University of Alberta

Dealing With a Latent Danger: Parents Communicating With Their School-Age Preadolescent Children About Smoking
A Grounded Theory Study

by

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Dedication

I dedicate this dissertation to my beloved family:

My husband, Daniel Simmons, for his immense and unwavering support and encouragement. I could not have done it without you;
could not even have entertained the thought.

Our three awesome daughters, Olivia Meredith, Louisa Madeleine, and Miriam Cecilia, for their love, encouragement, and help.
You enrich my life infinitely.

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My parents, John and Elvie Small, who never failed to show their pride in my accomplishments.

Abstract

Smoking in youth continues to be an important public health issue. Because adolescence is the key period for smoking initiation, prevention efforts need to take place before the adolescent years. Little is known about parental smoking prevention interventions. The purpose of this study, therefore, was to understand parental approach to the topic of smoking with school-age pre-adolescent children within the context of local policies and programs concerning smoking. The study was carried out using the grounded theory method of Strauss and Corbin (1998). The sample was purposive and consisted of 38 parents who had at least one child ranging in age from 5 to 12 years and 9 professionals whose work involved youths or smoking prevention. Data consisted of interviews with the parents and professionals and information obtained about smoking-specific public policies and programs that were relevant locally. The data from the parents were analyzed to construct a theory and from the professionals to generate themes.

The findings represent a substantive theory that explains how parents communicated with their children about smoking. Parents perceived smoking to be a latent danger for their children. That meaning was shaped by their knowledge of the health effects of smoking and their knowledge of the nature of youth smoking. They did not want their children to smoke and to deter it they communicated with them by taking action in the form of having a no-smoking rule and verbally interacting on the topic. Their verbal interaction consisted of discussing smoking with their children by intentionally taking advantage of

opportunities, telling their children about the health effects of smoking and their opposition to it by responding on the spur-of-the-moment if their attention was drawn to the issue by external cues, or acknowledging to their children the negative effects of smoking by responding only when their children brought it up. Their action and verbal interaction produced outcomes for them in the form of feelings and thoughts. The study has implications for further theory development and research. The understanding gained from the theory may be used in practice to guide interventions with parents about child smoking prevention.

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CHAPTER 1

INTRODUCTION

The Significance of the Problem

Smoking is the leading cause of preventable morbidity and mortality in Canada. It continues to be the primary risk factor for three of the most common causes of death, which are heart disease, lung cancer, and chronic lung disease (Health Canada, 2007a). However, because it is such a potent cause of disease, negative health effects occur in many other parts of the body as well. The number of diseases, for which there now is sufficient scientific evidence to infer a causal relationship to smoking, is so great that in the most recent report of the Surgeon General it was concluded that smoking harms nearly every organ in the body and causes general poor health. Before death from a smoking-attributed disease, many people who smoke live for years with a reduced quality of life as a result of chronic and debilitating health effects such as progressive shortness of breath and decreasing physical ability (Health Canada 2007b; United States Department of Health and Human Services [USDHHS], 2004a).

Smoking affects people throughout the life span. Smoking in childhood can impair lung growth. Youths who smoke are not as physically fit and have more breathing problems than those who do not smoke (USDHHS, 2004b). Adolescents and young adults have adverse effects to their reproductive and cardio-respiratory systems. By early middle age smoking can cause death from cancer and heart disease. As those who smoke age the prevalence of smoking-attributable diseases increases (USDHHS, 2004a).

Up to half of all lifetime smokers will die prematurely because of their smoking, most of them before their seventieth birthday (Health Canada, 2007b). Adults who continue to smoke lose an average of 13 to 14 years of life (USDHHS, 2004a). More than 37,000 Canadians die each year due to tobacco use (Health Canada, 2007b).

Persons who smoke have more work absenteeism and use more health care services than do non-smokers (USDHHS, 2004a). The personal and family burden due to chronic illness and disability and the socioeconomic burden as a result of health care costs and lost productivity are enormous (Health Canada, 2007a; USDHHS, 2004a).

Smoking is a behaviour most commonly tried and established in adolescence (Centers for Disease Control and Prevention [CDC], 2007). Of all Canadians who have ever smoked a cigarette about half have done so by 15 years of age, three-quarters by 17 years of age, and 85% by 19 years of age (Health Canada, 2008a). Often tobacco dependence occurs rapidly and can develop after only very low levels of exposure to nicotine (DiFranza, et al., 2002; DiFranza, et al., 2007; Gervais, O'Loughlin, Meshefedjian, Bancej, & Tremblay, 2006). Typically, it begins in the early years of use as a childhood condition (Difranza, et al., 2000; Gervais, et al., 2006; Hu, Muthen, Schaffran, Griesler, & Kandel, 2008) and has been described as a major pediatric disease (CDC, 2000; Lynk, 1998). That young adolescents become addicted to tobacco is supported by their own reports that they smoke because they need or are addicted to it and have

withdrawal symptoms on attempts to quit (Dozois, Farrow, & Miser, 1995; Johnson, et al., 2003; Rojas, Killen, Haydel, & Robinson, 1998).

Early age of initiation of smoking is associated, in later years, with stronger addiction, regular smoking, heavy daily consumption, and less likelihood of successful quitting (Breslau & Peterson, 1996; Chassin, Presson, Rose, & Sherman, 1996; Chassin, Presson, Sherman, & Edwards, 1990; Everett, et al., 1999; Hu, Davies, & Kandel, 2006; Taioli & Wynder, 1991). Early initiation and long-term heavy use of tobacco increase the risk of developing tobacco-attributable illness and dying prematurely (Crump, Packer, & Gfroerer, 1998; Lamkin, Davis, & Kamen, 1998). For example, starting to smoke before 15 years of age compared to starting at 20 years of age or later doubles the risk of developing lung cancer (Peto, et al., 2000).

Tobacco use is a strong predictor of subsequent alcohol and illicit drug use in youth (Challier, Chau, Predine, Choquet, & Legras, 2000; Milton, et al., 2004; Torabi, Bailey, & Majd-Jabbari, 1993). It is hypothesized that nicotine-induced structural and chemical changes in the developing brain make youths more vulnerable to alcohol and other drug abuse than otherwise would be the case (The National Center on Addiction and Substance Abuse at Columbia University [CASA], 2007). Data examined by CASA revealed that 12 to 17 year olds who were current smokers were five times more likely to drink alcohol and 13 times more likely to use marijuana than were non-smokers in the same age group. Compared to individuals who had never smoked, those who began smoking at age 12 or younger were about 3 times more likely to binge drink, 5 time more likely

to meet the criteria for alcohol abuse or dependence, 16 times more likely to meet the criteria for marijuana abuse or dependence, and 7 times more likely to use drugs such as heroin and cocaine. National studies in Canada also have revealed an association between smoking during youth and use of other substances. The prevalence of alcohol and cannabis use was higher among youths who had tried cigarette smoking than among youths who had never tried a cigarette (Health Canada, 2005a, 2007c, 2008b, 2010a). For example, 88% of children in grades 7 to 9 (12 to 14 years old) who were current smokers also had drunk alcohol in the past 12 months compared with 20% of those who had never tried smoking but had drunk alcohol. Of children in grades 10 to 12 (15 to 18 year olds) who were current smokers 93% also had drunk alcohol in the past 12 months compared with 57% of those who had never tried smoking but had drunk alcohol. Of children in grades 7 to 9 who were current smokers 53% also had used cannabis in the past 12 months; whereas, only 4% who had never tried smoking had used cannabis. Of those in grades 10 to 12 who were current smokers 82% also had used cannabis in the past 12 months; whereas, only 17% who had never tried smoking had used cannabis (Health Canada, 2010a). Because of the association between smoking and use of other substances, tobacco has been referred to as the gateway drug (e.g., CASA, 2007; Lindsay & Rainey, 1997). To the extent that biological alteration, activation, and desensitization from tobacco use play a role in later substance use, prevention of smoking is of prime importance (CASA, 2003, 2007).

The proportion of adults in Canada who are current smokers has declined considerably since 1965 when regular monitoring of smoking first began. However, the rate of decline has slowed in recent years. Within Canada current smoking among adolescents aged 15 to 19 had increased during the mid 1990s to a rate of 28% in 1999 after a decline in the 1980s to a low of 21% by 1991 (Health Canada, 2007d, 2009a; Pederson, 1993). Since 1999 there has been another decline that has levelled off from 2006 at 15%. Among the subgroup that is 15 to 17 years old 11% currently smoke. Adolescents who smoke daily consume on average 12 cigarettes a day. Within Newfoundland and Labrador the rate of current smoking for 15 to 19 year olds also is 15% and they smoke, on average, 14 cigarettes daily (Health Canada, 2009a). Among younger children, ages 10 to 14 years (grades 5 to 9), both nationally and within Newfoundland and Labrador, about 18 to 22% have at least tried a cigarette (Health Canada, 2007c, 2008b, 2010a).

The statistics on smoking rates in youth are based on cigarette use. Unfortunately, that tells only part of the story. What is alarming in recent reports is that many youths use little cigars, often referred to as cigarillos (Health Canada, 2008c; Physicians for a Smoke-Free Canada, 2008). Among Canadian adolescents in the age group 15 to 19 years 31% have reported trying little cigars and 9% have reported smoking a little cigar in the past 30 days (Health Canada, 2009a). Younger children also have reported trying cigar products (Health Canada, 2008b). Of children who were 11 to 14 years of age (grades 6 to 9) 10% had ever tried smoking cigarillos (Health Canada, 2010a). These results reveal that little

cigars are an important form of tobacco use among youths and when taken into account may mean that the rate of smoking in youth is higher than official statistics indicate (Physicians for a Smoke-Free Canada, 2008).

Clearly, tobacco use continues to be an important public health issue and cause for concern (Newfoundland and Labrador Department of Health and Community Services, 2007). It is disturbing that despite smoking prevention efforts for youths and the widespread availability of information concerning health risks, adolescents continue to initiate smoking at a high rate.

Research efforts in the area of youth smoking primarily have focused on adolescents with the main emphasis being on identifying factors that influence them to smoke. Numerous cross-sectional and longitudinal studies have been carried out and a large number of correlates and predictors of the behaviour have been identified, which may be broadly classified as social, psychological, personality, developmental, and genetic factors. The initiation, progression, and maintenance of youth tobacco use are complex with interdependences among different influences (Lindsay & Rainey, 1997; Moolchan, Ernst, & Henningfield, 2000; Tyas & Pederson, 1998; White, Hopper, Wearing, & Hill, 2003). One type of social influence that has been studied extensively is parental influence. Many parental characteristics and behaviours have been examined. However, findings from the largely quantitative correlational studies generally have been inconsistent and inconclusive. In particular, parental communication with their children about the topic of smoking is not well understood.

Traditionally, most prevention efforts were directed to youths themselves, through school programs, with the main emphases being on improving knowledge and averting peer and wider social influences. The results of such programs have been mixed. Some yielded a short-term positive effect on children's smoking behaviour; whereas, others did not produce an effect. There is no strong evidence for a long-term effect on smoking prevention (Bruvold, 1993; Dobbins, DeCorby, Manske, & Goldblatt, 2008; Thomas & Perera, 2006; Wiehe, Garrison, Christakis, Ebel, & Rivara, 2005).

The data on smoking indicate that future reductions in the morbidity, mortality, and personal and socioeconomic costs of smoking will require a sustained effort (USDHHS, 2004a). The high risk of adult smoking as a consequence of adolescent smoking provides support for the importance of primary prevention to deter initiation of smoking among youths (Chassin, et al., 1990). Increasingly, it has been acknowledged that interventions to curb smoking should be broad, taking into account the varied influences (CDC, 1994, 2000, 2007; National Cancer Policy Board, Institute of Medicine, & National Research Council, 2000; Sowden & Stead, 2003). Yet, little has been done to engage parents in prevention efforts; for the most part, they have not been targeted for intervention. Recently there has been greater recognition of the importance of involving parents in substance use prevention including smoking (e.g., Chassin, Presson, Rose, Sherman, & Todd, 1998; Engels & Willemsen, 2004; Jackson, 2002). An important first step is to determine the approach or approaches that parents normally take with their children about the topic of smoking. Because

adolescence is the key period for smoking initiation, to have an impact on prevention parents would need to take measures before the adolescent years.

The Purpose of the Study

The purpose of this study was to understand, within the local policy and program context concerning smoking, parental approach to the topic of smoking with their school-age pre-adolescent children.

The Research Questions

The main research question that was addressed in this study was *How do parents approach the topic of smoking with their school-age pre-adolescent children?* Four subordinate questions, which guided data collection, were (a) What meaning do parents apply to smoking behaviour among children? (b) How does the local policy and program context concerning smoking influence the way that parents approach the topic of smoking with their children? (c) How do the approaches of mothers and fathers compare? and (d) How do the approaches of non-smoking and smoking parents compare?

