting process if they buy their aids themselves.

Most of the supportive behaviors map conveniently into the stages of change,²⁴ which can provide a useful framework for presenting the information to supporters. During pre-contemplation and contemplation, a supporter should take care not to nag, to

attempt to learn what the chewer values about his ST use, and to frame her discussions with him in terms of love and concern. During the action stage, a supporter can respect the chewer's judgment about his choice of quitting methods, understand how difficult it is to quit, and help him by showing patience and minimizing his stress. During maintenance, she can express her pride in him, understand the nature of slips and relapse, and show him warmth and affection.

Findings from this study suggest that responsiveness theory could be used as a framework for providing support across a broad range of behavior-change contexts. In addition to overcoming addiction, the themes of respect, understanding, and care may be useful for supporters whose loved ones are trying to cope with chronic illness, manage their weight, or make the transition from adolescence to adulthood or from independence to elder care.

The responsiveness-theory categorical scheme also presents an opportunity to create more informative measures of partner support. Existing measures, such as the PIQ-20⁶ and the Support Provided Measure²⁵ have not always been adequate to capture the relevant aspects of support, even for effective interventions.¹⁸ Ideally, measures of partner support should address each of the three components of responsiveness theory, distinguish between attitudes and behaviors, and ask supporters about their tobacco-related behavior in general as well as specifically during the user's quit attempts.

Limitations

The primary limitation of the study is that only wives/partners of men who successfully quit ST were interviewed. Without interviewing the partners of men who have not quit ST, we cannot say with authority that any of the supportive behaviors were in fact related to the chewer's cessation success. It is possible that only a subset of the positive behaviors were helpful. Moreover, it may be that some of the behaviors classified as negative did contribute to the quitter's success. Further, the sample was primarily Caucasian and highly educated, and thus findings may not apply to supporters with diverse backgrounds.

Further, the interviews represented self-reported recall of attitudes and behaviors that the women had engaged in several months or years previously. More contemporaneous interviews would be more accurate, and eliciting the men's reports of what the women had done would also be beneficial.

Funding

This work was supported by the National Institute on Drug Abuse (grant number R01-DA033422).

Declaration of Interests

None declared.

Acknowledgments

The authors wish to thank Christi A. Patten and Edward Lichtenstein for helpful feedback on the manuscript, and Katie Clawson for transcribing the interviews and helping with manuscript preparation.

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