Overview of the Contents of the Subsequent Chapters

In this chapter, the rationale for the study was introduced. Chapter 2 entails a literature review. The purpose of that chapter is to discuss literature that represents the theoretical and research knowledge base that is relevant to the problem addressed in this study, *understanding parental approach to the topic of smoking with school-age preadolescent children*. The chapter starts with a description of the literature search strategy and results and rationale for the

literature review. The studies are broadly categorized according to whether they were conducted using quantitative or qualitative methods. The quantitative studies are further divided into three main categories: (a) theory-based parental influence on youth smoking, (b) parental antismoking socialization, and (c) parental socio-demographic influence. Methodological limitations within that body of research are addressed. The qualitative studies are divided according to whether they were based on (a) adolescents' perspectives or (b) parents' perspectives. An overview is provided of limitations in the qualitative research.

Chapter 3 is about the study method. It consists of a description of (a) grounded theory methodology; (b) the grounded theory method used in this study; (c) the sample, participant recruitment procedures, and participant sampling rationale; (d) data collection; and (e) data analysis. In particular, detail is provided of the procedures used in analyzing the data from the parents to construct a theory and from the professionals, who also participated in the study, to generate themes. The scientific rigor and research ethics regarding the study also are addressed.

Chapter 4 encompasses the study findings and is organized according to a description of (a) the local policy and program context concerning smoking; (b) the characteristics of the professionals; (c) the professionals' perspectives, which are represented by the theme *Smoking prevention requires a multipronged approach involving parents, school, and society*; (d) the characteristics of the parents; (e) the theory, in the form of an overview, which was constructed to explain parents' approaches concerning smoking and is referred to as *Dealing with a latent danger: Parents communicating with their school-age preadolescent*

children about smoking; (f) the specific components of the theory, which are central category, shared conditions, parental action, parental verbal interaction approaches and corresponding specific conditions, and parental outcomes; (g) the context for the parents' continuing action and verbal interaction; (h) the possible negative case that was identified in the parent data (i.e., the approach of one parent that does not completely fit the theory); and (i) the similarities and differences between professionals' perspectives and parents' perspectives and practices concerning smoking prevention for youths.

Chapter 5 is to discuss the meaning of the study findings and examine the findings in relation to previous research, extant theory, and other literature in the field. The chapter is organized to correspond with the main themes that were identified in the data from the parents and professionals. These are (a) parental action, (b) parental verbal interaction, (c) role of school, and (d) role of society. The chapter ends with my personal reflection on the adequacy and relevance of the substantive theory that was constructed from this study.

Chapter 6 is to examine implications of the study findings for (a) theory development, (b) further research, and (c) health promotion practice. Limitations of the study which should be taken into account when considering the implications for practice also are addressed.

CHAPTER 2

LITERATURE REVIEW

Literature Search Strategy and Results

A search of the English language literature was undertaken to identify research and theoretical publications that are relevant to parenting and youth smoking. An electronic search was limited to publications dating from 1990 to 2010. The rationale for the limited timeframe was that earlier research may not reflect current behaviour, actions, attitudes, and beliefs in relation to smoking. Social changes have occurred in recent years, starting in the 1990s, including decreased acceptance of smoking by the public, decreased normalcy of smoking, increased social restrictions on tobacco access and use, and increased knowledge among the public about the accompanying health effects (USDHHS, 2004a). The social context for smoking was different years ago.

Six electronic databases were searched including CINAHL, PubMed, PsychInfo, Social Services Abstracts, ERIC, and Cochrane Database of Systematic Reviews. Various combinations of terms were used in the different databases such as parenting, parenting skills, parental role, childrearing practices, parental influence, parent child relations, parent child communication, parental attitudes, socialization, antismoking socialization, smoking, tobacco use, smoking prevalence, smoking prevention, smoking control, smoking interventions, adolescence, child, school age, junior high school students, and high school students.

The retrieved articles then were searched for relevant references, which were cross checked with the electronic search to ensure inclusiveness. As a result of that search a number of other research publications were identified, including several that pre-dated 1990, and were collected because of potential relevance. The hand search was particularly useful in identifying book and journal references for theoretical literature, which then were retrieved.

Several internet sites were searched for studies and reports pertaining to smoking. These included the Newfoundland and Labrador Department of Health and Community Services (e.g., youth substance use), Health Canada and Statistics Canada (e.g., surveys on smoking prevalence and other characteristics), United States Department of Health and Human Services (e.g., Surgeon General's reports), Centers for Disease Control and Prevention (e.g., smoking prevention programs), and National Center on Addiction and Substance Abuse at Columbia University (e.g., surveys on youth substance use in the United States).

Overall, a large number of publications and documents were retrieved and reviewed. By far, most of the studies were carried out using quantitative methods but some were qualitative. Predominantly, the quantitative designs were cross-sectional but a number of more recent studies were longitudinal. Most of the qualitative studies involved generic qualitative data analysis. Only one was based on a formal method, that of grounded theory. A large majority of the studies were conducted in various parts of the United States. Many were carried out in different European countries and some in Australia. Although there were a number of Canadian studies on other aspects of youth smoking such as prevalence,

characteristics of the behaviour, and addiction, few Canadian studies were identified that involved parenting and youth smoking.

The quantitative studies that were found through the literature search pertained to various aspects of parental influence on youth smoking. Some of those studies were based on classic social or social-psychological theories. For other studies an explicit theory was not identified but those studies may be categorized under the concept *parental antismoking socialization*. The remaining studies were about parental socio-demographic factors. The qualitative studies were from either youths' perspectives or parents' perspectives. The studies consisting of youths were about their views on various aspects of smoking including parental influence and communication. The studies of the parents revealed their views on youth smoking, or interventions for youth smoking or environmental tobacco smoke (ETS), or a combination thereof.

Rationale for the Literature Review

Both quantitative and qualitative research are included in this literature review to illustrate existing knowledge about parenting children concerning smoking, gaps in the knowledge, and limitations in the research in order to demonstrate the basis for this study. Specifically, studies which were based on the social and social psychological theories yielded mixed support. Inconsistent and unexpected findings make it difficult to determine the adequacy of the various theoretical explanations. There also were inconsistencies in findings concerning the various parental antismoking socialization and socio-demographic factors, including parental communication with children, which preclude gaining a clear

understanding of those factors. Of particular note is that a theory was not found that addresses parental communication with children about smoking or that is specific to parental communication more generally. The qualitative studies were of special interest but there were few and although they shed some light on parental approach with children concerning smoking, none provided for a comprehensive understanding of the phenomenon. Details of the literature that was examined are provided in the following two sections, which are broadly organized in the first instance as to whether the research was quantitative or qualitative in design.

Quantitative Research

The quantitative research is presented according to whether it was theory-based, conceptualized as parental antismoking socialization, or about parental socio-demographic factors.

Theory-Based Parental Influence on Youth Smoking

Several classic, social and social psychological theories have been used as frameworks to examine youth smoking. These are the Theory of Planned Behavior, Social Cognitive Theory, Social Control Theory, Problem Behavior Theory, and Parenting Styles. These theories specify factors that put children at risk for a behaviour such as smoking and factors that protect them from initiating the behaviour (Petraitis, Flay, & Miller, 1995). A number of studies have been carried out in which these theories were used to investigate the influence of various parental factors on children's smoking.

Theory of Planned Behavior. The Theory of Planned Behavior (Ajzen, 1985, 1988, 1991) is an extension of its predecessor the Theory of Reasoned Action (Ajzen & Fishbein, 1980). As applied to smoking, a premise of the Theory is that youths will intend to smoke if they have a positive attitude toward it, believe that smoking is a prevalent behaviour and is approved by important others (subjective norms), and have strong smoking self-efficacy (e.g., the ability to carry out the behaviour). Having parents who smoke, are amenable to smoking, or fail to show disapproval of the behaviour can increase children's perceptions that smoking is acceptable, desirable, common, and devoid of serious consequences. It also can influence children to think that they will be able to access cigarettes and successfully use them (Petraitis, et al., 1995).

The Theory of Planned Behavior or Theory of Reasoned Action has had limited use in the examination of parental influence on youth smoking. In one study, the presence of parental smoking models was associated with stronger intentions to smoke but only in non-smoking adolescents from one of the two geographic regions from which the sample was selected (Presson, et al., 1984). In two studies, among adolescents, parental smoking had a significant indirect effect on smoking initiation, escalation, or both (Flay, et al., 1994; Harakeh, Scholte, Vermulst, de Vries, & Engels, 2004). In the study by Harakeh and colleagues, however, parental smoking also affected smoking onset directly, which is contradictory to the theoretical premise that all influences are mediated through cognitions and intentions. Quality of the parent-child relationship and parental knowledge of the child's whereabouts had inverse relationships with adolescent

smoking onset, which were evidenced indirectly as predicted. In another study, exposure to parent smoking increased positive expectancies about smoking (i.e., attitude), which in turn increased intentions to smoke. Intentions to smoke predicted subsequent initiation of smoking (Tickle, Hull, Sargent, Dalton, & Heatherton, 2006). However, several findings in that study were inconsistent with theoretical predictions. For instance, parent smoking was not associated with normative beliefs and normative beliefs were not associated with intentions to smoke. Similarly, in a study in which parental smoking and parental communication about smoking were examined as antecedents to adolescent cognitions, although there was support for the predictive value of attitude and self-efficacy, support for the predictive value of parental norms was not evident. Adolescent perceptions of parental norm, that is, whether their parents approved of adolescent smoking, did not influence their smoking intentions. However, intention to smoke predicted smoking behaviour as expected (Otten, Harakeh, Vermulst, van den Eijnden, & Engels, 2007).

Overall, there have been a number of studies in which the Theory of Planned Behavior or Theory of Reasoned Action or constructs from these were used to examine various influences on youth smoking. Some findings provided support for theoretical predictions; whereas, others were not consistent with expectations. Specifically, with respect to parental influence on youth smoking, the research findings make it difficult to determine whether the Theory provides a useful explanation.

Social Cognitive Theory. Social Cognitive Theory (Bandura, 1977, 1986) evolved from the earlier Social Learning Theory (Akers, 1977). As applied to smoking behaviour, premises of the Theory indicate that involvement with smoking role models allows for observation and imitation of smoking-specific behaviours; social reinforcement (e.g., encouragement of the behaviour); formation of positive expectations about the most likely social, psychological, and physiological consequences of future smoking; and enhancement of self-efficacy (Petraitis, et al., 1995). Parents, then, may set a negative example if they smoke. They may reinforce the behaviour by displaying favourable attitudes and beliefs toward it and failing to disapprove of it. Further, from smoking parents children may learn such things as how to acquire cigarettes, light a cigarette and inhale, and when to smoke (e.g., when socializing or drinking alcohol, or to relax), all of which enhance their use self-efficacy. Thus, children are likely to initiate smoking when they receive the message that smoking is acceptable, will not result in negative consequences for them but instead will have a positive effect such as portrayal of a mature image or control of stress, and can be successfully enacted.

The various aspects of parental influence that have been examined using Social Cognitive Theory are approval, negative attitude, smoking behaviour, antismoking communication, and disciplinary consequences. Parental approval of smoking predicted current and frequent smoking (Collins & Ellickson, 2004). Fathers' negative attitude, but not mothers', was protective for smoking initiation (Andrews, Hops, Ary, Tildesley, & Harris, 1993). Parental smoking predicted daily (regular) smoking (Bricker, et al., 2006; Otten, Engels, van de Ven, &

Bricker, 2007) and both predicted (Chassin, Presson, Sherman, Corty, & Olshavsky, 1984; Otten, Engels, van de Ven, & Bricker, 2007) and did not predict (Andrews, et al., 1993) initiation of smoking. Similarly, it both predicted (Otten, Engels, van de Ven, & Bricker, 2007) and did not predict (Chassin, et al., 1984) progression of smoking to an increased level. Further, for adolescent girls, but not boys, mothers' use of cigarettes was inversely related to maintenance of smoking such that girls who continued smoking had mothers who were less likely to smoke than girls who quit smoking. Fathers' smoking did not affect smoking maintenance for either boys or girls (Andrews, et al., 1993). Andrews and colleagues also found discrepant and unexpected results when they examined smoking-specific parental communication and disciplinary consequences. Mothers' cautionary statements regarding cigarette use positively predicted cigarette maintenance for girls, so that the more cautionary statements were made, the more likely the girls were to continue smoking. There was no effect for boys. Fathers' cautionary statements did not affect cigarette maintenance for boys or girls. Neither father nor mother cautionary statements affected smoking initiation. Negative consequences that parents had established for child smoking also did not predict initiation of adolescent smoking. However, the more negative consequences received from mothers, but not fathers, the more likely adolescent boys, but not girls, were to continue smoking. There are no obvious theoretical explanations for the parent and child sex differences in the findings.

Social Cognitive Theory, Social Learning Theory, or specific components of these have been used to guide a number of studies on youth smoking. However,

some findings have not provided support for theoretical predictions. Discrepant and unexpected findings make it difficult to determine whether the theory provides a useful explanation of parental influence on youth smoking.

Social Control Theory. There are several social control theories but the one that has been used in the youth smoking literature is the classic Social Control Theory of Hirschi (1969). Based on that theory, it may be argued that the stronger the attachment between parents and their children, the less likely it is that the children will smoke when the parents oppose it, the less susceptible they will be to pro-smoking social pressure such as peer influence, and the more likely it is that they will conform to parental antismoking measures. However, research findings have been mixed. Parental attachment, variously defined and measured, was found to be a predictor of adolescent smoking, both in the direction expected (Collins & Ellickson, 2004; Hoppe, et al., 1998) and in the direction opposite to that proposed by the Theory (Skinner, Massey, Krohn, & Lauer, 1985), and to have little or no importance (Foshee & Bauman, 1994; Friestad & Klepp, 1997; Krohn, Massey, Skinner, & Lauer, 1983).

A criticism of Hirschi's (1969) theory is that it does not take into account a causal role, in the etiology of problem behaviours, for bonding to those who themselves display the behaviour (Catalano & Kosterman, 1996). The theory emphasizes attachment to parents who express normative behaviours, but what of attachment to parents who are smokers? Foshee and Bauman (1992) found support for their prediction that for adolescents with a parent who smokes, the likelihood of smoking increases as attachment to that parent increases and for

adolescents with a parent who does not smoke, smoking decreases as attachment to that parent increases. The relationship between attachment and smoking was in the direction consistent with Social Control Theory when the parent was a non-smoker but was in the opposite direction when the parent was a smoker.

What is apparent is that findings based on Social Control Theory do not provide a clear understanding of the influence of parent-child attachment on youth smoking. It has been suggested that the mixed empirical support for Hirschi's theory may be due, at least in part, to the fact that it was developed to explain and predict adolescent deviant behaviours. It may be argued that smoking is not a deviant behaviour but is a disapproved and undesirable, yet widely prevalent behaviour. The influence of social bonding for adolescent smoking, then, may not be the same as that for other behaviours more suitably conceptualized as deviant (Friestad & Klepp, 1997).

Problem Behavior Theory. Based on Problem Behavior Theory (Jessor, 1987; Jessor & Jessor, 1977), it may be hypothesized that youths will be at risk for smoking if they perceive that their parents do not disapprove of the behaviour, if they do not have parental support (i.e., parental help, encouragement, and interest), and if their parents do not provide control (i.e., strict standards for behaviour and sanctions for behaviour that is not acceptable). All three theoretical concepts have been studied with respect to parental influence and youth smoking. Adolescents' perceptions of parental approval of smoking (or positive attitude) were associated with adolescent smoking as predicted (Collins & Ellickson, 2004) and were unrelated to it (Chassin, Presson, Sherman, Montello, & MGrew, 1986).

Similarly, perceived parental supportiveness showed a protective effect for adolescent smoking (Chassin, et al., 1986; Chassin, Presson, Sherman, & Pitts, 2000) and did not have an effect (Bryant, Schulenberg, O'Malley, Bachman, & Johnston, 2003; Chassin, et al., 1984). The outcome for perceived parental control also is unclear. It did not predict adolescent transitions to higher levels of smoking (Chassin, et al., 1984) or smoking trajectory over time (Chassin, et al., 2000). In one study, the findings were mixed depending on the adolescents' ages (Chassin, et al., 1986). Never smokers in grades 6 and 7 who had stricter parents were more likely to begin smoking than were their counterparts who had less strict parents. The effect was consistent with theoretical prediction for students in grades 10 and 11, with stricter parents resulting in more non-smoking. Parental strictness had no effect for adolescents in grades 8 and 9.

Problem Behavior Theory has been used in a small number of studies to examine parental influence on youth smoking. However, there is inconsistency in findings among studies, with lack of support for theoretical predictions evident in some. Thus, it is difficult to determine whether the Theory is suitable to explaining parental influence on youth smoking.

Parenting Styles. Baumrind (1968, 1991) identified four parenting styles, which refer to how parents interact with their children regarding limit-setting and nurturance. The styles are authoritative, characterized by a balanced approach of demandingness and responsiveness; authoritarian, characterized by high levels of demandingness but low levels of responsiveness; permissive, characterized by more responsiveness than demandingness; and rejecting-neglecting, characterized

by lack of demandingness and responsiveness. Baumrind (1991) predicted that authoritative parenting would result in better psychosocial development and behavioural outcomes than any of the other three styles.

With respect to smoking, then, authoritative parenting should result in children who are not inclined to smoke and who are less susceptible to peer influences than are other children (Simons-Morton, 2002). As well, such parenting practices are expected to provide an effect through selection of peers, with children from authoritative homes less likely than others to have friends who have problem behaviours and, consequently, less likely to be in circumstances where they are exposed to risks and temptations (Barber, 1992). A further effect of authoritative parenting is that it is expected to facilitate parental antismoking socialization of children by increasing the effectiveness of parental messages which discourage the behaviour (Simons-Morton, 2002).

There are a large number of studies that were carried out to establish the influence of parenting styles on youth smoking. In some of those, Baumrind's (1991) or analogous parenting style typologies (e.g., Maccoby & Martin, 1983) were examined, for instance authoritative, authoritarian, permissive, and unengaged styles. In many other studies, specific aspects of parenting style were examined, rather than typologies per se, which may be categorized as monitoring, supervision, support, quality of parent-child relationship, conflict, involvement, communication, and discipline.

With respect to the typologies, the unengaged (i.e., rejecting-neglecting) parenting style seems to have the most consistent support for theoretical prediction. It performed as expected in a number of studies. Adolescents were at risk for smoking when they perceived that their parents displayed that style of parenting (Adalbjarnardottir & Hafsteinsson, 2001; Chassin, et al., 2005; Glendinning, Shucksmith, & Hendry, 1997; Radziszewska, Richardson, Dent, & Flay, 1996; Richardson, Radziszewska, Dent, & Flay, 1993).

The findings for authoritative parenting were mixed. In several studies, authoritative parenting, as perceived by preadolescents or adolescents, was associated with lower rates of smoking among them (Adamczyk-Robinette, Fletcher, &Wright, 2002; Castrucci & Gerlach, 2006; Jackson, Bee-Gates, & Henriksen, 1994; Pierce, Distefan, Jackson, White, & Gilpin, 2002; Stephenson & Helme, 2006). An indirect relationship of authoritative parenting to smoking, through the adolescents' peers, also was found. Whether measured by children's perceptions of their parents' styles or a composite index that included child, parent, and independent observer ratings of parenting style combined, adolescents with authoritative parents were more likely to associate with peers who did not smoke than with peers who smoked (Adamczyk-Robinette, et al., 2002; Melby, Conger, Conger, & Lorenz, 1993). Those findings provide support for the contention that effective parenting reduces children's risk of associating with smoking peers who model or encourage the behaviour. In other studies, authoritative parenting did not discriminate for smoking and non-smoking in the way that was expected. There was no difference in adolescent smoking behaviour

between authoritative and authoritarian parents (Adalbjarnardottir & Hafsteinsson, 2001; Chassin, et al., 2005), between authoritative and permissive (i.e., indulgent) parents (Chassin, et al., 2005), or among authoritative, autocratic (authoritarian), or permissive parents (Radziszewska, et al., 1996; Richardson, et al., 1993).

Monitoring, supervision, support, quality of parent-child relationship, conflict, involvement, communication, and discipline all have been found to be associated with youth smoking in the direction expected and to not have an effect (for a list of relevant studies see Appendix A, pp. 340). Inconsistencies in findings across studies may be due, in part, to differences in definition and measurement of the particular concept. Discrepancies in findings within some studies also were noted. These discrepancies were dependent on such variables as the smoking outcome measured, smoking status of the parent, sex of the youths, or whether the parenting characteristic was maternal or paternal, or was reported by the parent or reported as perceived by the child.

Although there are inconsistencies in the findings, the weight of the evidence appears to be that positive constructive parenting, as shown by authoritative parenting style, is protective for youth smoking. As suggested by Steinberg (2001), there does not appear to be any evidence indicating that children do better when they are raised by any of the other parenting styles. However, although general parenting style is considered to be important for child outcomes, specific socialization practices also are considered to be relevant. Socialization practices operate in circumscribed domains such as may be the case

with particular problem behaviours (Darling & Steinberg, 1993). With respect to smoking, protective socialization practices are referred to as antismoking socialization.

Parental Antismoking Socialization

Parental antismoking socialization may be defined as messages conveyed to children by way of beliefs, attitudes, behaviours, and actions to discourage them from smoking. Examples include displaying disapproval of smoking, modeling non-smoking, discussing pro-smoking influences and the negative health effects of smoking, having rules against exposure to smoking (e.g., no smoking in the home), offering positive reinforcement for not smoking, and conveying potential disciplinary consequences for smoking (Henriksen & Jackson, 1998; Jackson & Dickinson, 2003; Johnson & Johnson, 2001). Specific aspects of parental antismoking socialization which have been studied are parental smoking behaviour, beliefs about smoking, attitude towards smoking, discussion concerning smoking, negative consequences for the child, and rules restricting exposure to smoking.

Parental smoking behaviour. The influence of parental smoking on child smoking has been investigated in a large number of studies. A positive relationship between parent current smoking and various child smoking outcomes, such as smoking onset, frequency of smoking, number of cigarettes smoked, and transition to higher levels of smoking, was observed in a majority of the studies (for examples of relevant studies see Appendix B, p. 342). Further, a dose-response effect was demonstrated, that is, adolescents were at a greater risk for

smoking when both parents currently smoked compared to when only one parent smoked (Chassin, et al., 2000; Flay, Hu, & Richardson, 1998; Foster et al., 2007; Gilman et al., 2009; Otten, Engels, van de Ven, & Bricker, 2007; Peterson, et al., 2006). In a considerable number of studies, however, the findings were not significant for a relationship between parental and youth smoking (see Appendix B, p. 342). Regardless of the inconsistency in statistical findings, many parents and youths, including tobacco users and nonusers, have reported that they viewed parental smoking to be a negative influence (Binns, O'Neil, Benuck, & Ariza, 2009; Clark, Scarisbrick-Hauser, Gautam & Wirk, 1999; Kegler & Malcoe, 2005; Nilsson, Weinehall, Bergstrom, Stenlund, & Janlert, 2009).

When parental former smoking was examined, it too revealed inconsistent effects. In some studies, it was associated with an elevated risk of youth smoking (e.g., Jackson & Henriksen, 1997; Kodl & Mermelstein, 2004; Otten, Engels, van de Ven, & Bricker, 2007) and in others it was found to not have an effect (Boomsma, Koopmans, van Doornen, & Orlebeke, 1994; Gilman, et al., 2009). When compared to children of currently smoking parents, however, children of formerly smoking parents were less likely to smoke (Bricker, Leroux, Andersen, Rajan, & Peterson, 2005; Farkas, Distefan, Choi, Gilpin, & Pierce, 1999; Jackson & Henriksen, 1997; Kandel & Wu, 1995

Sex specific differences also have been examined, both in terms of child and parent sex. The findings for a select impact of parental smoking on boys or girls are inconsistent. For instance, parental smoking was positively associated with boys' but not girls' smoking (von Bothmer, Mattsson, & Fridlund, 2002).

Conversely, parental smoking had a stronger effect on girls' than on boys' smoking (Flay, et al., 1998; Hu, Flay, Hedeker, Siddiqui, & Day, 1995). Still, in another study, parental smoking did not have a differential impact between adolescent boys and girls (Peterson, et al., 2006). When examined by parental sex, maternal smoking seemed to play a larger role in adolescent smoking than did paternal smoking. Mothers', but not fathers', current smoking was associated with an increased risk of current smoking (Engels, Knibbe, & Drop, 1999; Fagan & Najman, 2005; Pederson, Koval, McGrady & Tyas, 1998; Rosendahl, Galanti, Gilljam, & Ahlbom, 2003), heavy smoking (Griffin, Botvin, Doyle, Diaz, & Epstein, 1999), smoking initiation (Engels et al., 1999), and lifetime smoking and smoking within the last year (Kandel and Wu, 1995). Yet, there are studies in which rates of adolescent smoking were the same regardless of whether it was the mother or the father who was smoking (Gilman, et al., 2009; Peterson, et al., 2006).

It is less clear as to whether parental smoking has a stronger influence when the parent is the same sex as the child. In some studies a sex-specific effect of maternal smoking influencing daughter smoking was found (Friestad & Klepp, 1997; Vink, Willemsen, & Boomsma, 2003; Wang, Fitzhugh, Turner, & Fu, 1997). In one study, although mother smoking increased the risk of smoking for both daughters and sons, the increased risk was greater for daughters (Ashley, et al., 2008). In other studies, mothers' smoking was not related to daughters' smoking (Peterson, et al., 2006; Wang, Fitzhugh, Eddy, Fu, & Turner, 1997). Similar variance was found with fathers' smoking. Fathers' smoking both

predicted sons' smoking (Ashley, et al., 2008; Friestad & Klepp, 1997; Gilman, et al., 2009) and did not have an effect (Andrews, et al., 1993; Kandel & Wu, 1995; Peterson, et al., 2006). Interestingly, cross sex effects also have been observed. In one study, it was fathers' smoking, not mothers' smoking, that predicted the onset of smoking for daughters (Wang, Fitzhugh, Eddy, et al., 1997).

In conclusion, parental smoking was found to be positively associated with youth smoking in a large number of studies. However, lack of an effect was demonstrated in others. As noted by Avenevoli and Merikangas (2003) in their review of familial influences on adolescent smoking, inconsistencies in findings across studies suggest that parental smoking status may have only a modest influence on children's smoking behaviour. Other factors also play important roles.

Parental beliefs about smoking. Parental beliefs about smoking that have been examined concern health effects, the nature of youth smoking, and antismoking socialization. There is evidence that some parents hold weak or misinformed beliefs about the normative nature of youth smoking and the effectiveness of parental antismoking socialization (Clark, et al., 1999; Kegler & Malcoe, 2005). Factors that have been shown to affect parents' smoking-related beliefs are smoking status, educational level, and sex. Parents who smoked were more likely than non-smoking parents to have weaker health beliefs and weaker beliefs about the nature of youth smoking (Kodl & Mermelstein, 2004). Similarly, parents who had less education compared with parents who had more education viewed smoking as less dangerous to health (Fearnow, Chassin, Presson, &

Sherman, 1998) and had weaker beliefs about antismoking socialization of youth (Kegler & Malcoe, 2005). Mothers had stronger beliefs than did fathers about the dangerous health effects of smoking (Fearnow, et al., 1998).

When examined for effect on children's smoking, self-reported parental beliefs were shown to be both related and unrelated to the behaviour. Parents, 86% of whom were mothers, who held weaker beliefs about the health effects of smoking and the normative nature of youth smoking were more likely to have adolescents who had tried smoking or who were regular users than parents who held stronger antismoking beliefs (Kodl & Mermelstein, 2004). In another study of mothers, health beliefs about smoking did not influence their pre-adolescent and adolescent children's own smoking health beliefs or smoking behaviour (Chassin, Presson, Rose, & Sherman, 1998).

In effect, there is little research about the influence of parental beliefs on youth smoking and the findings are inconsistent. Of course, whether a belief, or any antismoking socialization message or practice for that matter, will make a difference depends on it being accurately perceived and accepted by the child (Grusec & Goodnow, 1994). Children's perspectives were not represented in the research on parental beliefs.

Parental attitude towards smoking. A great deal of research has been carried out on parental attitude towards smoking. Other concepts, likened to attitude and sometimes used interchangeably in the literature, which also have been examined are disapproval, approval, opinion, and concern. One factor that

long has been considered to play a role in the determination of parental attitudes is parental smoking status. Indeed, parents who smoke have been found to have a less negative attitude toward it. For instance, compared to non-smoking parents they placed lower value on their children not smoking (Fearnow, et al., 1998), showed greater approval of smoking in general and of adolescent smoking, were more likely to own tobacco promotional items and allow their children to use them, and were more likely to allow their children to use candy cigarettes (Clark, et al., 1999). Some adolescents reported that their smoking parents actually engaged in prompting such as requesting them to empty and clean ashtrays and bring cigarettes (Laniado-Laborin, Candelaria, Villasenor, Woodruff, & Sallis, 2004). These requests may be perceived as a lack of disapproval of or concern for the behaviour. There is other evidence, however, which indicates that parental smoking status may not affect parental attitude. When either parental approval or disapproval of smoking was examined there was no difference between smoking and non-smoking parents (Engels & Willemsen, 2004; Tilson, McBride, Albright, & Sargent, 2001).

There also was variance in findings when parental attitude was examined for effect on youth smoking. In some studies, whether measured as parental attitude or an analogous concept, a more positive (or less antismoking) attitude, as perceived by the children, increased the risk of smoking (e.g., Berg, Choi, Kaur, Nollen, & Ahluwalia, 2009; Collins & Ellickson, 2004; Distefan, Gilpin, Choi, & Pierce, 1998; Flay, et al., 1998; Kalesan, Stine, & Alberg, 2006; Pederson, et al., 1998; Wang, Fitzhugh, Westerfield, & Eddy, 1995; Wiium & Wold, 2006). As

well, mothers' smoking attitudes were positively related to adolescents' smoking attitudes such that adolescents who perceived their mothers to be aware and concerned about the harms of smoking held the same views (Herbert & Schiaffino, 2007).

In other studies, parental attitude did not have an effect on youth smoking either when it was reported as perceived by the children or self-reported by the parents (e.g., Bailey, Ennett, & Ringwalt, 1993; Dalton et al., 2009; den Exter Blokland, Hale, Meeus, & Engels, 2006; Ennett, Bauman, Foshee, Pemberton, & Hicks, 2001; Hill, Hawkins, Catalano, Abbott, & Guo, 2005; Tilson, McBride, Lipkus, & Catalano, 2004; Tucker, Ellickson, & Klein, 2003; Zapata, et al., 2004). In one study, the effect depended on the particular attitude expressed. When parents reported that they had a more permissive attitude specifically toward adult smoking, their adolescent children had higher levels of smoking. Their attitudes toward smoking regulations, laws, and bans were found not to be associated with their children's smoking (Komro, McCarty, Forster, Blaine, & Chen, 2003). In another study, the effect depended on the number of disapproving parents. Pre-adolescent and adolescent children were at less risk for established smoking when they perceived that both parents disapproved of the behaviour than when they perceived that neither parent disapproved. There was no effect on smoking when the children perceived that only one parent was disapproving (Sargent & Dalton, 2001).

Two variables that have been examined for moderator effects on the relationship between parental attitude toward smoking and youth smoking are

child sex and parental smoking status. Parental attitude was more important for girls. A perceived antismoking attitude was predictive for less smoking in girls with no effect for boys' smoking (Griffin, et al., 1999). Similarly, for perceived parental approval, adolescent girls were more likely than boys to be current smokers (Siddiqui, Mott, Anderson, & Flay, 1999) and to intend to smoke in the future (Flay, et al., 1994).

The effect of parental smoking status on the relationship between parental attitude and youth smoking is less consistent. In one study, self-reported parental antismoking attitude did not have an effect on the smoking behaviour of their adolescent children if one or both parents smoked. However, when both parents were non-smokers, strong antismoking attitudes were associated with a 50% reduction in the prevalence of smoking among their children. Attitude was important only when behaviour was consistent with the attitude (Andersen, et al., 2002). In another study, although perceived parental concern about smoking had an inverse effect on adolescent current smoking, the effect was greatest when parents did not smoke. Parental smoking and less parental concern acted synergistically to worsen the risk (Kalesan, et al., 2006). In contrast, in another study, perceived parental disapproval of smoking had just as strong an effect when the parents were smokers as when they were non-smokers (Sargent & Dalton, 2001).

Taken as a whole, although it seems intuitive that an unfavourable parental attitude toward smoking would be protective for youth smoking, the evidence is

inconsistent. The importance of parental attitude towards youth smoking remains unclear.

Parental discussion concerning smoking. There is evidence that many parents raise the topic of smoking with their adolescent children, although some may do so infrequently and the discussions may not be in-depth (e.g., Baxter, Bylund, Imes, & Riutsong, 2009; Bush et al., 2005; Chassin, Presson, Rose, Sherman, & Todd, 1998; de Leeuw, Scholte, Harakeh, van Leeuwe, & Engels, 2008; Ennett, et al., 2001; Muilenburg & Legge, 2009; Riesch, et al., 2000; Tang, Rissel, & Rowling, 1999; Throckmorton-Belzer, et al., 2009; von Bothmer & Fridlund, 2001; Wyman, Price, Jordan, Drake, & Telljohann, 2006). Little is known about whether and to what extent parents discuss smoking with their young children as that subject has not received much research attention.

In one study, across eight smoking content items for discussion, between 46% and 82% of parents reported talking one or two times with their adolescents in the last 6 months (Ennett, et al., 2001). In another study, when parents were asked whether they had discussed with their adolescents within the past year the importance of being a non-smoker 82% responded affirmatively (Tang, et al., 1999). Similarly, 83% reported that they had ever talked to their adolescents about their rules regarding the use of tobacco (Wyman, et al., 2006). In a study involving 10 to 11 year old pre-adolescents 91% of parents reported that they had ever spoken to their children about smoking tobacco. However, some parents described the level of engagement of the child during the discussion and the extent of the discussions, in terms of duration and number of topics, as not high

(Beatty, Cross, & Shaw, 2008). When adolescents were asked whether their parents had talked to them about the dangers of smoking about 68% reported that at least one parent had done so (Muilenburg & Legge, 2009).

In other studies, parents reported that they infrequently discussed smoking with their preadolescent and adolescent children (Chassin, Presson, Rose, Sherman, & Todd, 1998) or adolescent children (Riesch, et al., 2000; von Bothmer & Fridlund, 2001). Only 8.4% and 19% of parents talked to their children *a lot* or *often* about the matter (Chassin, et al., 1998; von Bothmer & Fridlund, 2001). Those findings are consistent with reports by adolescents that their parents did not talk very often about smoking-related issues (de Leeuw, et al., 2008). There is evidence, however, that discussions about smoking generally go well. In one study, mothers reported that there was little conflict when they discussed smoking with their sixth to eighth grade daughters. The daughters reported that their mothers' advice about smoking was helpful (Ary, James, & Biglan, 1999).

Four parental factors that have been examined for influence on smoking-specific discussion are smoking status, attitude towards smoking, parenting style, and education. In some studies, based on parent self-reports, there was no difference between smoking and non-smoking parents as to how frequently or how often they talked with their children (Engels & Willemsen, 2004; Kodl & Mermelstein, 2004). In other studies, compared with non-smoking parents, smoking parents reported giving more antismoking messages to their adolescents (Herbert & Schiaffino, 2007) or more frequently talking about smoking and

warning them of the dangers and disadvantages of the behaviour (den Exter Blokland, et al., 2006). Similarly, parents with a more negative attitude toward smoking, compared to parents with a less negative attitude, reported sending more antismoking and fewer pro-smoking messages to their children (Herbert & Schiaffino, 2007). In one study, parent self-reports indicated that there was no difference between smoking and non-smoking parents with respect to communication about media influence. However, communication concerning rules about tobacco use and discipline occurred more frequently when one or both parents smoked than when neither parent smoked (Ennett, et al., 2001). Findings also were mixed when preadolescent and adolescent children reported on their parents' smoking-specific discussions. In one study, parental smoking was not associated with frequency of such communication (de Leeuw, et al., 2008); whereas, in other studies, smoking parents were viewed as less likely than non-smoking parents to engage in such communication (Henriksen & Jackson, 1998; Herbert & Schiaffino, 2007). They also were perceived as sending less consistent antismoking messages, being less credible sources for smoking messages (Herbert & Schiaffino, 2007), and being less constructive and supportive in their communication about smoking (de Leeuw, et al., 2008).

Parenting style was related to parental smoking-specific discussion both when reported by parents and when reported by children. Based on mothers' reports, those who had a disengaged parenting style were the least likely to discuss smoking with their children. Their adolescent children's perceptions of parenting style and parental smoking-specific discussion also indicated that

children from disengaged parents had the least discussion. Adolescents who indicated that their parents were authoritative reported the most discussion (Chassin, et al., 2005). Similarly, authoritative parenting was positively associated with maternal communication about smoking risks when preadolescent and adolescent children reported about their mothers (Henriksen & Jackson, 1998).

In the one study in which parental education was examined, the effect on discussion with their children varied by the content of the antismoking message. More highly educated parents had less discussion about both rules and discipline concerning smoking. Communication about media influence on adolescent smoking did not vary by parental education (Ennett, et al., 2001).

Aspects of parental, smoking-specific discussion that have been examined for effect on youth smoking are quality, content, and extent (meaning how much or how often parents talk with their children). The quality of discussion (e.g., constructive, equal, respectful) was found to be important whether examined from parents' or adolescents' perspectives. Adolescents were less likely to engage in smoking when the quality of the discussion was higher (den Exter Blokland, Engels, Harakeh, Hale III, & Meeus, 2009; Harakeh, Scholte, de Vries, & Engels, 2005).

The findings were variable when content of parental communication was examined. When adolescents were asked about their parents' communication about smoking, findings revealed that what was discussed made a difference (Huver, Engels, & de Vries, 2006). Talking about the health risks of smoking and

breathing in smoke and the addictive qualities of smoking was related to less smoking among adolescents; whereas, talking about being allowed to smoke, the price of cigarettes, and friends smoking was related to increased risk of smoking. The effects were more direct at grade 7 but were mediated through cognitions by the time the adolescents reached grade 9. When parents were asked about their smoking communication, findings revealed that talking about family smoking rules did not have an effect on whether or not their children smoked. However, their children were more likely to be current smokers when the parents talked about the consequences of breaking family rules or expectations against smoking (Komro, et al., 2003).

A greater extent of communication variously had a protective effect, no effect, or an adverse effect on children's smoking outcomes. An effect was evident in several studies in which preadolescents or adolescents reported on parental communication. For instance, less communication with their parents about smoking was associated with greater smoking onset (Jackson, 1997; Jackson & Henriksen, 1997), greater lifetime and current smoking (Otten, Engels, & van den Eijnden, 2007), and a more positive attitude towards smoking (Huver, et al., 2007a). In one study, middle school children who already had tried or experimented with smoking were less likely to intend to smoke the more they had discussed the dangers of smoking with their parents. Parental discussion did not have an effect on intent for high school triers and experimenters (Paek, 2008). In several studies, an effect for extent of discussion on outcomes, such as onset, smoking status, experimentation, intention to smoke, and attitude toward

smoking, was not apparent among pre-adolescent or adolescent children. That was the case when it was children who were reporting (Henriksen & Jackson, 1998; Huver, et al., 2007a; Miller, Burgoon, Grandpre, & Alvaro, 2006; Thompson & Gunther, 2007) and when it was parents who were reporting (Bush, et al., 2005; den Exter Blokland, et al., 2006; Engels, Finkenauer, Kerr, & Stattin, 2005; Engels & Willemsen, 2004; Ennett, et al., 2001; Kodl & Mermelstein, 2004). Surprisingly, in some studies, when examined from either parents' or adolescents' perspectives, the more frequently that parents communicated with their adolescents about smoking, the more likely the adolescents were to smoke (Harakeh, et al., 2005; Huver, et al., 2006). In one study, while frequency of communication did not have an effect on smoking onset for 15 year old adolescents, it was positively associated with smoking onset for 13 year olds (den Exter Blokland, et al., 2009).

Based on the research evidence, it appears that the quality of communication, or how parents discuss smoking with their children, is important to smoking outcomes. There is little evidence to support the effectiveness of particular content and the effectiveness of the extent to which parents talk with their children is unclear.

Parental negative consequences for the child. Negative consequences that children may receive from their parents for smoking may be classified as behavioural, which involve disciplinary actions or withdrawal of rewards and privileges, and emotional, which include such parental reactions as upset, anger, and disappointment (Kodl & Mermelstein, 2004). Little is known about the extent

to which parents have consequences and actually communicate the consequences to their children. In one study, according to both parent and adolescent reports, adolescent non-smokers rarely had received messages about the negative consequences they would receive from their parents should they ever smoke (Andrews, et al., 1993).

Three factors that have been investigated for possible influence on parental tendency to have consequences for smoking are smoking status, attitude toward smoking, and parenting style. The findings with respect to smoking status are inconsistent. For instance, in a study of mothers, those who currently smoked, compared to those who were non-smokers, sent more messages to their adolescents about the disciplinary consequences they could expect for smoking. Likewise, mothers with a more negative attitude toward smoking, compared to mothers with a less negative attitude, sent more messages to their children about their intention to impose disciplinary consequences for any smoking (Herbert & Schiaffino, 2007). In other studies, based on self-reports, parents who smoked were less likely than non-smoking parents to show disappointment or react in other emotional ways should their children smoke (den Exter Blokland, et al., 2006; Kodl & Mermelstein, 2004). They also were less likely to impose punishment in the case of smoking detection (den Exter Blokland, et al., 2006). Similarly, based on adolescents' perceptions, mothers who were smokers compared to mothers who were non-smokers were considered to be less likely to impose punishment for smoking. However, when mothers reported, a relationship was not found between their smoking and smoking-specific punishment (Chassin,

Presson, Rose, Sherman, & Todd, 1998). In other studies, smoking status was not related to parental punishment for smoking, either when the findings were based on parent self-reports of what they would do or child reports of expected punishment (Henriksen & Jackson, 1998; Kodl & Mermelstein, 2004).

Whether parenting style affected parents' tendency to have smoking-specific punishment varied by whose perspective was being examined. An effect was not observed when parents reported on their own characteristics. However, when adolescents reported on their perceptions of their parents, those from disengaged families were the least likely to receive punishment for smoking. Those from authoritarian and authoritative homes were the most likely to receive punishment (Chassin et al., 2005). Similarly, based on preadolescent and adolescent children's reports about their parents, authoritative parenting was positively associated with anticipation of punishment as a consequence for smoking (Henriksen & Jackson, 1998).

When examined for relationship to youth smoking, parental smoking-specific discipline variously was shown to have a beneficial effect and no effect. In some studies, when pre-adolescent and adolescent children expected that there would be punishment or other negative consequences for smoking they were less likely to have tried or initiated smoking or to be lifetime or current smokers (Chassin, Presson, Rose, Sherman, & Todd, 1998; Henriksen & Jackson, 1998; Jackson, 1997; Jackson & Henriksen, 1997; Kristjansson, Sigfusdottir, James, Allegrante, & Helgason, 2010; Otten, Engels, & van den Eijnden, 2007). Parental smoking status did not make a difference; children were less likely to smoke

regardless of whether or not their parents smoked (Henriksen & Jackson, 1998; Jackson & Henriksen, 1997). In one study, the more disappointed youths thought their mothers would be if they were caught smoking, the less likely they were to have ever smoked. There was no effect for perceived paternal disappointment (Zapata, et al., 2004). A protective effect also was found when parents reported on their negative consequences for smoking (den Exter Blokland, 2006; Komro, et al., 2003). However, in one study, the effect was contingent on parental smoking status. Showing anger and imposing punishment had a protective effect only on children of non-smoking parents, not on children of smoking parents (den Exter Blokland, et al., 2006). In several studies, parental negative consequences did not have an effect on various indices of youth smoking, in some cases when parents self-reported and in other cases when children reported on what they expected to happen for smoking (Chassin, et al., 2005; Chassin, Presson, Rose, Sherman, & Todd, 1998; den Exter Blokland, et al., 2009; Kodl & Mermelstein, 2004; Simons-Morton, 2002).

To summarize then, although there were some studies in which an effect was not observed, in a number of studies the evidence indicates that having potential negative consequences for smoking is an important parental antismoking socialization strategy.

Parental rules to restrict exposure to smoking. There is conclusive evidence that exposure to ETS, also known as second-hand smoke, is harmful to health. Therefore, restrictions on exposure to smoking are an important health measure (USDHHS, 2006). Restrictions on exposure to smoking also have

received attention as a preventative measure for youth smoking (Alesci, Forster, & Blaine, 2003; American Academy of Pediatrics, 2009; Clark, et al., 2006; Corbett, 2001; Turner, Mermelstein, & Flay, 2004). Much research has been carried out in recent years on parents' involvement in protecting their children from exposure to smoke and smoking. Although other antismoking rules, such as requiring non-smoking spaces in public places, requiring that individuals not smoke in their presence, and not allowing smoking in their vehicles, also were investigated in a few studies, most of the research pertaining to parents is about household antismoking rules.

In the past it was common to not have restrictions on smoking in the home (e.g., Biener, et al., 1997; Clark, et al., 1999). For instance, in one study, nearly 50% of parents reported either that they allowed their adolescents to smoke inside or outside the home, did not have home antismoking ground rules, or had such rules but had not explicitly articulated the rules to their children (Clark, et al., 1999). However, much of the recent evidence suggests that many parents now at least have partial restrictions on smoking in their homes with a majority having a total ban, meaning no smoking whatsoever in the home; although, some do not have any restrictions (e.g., Binns, O'Neil, Benuck, & Ariza, 2009a; Fisher, Winickoff, Camargo, Colditz, & Frazier, 2007; Health Canada, 2008a, 2009a; Kegler, Escoffery, Groff, Butler, & Foreman, 2007; Muilenburg & Legge, 2009; Rainio & Rimpela, 2007; Rodriguez, Tscherne, & Audrain-McGovern, 2007; Szabo, White, Hayman, 2006; Thomson, Siegel, Winickoff, Biener, & Rigotti, 2005; Yousey, 2006). In Canada exposure of children to ETS in the home has

declined considerably in recent years. Thirty-three percent of children who were under the age of 12 years were regularly exposed to ETS in the home in 1996-1997. In 2000 the rate had declined to 25% and in 2009 it was 5% (Health Canada, 2007d, 2010b). Interestingly, adolescents support the notion of antismoking rules. When asked about their expectations concerning parental action on child tobacco use 86%, including tobacco-users and non-users, indicated that parents should not allow their children to smoke at home (Nilsson, et al., 2009).

A number of factors have been examined for influence on parental tendency to have household rules including parental smoking status, attitude toward smoking or ETS, awareness of the health effects of smoking or ETS, and education, and family income and structure. More specifically, based on their own reports, parents with a history of smoking were less likely to have household antismoking rules, or had less strict rules, than those who were never smokers, with current smokers being the most permissive (e.g., Berg, et al., 2009; Binns, et al., 2009; Bricker, et al., 2005; den Exter Blokland, et al., 2006; Engels & Willemsen, 2004; Fearnow, et al., 1998; Harakeh, et al., 2005; Herbert & Schiaffiano, 2007; Kodl & Mermelstein, 2004). Those findings are supported by children's reports that rules against smoking were less likely or less strict when one or two parents smoked than when neither parent smoked (Akhtar, Haw, Currie, Zachary, & Currie, 2009; Ditre, Corragio, & Herzog, 2008; Fisher, et al., 2007; Henriksen & Jackson, 1998; Huver, Engels, Vermulst, & de Vries, 2007b; Proescholdbell, Chassin, & MacKinnon, 2000; Thomson, et al., 2005).

Similarly, whether self-reported or reported as perceived by adolescents, parents' attitudes toward smoking were related to having antismoking rules. The more negative parents' attitudes were toward smoking (Proescholdbell, et al., 2000) or ETS exposure (Yousey, 2006), the more likely they were to have more restrictive home smoking policies. Parental awareness of health effects also was important. The more mindful and concerned that mothers were about the health consequences of smoking, the more likely they were to have antismoking rules (Herbert & Schiaffino, 2007). Further, a strong perception of the harmfulness of ETS was associated with having a home smoking ban (Binns, et al., 2009).

Findings were inconsistent for other potential influencing factors. Less parental education, low family income, and non-intact family structure were associated with not having a smoking ban or having less strict rules and were unrelated to smoking restrictions (e.g., Binns, et al., 2009; Kegler, et al., 2007; Proescholdbell, et al., 2000; Rainio & Rimpela, 2007; Thomson et al., 2005; Yousey, 2006).

When examined for relationship to youth smoking, parental antismoking rules to restrict exposure to smoking most often were found to be negatively related to various indices of youth smoking such as current smoking, experimentation, cigarette consumption, and smoking onset (e.g., Bernat, Erickson, Widome, Perry, & Forster, 2008; Bricker, et al., 2005; Clark, et al., 2006; Ditre, et al., 2008; Henriksen & Jackson, 1998; Huver, et al., 2006; Jackson & Henriksen, 1997; Kodl & Mermelstein, 2004; Luther, et al., 2008; Otten, Engels, & van den Eijnden, 2007; Rainio & Rimpela, 2007; Wakefield, et al.,

2000). In some studies, however, such rules were found not to have an effect on youth smoking (e.g., Berg, et al., 2009; Biener, Cullen, Di, & Hammond, 1997; Castrucci & Gerlach, 2006; den Exter Blokland, et al., 2006; Engels, et al., 2005). Where household smoking rules were found to be important, a complete ban on smoking was more effective than a partial ban such as restricting smoking to a certain area in the home or a certain time (Clark, et al., 2006; Farkas, Gilpin, White, & Pierce, 2000; Powell & Chaloupka, 2005; Szabo, et al., 2006). Further, adolescents who lived in a home with a household smoking ban were more likely than were those without a household smoking ban to perceive that fewer adults in the community smoked and that smoking was not socially acceptable (Thomson, et al., 2005). A more restrictive home smoking policy also was associated with a stronger perception by adolescents that smoking is harmful (Ditre, et al., 2008).

When the relationship of antismoking rules to adolescent smoking outcomes was examined by parental smoking status, findings continued to be mixed. In one study, rules against smoking in the home had an influence on adolescents' rates of daily smoking but only in families where a parent smoked, not in families where the parents were non-smokers. When a parent smoked, the presence of home antismoking rules was a deterrent to daily smoking (Andersen, Leroux, Bricker, Rajan, & Peterson, 2004). The opposite effect for smoking status also was found. When parents were non-smokers, antismoking home rules were associated with a lower likelihood among adolescents of trying or experimenting with smoking. When they were smokers, antismoking rules either were not as effective among adolescents or were not related to smoking at all (Albers, Biener,

Siegel, Cheng, & Rigotti, 2008; Proescholdbell, et al., 2000; Szabo, et al., 2006). Yet in other studies, parental smoking status did not make a difference. Negative relationships between antismoking rules and adolescent smoking were demonstrated regardless of whether the parents were smokers or non-smokers (Bricker, et al., 2005; Rainio & Rimpela, 2007; Wakefield, et al., 2000). The implications of these findings are difficult to determine. On the one hand, it seems that consistent parental messages (i.e., non-smoking parents with restrictive smoking rules) are important to smoking prevention among adolescents. On the other hand, the findings suggest that restrictive rules reduce the likelihood of adolescents smoking even when parents smoke.

From this review, it seems that most of the research evidence is supportive of the suggestion in the smoking prevention literature that restrictions on exposure to smoking are protective for youth smoking. However, there are some research findings which are contrary to that position.

Parental Socio-Demographic Influence

Parental socio-demographic factors which most commonly have been examined for effect on youth smoking are education, socioeconomic status, and family structure. Parent education was found both to be inversely related to smoking among adolescents (e.g., Agrawal, et al., 2005; Soteriades & DiFranza, 2003; Waldron & Lye, 1990) and to be not associated with it (e.g., Ashley, et al., 2008; Bryant, et al., 2003; Chassin, et al., 2005; Collins & Ellickson, 2004; Fagan & Najman, 2005; Glendinning, et al., 1997; Miller, et al., 2006; Powell & Chaloupka, 2005; Simons-Morton, Haynie, Crump, Eitel, & Saylor, 2001; Tilson,

et al., 2004; Wen, Van Duker, & Olson, 2009). In some studies, the relationship varied depending on particular factors such as adolescent sex and the smoking outcome measured. For instance, a negative relationship was evident only for girls (Chassin, Presson, Sherman, & Edwards, 1992) or only for boys (Simons-Morton, et al., 1999). It was evident for having smoked in the last year but not for lifetime smoking (Kandel & Wu, 1995) or smoking initiation (Finkelstein, Kubzansky, & Goodman, 2006).

Parental socioeconomic status also has shown inconsistency in influence. It too was both inversely related to youth smoking (e.g., Hill, et al., 2005; Macleod, et al., 2008; Soteriades & DiFranza, 2003; Stanton, Oei, & Silva, 1994) and not related to it (e.g., Fagan & Najman, 2005; Fleming, Kim, Harachi, & Catalano, 2002; Shakib, et al., 2003; Wang, et al., 1999; Wen, et al., 2009). In one study, socioeconomic status negatively influenced adolescent smoking indirectly through parent and peer smoking. Adolescents from a low socioeconomic background had parents and peers who had high rates of smoking that influenced their smoking directly (Geckova, et al., 2005).

Most often the evidence concerning family structure is that an intact two-parent family is protective against smoking (e.g., Bernat, et al., 2008; Challier, et al., 2000; Chassin, et al., 2005; Cohen, Richardson, & LaBree, 1994; Fors, Crepaz, & Hayes, 1999; Griffin, Botvin, Scheier, Doyle, & Williams, 2003; Oman, et al., 2007; Pederson, et al., 1998; Powell & Chaloupka, 2005; Tucker, Ellickson, Orlando, & Klein, 2006) and a single parent or reconstituted family is a risk for smoking (e.g., Ashley, et al., 2008; Glenninding, et al., 1997; Norton,

Lindrooth, & Ennett, 1998; Otten, Engels, van de Ven, & Bricker, 2007; Stanton, et al., 1994). As with the other socio-demographic factors, however, there are studies in which a relationship was not found between family structure and youth smoking (Ennett, et al., 2001; Fagan & Najman, 2005; Fleming, et al., 2002; Richardson, et al., 1993; Svensson, 2000; Wen, et al., 2009).

Although it often is assumed that low parental education and socioeconomic status are risk factors for youth smoking, the evidence is unclear. There seems to be more support for a protective effect of an intact two-parent family.

Limitations of the Quantitative Research

The inconsistency in findings makes it difficult to know what parent factors are important to youth smoking. Youth smoking is a complex behaviour with many potential contributing factors and interrelationships among factors. Those that influence children to begin smoking may be different from those that influence them to continue smoking. Indeed, nicotine dependence is a strong stimulus for smoking maintenance (DiFranza, et al., 2007). Factors that demonstrate an effect in bivariate relationships may not demonstrate an effect or may demonstrate a weak effect when examined in multivariate models depending on the number of variables investigated and their relative importance (Turner, et al., 2004).

Other methodological differences or issues, as well as measurement variances, also may lead to disparate findings in and among studies. Aside from

the question of whether any particular theory is adequate to providing an explanation of parental influence on youth smoking, the failure of support for theoretical predictions and lack of coherence in the quantitative research findings may be due to any of the following factors: (a) proxy reporting by children of various parental factors (e.g., smoking behaviour, attitude, and parenting style); (b) different smoking outcomes among studies (e.g., experimentation, initiation, current, maintenance, and progression); (c) non-standardized measures of smoking (i.e,. lack of consistent operational definitions for smoking outcomes such as experimentation, initiation, current, and regular); (d) different conceptual and operational definitions for the independent (predictor) variable (e.g., parent attitude, supervision, support, and involvement); (e) sampling inadequacies (e.g., low power, selection bias, and attrition); (f) different sample characteristics (e.g., younger vs. older adolescents); (g) cross-sectional versus longitudinal designs; and (h) failure to take into account moderator and mediator variables, both of which can affect the strength of the relationship between two variables (Avenevoli & Merikangas, 2003).

Qualitative Research

Of the 10 qualitative studies that were found in the literature, 5 involved eliciting youths', predominantly adolescents, perspectives. In four of those, youths provided their views about smoking and the social context for smoking including parental influence. In one, they talked about communicating with their parents about tobacco and other substance use. The other five studies involved

parents' perspectives. In those, parents revealed their outlook on and approach toward youth smoking or second-hand smoke, or both.

Adolescents' Perspectives

One of the studies regarding youths' perspectives yielded three publications. Crawford and colleagues (2001) and Mermelstein and colleagues (1999) used the complete data set, which was obtained from 178 focus groups, totalling 1175 youths from across 11 American states. The participants ranged in age from 11 to 19 years (M = 14.5). Kegler and colleagues (2002) used a sub-sample of 132 of the focus groups, totalling 889 participants from 6 American states. The youths were from urban and rural areas and included smokers and non-smokers. They were recruited in 1996 through schools and community facilities and represented five ethnic groups (White, African-American, Hispanic, Native American, and Asian/Pacific Islander).

Similarities across ethnicity were evident among many of the findings. Youths reported that the most frequent source of both pro-smoking and antismoking messages was the family (Mermelstein, et al., 1999). Some told of a strong family antismoking foundation. When smoking was discussed within these families, the messages conveyed generally focused on the health effects of smoking (Kegler, et al., 2002). Many, however, reported having had a lack of guidance from parents concerning smoking. Parents and other family members frequently were cited as influences toward smoking. In addition to family modeling of smoking, youths reported receiving recruiting or facilitating messages from the family such as parents offering them a cigarette, having the

youths light a cigarette for them, sending the youths to the store to buy cigarettes for them, and leaving cigarettes around with the youths having an opportunity to take them (Crawford, et al., 2001; Mermelstein, et al., 1999). Youths reported continuing to smoke not only because of nicotine addiction but also because they received few antismoking messages. Some parents simply accepted their smoking and did not try to do anything about it (Crawford, et al., 2001; Kegler, et al., 2002).

For many of the youths messages from families frequently were unclear or seemed hypocritical. When messages were unclear often the children's interpretation was that the parents were disinterested or, in essence, were giving implicit permission to smoke (Crawford, et al., 2001; Kegler, et al., 2002). Although a few reported that there were strict smoking restrictions in their homes, at least some in all ethnic groups reported that smoking was allowed (Kegler, et al., 2002). In general, the youths thought that if their parents smoked, they also could (Mermelstein, et al., 1999). They perceived that their parents considered smoking to be less detrimental than other high-risk behaviours or to be a temporary experiment or a normal adolescent behaviour (Crawford, et al., 2001).

White and American Indian youths demonstrated some differences from the other ethnic groups. They were more likely to report that their parents believed that their decision to smoke was theirs alone. Their perceptions were that parental reactions to their smoking would be inconsequential and not to be taken seriously. The other groups perceived harsher consequences for smoking (Crawford, et al., 2001; Kegler, et al., 2002). Whites, more than the other youths,

indicated that their families were lenient toward adolescents smoking in their homes (Kegler, et al., 2002).

Social influences on youth smoking also were examined in another study that involved African-American and White adolescents (Gittelsohn, Roche, Alexander, & Tassler, 2001). The adolescents were recruited through community centers and schools in an American city. Data collection occurred in 1996 and strategies included in-depth interviews with 21 adolescents (14 to 17 years old) and 18 focus groups involving 125 adolescents (13 to 18 years old). Both smokers and non-smokers were represented in the sample.

The adolescents described parents as an important influence on youth smoking, being second only to peers in significance. They perceived that parental smoking was the most likely familial reason for adolescents to begin smoking. Peaked curiosity and access to parents' cigarettes were given as the two main means through which parental smoking influenced adolescents toward the behaviour.

There were some ethnic and sex differences among the findings. Overall, social influences were more salient for White adolescents compared with the African-Americans. They identified more social influences toward smoking and perceived them to be stronger forces. Parental permissiveness towards smoking seemed to be an important factor especially for White female adolescents and to a lesser extent for African-American female and White male adolescents. White females who smoked described permissiveness that ranged from passive

disapproval to active encouragement (e.g., parents actually buying the cigarettes for the adolescents). They described how their parents viewed smoking as a lesser evil; for example, not as serious as drugs or alcohol. Reports by African-American males indicated that they had the strictest parental restrictions against smoking.

In two other studies there was representation from African-Americans (i.e., Denham, Meyer, & Toborg, 2004) and both African-Americans and other ethnic groups (i.e., Plano Clark, et al., 2002). However, the samples were composed predominantly of White adolescents and comparisons were not carried out among the groups.

Denham and colleagues (2004) focused on adolescents from tobacco-growing regions as they have a higher prevalence of tobacco use and start smoking earlier than do other youths. Six focus groups were conducted that were comprised of 43 smoking and non-smoking 13 year-old girls from rural areas in 6 American states. The year in which the data were collected was not identified.

Many of the adolescents had parents who smoked. Several reported that parental smoking had influenced them to start smoking. Some had been advised by their parents not to smoke. However, those with smoking parents felt that such advice was hypocritical. Others thought that their parents were indifferent to their smoking and did not actively discourage it. Some families had rules against smoking and did not permit it to occur in their homes; others did not have any antismoking home rules. The adolescents described having easy access to tobacco

products including getting cigarettes from parents and other family members. Some reported that they purchased cigarettes for their parents.

Plano Clark and colleagues (2002) also used focus groups but had adolescents themselves facilitate the groups. Sixty-six students from four rural, urban, and suburban highschools were trained to lead 31 groups of 205 fellow students including smoking and non-smoking participants. The average age of the students was 16.3 years. Data collection occurred in 1999 in the United States mid-west.

The students believed that parents often are the key as to whether a child ends up trying tobacco. They commented that parents who smoke model the behaviour for their children, make it easy for children to access tobacco by having it around, and are lenient with children who smoke. They also commented that parents can be effective in discouraging smoking by giving clear messages that smoking will not be tolerated. They believed that adolescents tend not to smoke when they perceive that they will be disciplined in some manner for it. They suggested that to deter smoking parents should talk to their children about it and its consequences (e.g., health risks), set rules against it, be strict when adolescents are young, and use disciplinary measures when necessary.

In the one other study involving youths' perspectives, children talked about communicating with their parents concerning alcohol, tobacco, and other drugs (ATOD) (Miller-Day, 2002). The specific substances were not singled out for analysis. Interviews were carried out with 67 African-American (60% of the

sample) and White youths who were recruited through community facilities and schools in an American inner-city area. The youths were 11 to 17 years old (*M* = 13 years). The year in which the data were collected is not provided. There were no differences in findings between the African-American and White adolescents.

Only 29 of the youths indicated that they had had a conversation with their parents about ATOD. A further 11 reported that their parents mentioned to them not to indulge in ATOD use. Thus a total of about 60% of the youths reported that their parents at least had mentioned avoiding ATOD, leaving 40% not having communicated at all with their parents about ATOD. The youths reported feeling emotionally closest to their mothers and preferring to talk with their mothers, rather than their fathers, about important topics.

Based on the foregoing studies, it is clear that adolescents saw parents as an important influence concerning whether children smoke or not; on the one hand, having the potential to convey messages that influence children toward smoking and on the other, the potential to convey messages that discourage it. Many also viewed parents as sending few antismoking messages, if any, or sending unclear antismoking messages, leaving children to think that it is not an important issue for the parents.

Youths' perceptions that parents do not engage in antismoking measures are consistent with adolescents' reports in other research that their parents did not talk very often about smoking-related issues (de Leeuw, et al., 2008). It also is consistent with parents' own reports indicating that many do not talk a lot or

frequently with their children about smoking and either do not have or do not strictly enforce antismoking rules (Chassin, Presson, Rose, Sherman, & Todd, 1998; Clark, et al., 1999; Riesch, et al., 2000; Tang, et al., 1999; von Bothmer & Fridlund, 2001). Their perceptions that cigarettes are easy to access through parents and that some parents facilitate smoking through prompting behaviours and requests are consistent with those of adolescents (Laniado-Laborin, et al., 2004) and pre-adolescents (Jackson, 1997) in other research. That adolescents may prefer to talk with their mothers about important topics such as ATOD may help to explain why, in another study, when they were asked what parent was most influential concerning their decisions to smoke or not, most reported that it was their mothers (Herbert & Schiaffino, 2007). Interestingly, also in that study, some (15%) reported that neither parent was important. That may be a reflection of the aforementioned perception of adolescents that many parents do not provide adequate antismoking messaging.

Parents' Perspectives

Clark and colleagues (1999) conducted twelve focus groups with 70 White (54% of the sample) and African-American smoking parents, of children 8 to 17 years old, to determine their perceptions and behaviours toward youth smoking. Data were collected in 1997 in an American state. There were notable differences between White and African-American parents, with African-Americans holding stronger views against smoking and being more involved in antismoking socialization.

White parents were much less certain about the usefulness of setting ground rules against smoking and about their ability to have any positive influence in deterring smoking among their children. They referred to smoking as a teenage behaviour and talked about the causative relationship between peer and adolescent smoking, which they considered to be unalterable. Many of the White parents held the view that smoking was not worth getting into a battle over with their adolescents and that other problem behaviours were of greater concern, for example, drug use. They had difficulty talking with their children about not smoking because of their own smoking which made them feel hypocritical. Mothers, in particular, felt guilty about their negative influence on their children. Many of the parents felt that they did not have to worry about their children beginning to smoke because they were exposed to smoking prevention at school. Some believed that should they find their children using tobacco, there was not much they could do that would make a difference. Others thought that talking to the child or using discipline might make a difference. Some thought that 16 years is the age at which children should be able to make up their own minds about whether or not to use tobacco.

Perspectives on antismoking practices, namely antismoking discussions and household smoking restrictions, also were examined in another study that involved mainly African-Americans (70%) and Whites (27%) (Butler, Kegler, & Escoffery, 2009; Kegler, et al., 2007). The 158 participants were smoking and non-smoking parents or other caregivers of 10 to 14 year old children and were drawn from rural counties in a southern US state. Interviews with the participants

were carried out in 2004 and 2005. Information about antismoking discussions was reported for the African-American participants only (Butler, et al., 2009) and information about smoking restrictions was reported for the entire sample (Kegler, et al., 2007).

Fifty-seven percent of the African-Americans said that they frequently talked to their children about smoking (Butler, et al., 2009). The topics most often discussed were negative health and economic consequences of smoking and peer pressure. The strongest antismoking discussions were by non-smokers and former smokers. The children's responses were to assure their parents that they would not smoke and encourage parents and family members who smoked to quit. The participants indicated that should their children be caught smoking, they would react by talking to them about the health dangers and taking away privileges and they believed that their children expected that there would be such consequences. Some thought that their children expected that they also would become angry or give them a spanking. Overall, the participants felt that the best way to keep their children from smoking was to continue talking to them about the dangers of smoking, lead by example, and not smoke around them. Some of the smoking participants said they do not leave their cigarettes where their children could find them.

Many of the participants reported that they had at least some restrictions on household smoking; 34% had a complete ban, 54% had a partial ban, and 12% did not have any restrictions (Kegler, et al., 2007). Households with all non-smokers were more likely to have a total ban than households with any smokers.

Households that had a mix of smoker and non-smoker residents typically had partial bans. In most households in which all adults smoked, smoking restrictions were not considered. For the most part, disagreements about home smoking restrictions were rare; although, in some families the restrictions caused tension due to resistance by family members who smoked. In those situations the issue remained unresolved with continued smoking in the home by the smoker, resulted in a negotiated compromise, or resulted in resignation by the non-smoker to a lower level of restriction than desired. The main reason given by the participants for having smoking restrictions was related to protecting their children's health, both for healthy children and children with respiratory illnesses. A large number of the participants believed that ETS is harmful to children. Other reasons included that their children did not like being around smoke and the smell is aversive. Some non-smoking parents reported that they also had smoking restrictions because as a child they themselves disliked growing up in smoking homes.

Parental views on and interventions for ETS were explored in two other studies as well (i.e., Hill, Farquharson, & Borland, 2003; Robinson & Kirkcaldy, 2007a, 2007b). Robinson and Kirkcaldy (2007a, 2007b) carried out seven focus groups with a sample of 54 mothers of pre-school children. All either currently smoked or had given up smoking within the previous 6 months. Eighty-nine percent were of White ethnicity and all were from socially and economically disadvantaged neighbourhoods in a city and surrounding communities in England. Data were collected in 2004.

The mothers were aware of at least some of the accepted health risks to children of exposure to ETS, in particular, short-term or common health problems such as cough, colds, bronchitis, and asthma. However, the majority did not associate long-term serious health effects, such as cancer, to exposure to second-hand smoke. The consensus within the groups was that serious long-term health effects to children as a result of breathing in smoke in the home were remote and not inevitable (Robinson & Kirkcaldy, 2007a). Although they displayed some knowledge and acceptance of the health effects on children of smoking in their presence and although they all had at least some restrictions on smoking in their homes, the number of mothers who had complete non-smoking homes was low (Robinson & Kirkcaldy, 2007b). In many cases the restrictions were partial and may be described as random in the sense of not being consistently applied or based on recommendations. For instance, smoking may not have occurred in children's bedrooms but may have occurred in other rooms of the home or in the doorway. Smoking may not have been allowed in the home during the daytime when the children were around but may have been allowed after the children had gone to bed. Visitors may have been allowed to smoke.

An explanation for failure of mothers to have an effective home antismoking rule, even though they knew of messages that link ETS to childhood illnesses, is that they tended to question the validity of or minimize the health risks. Further, many tended to disregardt research findings of a relationship between parent and child smoking (Robinson & Kirkcaldy, 2007a). To counter the scientific claims the mothers relied on such sources as their own experience of

smoking or as children of smoking parents, observations of their own or other people's children, observations of people living around them, and information from relatives. They offered alternative explanations, such as genetics and pollution, for health effects and believed that children smoke because of their own personal choice not because of exposure to parental smoking. Further, similar to what Kegler and colleagues (2007) found about smoking restrictions causing tension in families where there were smokers who impeded rules, mothers in this study who lived with others who smoked had to negotiate restrictions with them and some did not feel supported because the smokers either broke the rules or complained about having to comply (Robinson & Kirkcaldy, 2007b).

Hill and colleagues (2003) examined strategies that smokers used to protect non-smokers, especially children, from exposure to tobacco smoke in their homes. Interviews were carried out with 20 adults who lived in apartments in an Australian city. Sixteen lived in public housing and were of low or very low socioeconomic status. Although it appears that the focus was on parents, it is not clear as to whether all the participants were actually parents. Sixteen lived with children who were under 18 years of age. The year in which the data were collected is not provided.

All of the participants smoked in their homes. Eighty percent said that they would prefer to have a smoke-free home but did not ban smoking inside for such reasons as wanting warmth, privacy, and comfort when they smoked; being nicotine dependent and not able to quit smoking despite wanting to do so; wanting to accommodate family members or friends who smoked; lacking access to

suitable outdoor space due to apartment dwelling; and needing to supervise young children while they smoked. The findings indicate that the parents knew that ETS is harmful. Forty percent reported that they knew that ETS in the home caused their children's existing illnesses or respiratory problems to be worse. In general, the participants believed that it was better to do something than do nothing to try to protect non-smokers in their homes from ETS. Their two main strategies were to open windows and doors or smoke in a separate room with the door shut.

In the one other study involving parents' perspectives, a grounded theory was generated to understand non-smoking parents' experiences in having adolescent children, ages 15 to 19 years, who had become smokers (Small, Brennan-Hunter, Best, & Solberg, 2002). Data were collected from 25 parents in a Canadian city in 1999. The theoretical model revealed that the parents struggled to understand how their children could have started to smoke, why it continued, and what they should do about it. The parents had not expected their children to smoke because they themselves were non-smokers and their children had been opposed to smoking when they were younger. Most felt that they had done a good job in informing their children about the hazards of smoking and their disapproval of it. However, some questioned the approach they had used and wondered whether a different approach may have made a difference. Overall, although the parents were concerned about their children's smoking because of the health effects and worried continuously about it, they perceived that smoking was not as serious as some other behaviours in which their children were or could be involved such as alcohol and drug use.

To summarize, some of the evidence from the studies on parents is consistent with the adolescents' perceptions that many parents do not engage in strong antismoking measures. For instance, some of the smoking parents were uncertain about the usefulness of having ground rules against smoking and their ability to have a positive influence on deterring smoking. Further, consistent with the adolescents' perceptions that some parents view smoking as less serious than other problems, there were parents in these studies who also held that belief. Similar to findings in quantitative research (Binns, et al., 2009; Kegler & Malcoe, 2005), some of the parents viewed parental smoking as a negative influence for youth smoking. However, parents in one study refuted such a relationship and believed that youths smoke because of personal choice. Some parents attributed youth smoking to expected adolescent behaviour and emphasized peer influence. It is conceivable that beliefs about personal ineffectiveness and attributions of influence to factors that are outside of their control could deter parents from engaging in strong efforts against smoking.

On the other hand, there were at least some parents who believed that parental efforts are important to preventing smoking among children. Similar to findings from the quantitative literature (e.g., Binns, et al., 2009; Clark, et al., 2006; Ennett, et al., 2001; Fisher et al., 2007; Throckmorton-Belzer et al., 2009; Wyman, et al., 2006; Yousey, 2006), some parents and guardians had talked about smoking with their children and had rules restricting smoking in their homes. However, also consistent with other studies (e.g., Binns, et al., 2009; Bricker, et al., 2005; den Exter Blokland, et al., 2006; Engels & Willemsen, 2004; Harakeh,

et al., 2005), many parents had only partial restrictions and smoking was more permissive in homes where there were parents and others who were smokers. Some parents smoked in their homes and allowed others to do so despite knowing that ETS is harmful.

Limitations of the Qualitative Research

Of the five studies that involved an examination of the perspectives of adolescents, little detail is provided about socio-demographic characteristics of the samples. Most included both smoking and non-smoking adolescents, but in one study, smoking status of the adolescent participants was not provided (i.e., Miller-Day, 2002). One study involved female adolescents only (i.e., Denham, et al., 2004). Of the 5 studies that were about parent perspectives, some had select samples such as mothers (i.e., Robinson & Kirkcaldy, 2007a), parents who were current or former smokers (i.e., Clark, et al., 1999; Robinson & Kirkcaldy, 2007a) or non-smokers (i.e., Small, et al., 2002), and parents from disadvantaged neighbourhoods (i.e., Robinson & Kirkcaldy, 2007a) or low or predominantly low socioeconomic background (i.e., Hill, et al., 2003; Kegler, et al., 2007). Half of the 10 qualitative studies took place in the mid to late 1990s. It appears that all took place between 1996 and 2005. The social context for smoking has changed in recent years and smoking rates among both adults and youths have declined since the 1990s. Hence, findings from early studies may not reflect youths' and parents' perspectives and parental interventions more currently. None of the studies that involved parents provided a comprehensive examination of parental approaches with children who are younger than adolescence.

Conclusion

Youth smoking is a complex behaviour with many different influences, from intra-individual to various social factors. The theoretical literature indicates that parenting factors are important. However, findings from research have been mixed, with some not supporting theoretical predictions. Inconsistency in and unexpected findings make it difficult to determine the adequacy of the various theoretical explanations. Coherent with what was found in this review, it has been suggested in the literature that existing etiologic theories do not provide a clear and comprehensive picture of youth substance use (Petraitis, Flay, & Miller, 1995).

In addition to the studies which were based on explicit theoretical models, there are a large number of other quantitative studies in which various aspects of parental antismoking socialization and socio-demographic factors were examined. However, there also are inconsistencies in findings among those studies, making it difficult to determine the importance of the various factors to youth smoking.

Discrepant and unexpected findings in the quantitative research may be due to differences in methods across studies and limitations within studies. Many of the studies were correlational in design, which precludes separating out the antecedents of a behaviour from its consequences. Longitudinal research also poses challenges for studying process.

Overall, a large number of studies have been carried out on parental factors in relation to youth smoking. Many were about adolescents, with a smaller

number focusing on or including children who were pre-adolescent. Oftentimes it was children who were reporting on parental attitudes, behaviours, and actions (proxy reporting). Some studies involved parents reporting about themselves. Only a few qualitative studies were found that addressed youth smoking or parenting relative to the behaviour. Five of those entailed eliciting adolescents' perspectives on various aspects of youth smoking. The other five studies were about parents' perspectives on and interventions regarding youth smoking or ETS.

More specifically, although parental communication with children was examined in some studies, including qualitative research, generally the focus was narrow (e.g., whether discussion occurred or there were antismoking rules, or a particular aspect of communication such as frequency of discussion) or attention was not paid to gaining an in-depth understanding. The studies largely were about communicating with adolescent or late pre-adolescent children and many were from the children's perspectives. Inconsistencies in study findings make it difficult to draw conclusions about particulars of parental smoking-related communication. No studies were found about parental communication with young school-age children concerning smoking. Further, there does not appear to be a theory in the literature that describes or explains parental communication with children about smoking. There also does not appear to be a theory that is specific to the concept of parental communication with children more generally. Hence, the approach or approaches that parents may take with their children about the topic of smoking is little understood. What is missing from the literature is good information on how parents approach the topic, the conditions that influence their

approach, and the consequences of their approach. Because most children start to smoke during adolescence, it is important to gain an understanding of parental approach with younger children.

CHAPTER 3

STUDY METHOD

Grounded Theory Methodology

Grounded theory methodology is an approach to the development of theory that is grounded in data; data which are systematically collected and analyzed (Corbin & Strauss, 2008; Strauss & Corbin, 1998, 1999). Theories derived from this methodology may be substantive or formal. A substantive theory is generated from and explains a specific and delimited area and provides a guide to action for the particular problem or concern. A formal theory is less specific and generally pertains to a range of related topics, problems, or concerns. It is more abstract than a substantive theory and has broader applicability.

Grounded theory methodology originated from symbolic interactionism, a sociological orientation which emerged out of American pragmatism, a humanistic movement in philosophy that evolved in the late nineteenth and early twentieth century (Strauss, 1987). Pragmatist philosophers challenged the mechanistic world-view and dualistic assumptions of the dominant philosophy of the time, classical rationalism. They rejected the rationalist postulate of universal determinism and argued that contingency, ambiguity, uncertainty, and indeterminacy are inherent in social situations and the world, generally. They placed emphasis on human agency, meaning, and the role played by humans in shaping reality. In contrast to the rationalists, who viewed things as existing on their own and separate from the knower, pragmatists viewed individuals as active knowers and the observed as inseparable from the observer. They rejected the

notion of knowledge production for its own sake, that is, the desire to simply know things, and believed that the importance of knowledge production is in its practical utility. To pragmatists, knowledge is about enabling people to act and solve problems (Shalin, 1986, 1991).

Symbolic interactionism itself usually is spoken of as a theoretical perspective, rather than as a theory (Williams, 1999). As the label suggests, the focus is on symbols and interactions, which together produce meaning (Adams & Sydie, 2002). Central to the symbolic interactionist perspective are the following three premises as articulated by Blumer (1969) who is credited with delineating the perspective.

> … human beings act toward things on the basis of the meanings that the things have for them…. the meaning of such things is derived from, or arises out of the social interaction that one has with one's fellows…. these meanings are handled in, and modified through, an interpretative process used by the person dealing with the things he encounters. (p. 2)

Hence, people are not responding organisms but acting organisms. They construct their actions based on their own interpretations that they make in the course of social and self interactions (Musolf, 2003).

Interactionist concepts reflect an interpretivist perspective, an approach to research that endeavours to understand peoples' behaviour (Musolf, 2003). To understand, the researcher must look beyond the behaviour to the meaning that drives it (Milliken & Schreiber, 2001). The use of such tactics as sympathetic introspection and taking the role or attitude of the other allows the researcher to imaginatively place himself or herself in the position of the other, thus yielding

the best understanding of the subjective definitions of situations and intentions of the other. The understanding gained provides for an "in-depth, contextualized explanation of human behavior" (Musolf, 2003, p. 97). The main methodological implication of symbolic interactionism that is addressed with use of the grounded theory approach is the fundamental importance of understanding (Milliken & Schreiber, 2001).

The Grounded Theory Method Used in This Study

The grounded theory method used in this study is based on the work of Strauss and Corbin (e.g., Strauss & Corbin, 1998, 1999). Grounded theorists interpret data of varied forms, such as interviews, video-recordings, audio-recordings, documents, and participant observation, to construct a theory to explain the phenomenon of concern (Strauss & Corbin, 1998). They are interested in learning about process (Strauss & Corbin, 1999). Process refers to the flow of action or interaction or both that occurs in response to a situation, happening, or problem, the purpose of which is to reach a goal or handle the problem (Corbin & Strauss, 2008). Conditions, which form the structure or context, shape the nature of the circumstance to which the individual is responding by way of action or interaction. In turn, the action or interaction produces outcomes that can feed back and influence conditions. Adjustments in action and interaction are made as conditions change. As expected, any action or interaction depends upon how the individual defines the circumstance and the meaning applied to it. Process and structure are related such that process answers the question pertaining to how persons act or interact and structure answers the question pertaining to the reasons

they act or interact. Examining process and structure allows one to see the complexity in what is going on relative to the phenomenon (Corbin & Strauss, 2008; Strauss & Corbin, 1998).

With grounded theory method, the theorist begins inductively and generates hypotheses from the data (Strauss & Corbin, 1998). The hypotheses are confirmed or disconfirmed through deduction with subsequent data. Thus, relationships are established among categories (high level concepts) and the theory is built around a central category. Grounded theory has a number of distinctive features to ensure full concept development and theoretical density including constant comparison analysis, a coding paradigm, theoretical sampling, theoretical saturation, and theoretical sensitivity.

Strauss and Corbin (1998) suggested that grounded theory can be used to study an area for which little is known. Alternatively, it can be used to study an area for which much is known but for which something about the problem remains elusive or unclear. In that case, a novel approach is needed to construct understanding. In some cases there may be ambiguities or contradictions in findings within or among the prior studies and a new approach may help to resolve the discrepancies. Although there has been some work carried out on parental communication with children about smoking, much of it pertains to communicating with adolescents, is based on children's perspectives, and is narrow in focus. Further, there is inconsistency among findings. How parents actually approach the topic of smoking with their children is not well understood, particularly as it relates to children who are younger than the adolescence stage.

Grounded theory is suited to gaining an in-depth understanding of a phenomenon through theory development. Hence, I designed a grounded theory study to examine from parents' own perspectives their approach to the topic of smoking with their school-age preadolescent children.

Sample

The study took place in a city in Newfoundland and Labrador. The sample was comprised of two groups of participants. The primary group was composed of 38 parents who had at least one school-age child ranging from 5 to 12 years of age (i.e., kindergarten to grade 6). Most children who start smoking do so during adolescence (CDC, 2007). The aim was to determine how parents approach the topic of smoking with children before children become smokers. Parents' approaches may be different once a child has started to smoke. The other group of participants consisted of 9 professionals whose work involved children or smoking prevention. These professionals were selected because they had experience in teaching school-age children or expertise in youth smoking, smoking prevention, and tobacco control. It was anticipated that information from the professionals would provide insight into the local situational context for smoking.

Recruitment. The parents were self-selected for inclusion in the study through three recruitment means:

1. Permission was obtained from a metropolitan school board to contact principals in elementary schools (kindergarten to grade 6) in the city and ask for

their assistance in having brochures that described the study sent home to parents as a part of the regular school correspondence to them. The brochures had my contact information so that interested parents could get in touch with me. They were designed as a tri-folded letter-size page and printed in color. Attention was paid to readability to take into account the range of literacy in the adult population. About 9 million Canadians, aged 16 to 65, have been found to be below the desired level for the ability to understand and use text information (Statistics Canada, 2005). The marker that often is used for basic literacy is grade 9 school education (Zubrow, et al., 2008). Research ethics requirements generally include that the level of language for research materials directed to potential participants must be less than grade 9; normally between grade 6 and 8 (Health Canada, 2010c). Because only a simple and brief description of the study and participation was required for the brochure, a Flesch-Kincaid grade level of 6.5 was achieved (see Appendix C for a black and white, reduced version of the brochure, p. 343).

2. Permission was obtained to display study brochures and study posters in various community settings in the city. The posters had most of the information that was printed on the brochures, the same attention to readability, and tear-off tabs with my contact information for easy take-away. They were 11 x 14 inches in size, were printed in color on poster board stock, and as with the brochure, the study information was at a 6.5 Flesch-Kincaid grade level (see Appendix D for a black and white, reduced version of the poster, p. 345).

3. The snowball technique was used whereby parents who already were participants in the study were asked whether they would be willing to assist with identifying other potential participants. Those who agreed were asked to contact parents whom they knew and thought would be suitable participants, tell them about the study and should they be interested in the study, give them a study brochure or my contact information.

Recruitment of parent participants occurred in two stages over a six month period. The first stage involved recruitment through schools and community settings. A brochure was sent home with each student in six elementary schools. These schools ranged in size from approximately 200 to 600 students. In addition, brochures and posters were displayed in community settings including two large community recreational facilities, a childcare center, a medical family practice, a nongovernmental organization (NGO), and three family resource centres. The family resource centres were targeted in particular because they provided services to low income families and individuals from such background tend to be less likely than others to participate in research (e.g., Post, Galanti, & Gilljam, 2003; Sandelowski, 1986). Both the brochures and posters had a statement indicating that expenses for travel and childcare, incurred as a result of attending an interview, would be reimbursed.

That recruitment effort yielded 17 parent participants over a four month period. Ten had learned of the study through brochures from the schools and 7 through community sources. There were three other parents who expressed an interest in the study and were given detailed information about it. However, they

did not follow through with an interview. Although direct contact had been made with the Directors at each of the three family resource centres and they had offered to promote the study with their clients, no parents were forthcoming from those centres.

As it turned out, those first 17 parents were relatively homogeneous. All had at least some university or college education and all but one had middle or high household income. Sixteen had never smoked or had smoked formerly and just one currently smoked. Only three were fathers. Further, preliminary analysis of the data revealed that there was some variability among emergent categories but more parents were needed to adequately build the theory.

The second recruitment stage, then, was intended to increase sample diversity and size in an effort to (a) ensure that the perspectives of parents from low socioeconomic status, parents who smoked, and fathers were adequately represented; and (b) maximize the opportunity to identify relevant concepts, increase density within concepts, and delineate variation. The two affiliated university ethics committees were consulted and permission was obtained to offer potential participants a small gift incentive. Consequently, the study brochures were adjusted to include a statement indicating that a $30.00 food gift certificate for a local supermarket was available to participants. The brochures then were distributed to parents through two more schools that had about 200 and 500 students. These were inner city schools in low income neighbourhoods. During this stage the original community settings continued to display the study brochures and posters and another family resource centre for low income families

was added. This second more focused recruitment yielded an additional 21 participants over 2 months; 12 through school-distributed brochures, 5 through community sources, and 4 through snowballing. Again, there were three other parents who expressed an interest in the study and were given detailed information about it but did not follow through with setting up an appointment for an interview. As in the first recruitment stage, no parents were forthcoming from the family resource centres.

The other sample for this study, comprising professionals, was sought through select workplaces or organizations in the city including schools, a community health authority, and three NGOs. In the case of schools, permission was obtained from the School Board before principals were contacted about the study. In the other cases, administrators were contacted directly. In all cases, the principals and administrators were given information about the study and the rationale for including professionals. They were asked to speak about the study to any suitable employees and should employees be interested in the study, obtain permission for their names and contact information to be given to me. Although a number of schools were contacted, only one principal responded, identifying two teachers and a guidance counsellor. The health administrator identified two public health nurses and the three NGO administrators identified five professionals in total. I then contacted each professional individually and gave full detail about the study. Subsequently, all but one agreed to participate. The guidance counsellor did not respond to my initiative to schedule an interview.

Participant sampling. Sampling was purposive which means that participants who best represented or had knowledge relevant to the research questions were sought for inclusion in the sample (Morse, Barrett, Mayan, Olson, & Spiers, 2002). This study was about how parents approach the topic of smoking with their children and so it was parents who had that knowledge and experience. Thus, the primary sample consisted of parents who were willing to reflect on their experience and share their views.

I carried out data collection and beginning analysis concurrently. In grounded theory method the process of analyzing the data and clarifying and expanding on study findings with subsequent participants allows for the most complete understanding of the phenomenon of interest (Strauss & Corbin, 1998). Thus, I continued to recruit participants into the study until I was satisfied that I had sufficient data to understand the approaches that parents take with their children about the topic of smoking. Finding a negative case, which is a case that does not fit the theory that is being constructed, is important as it allows for a fuller exploration of a phenomenon and points out that there are exceptions that, while not negating the theory, need to be explained (Corbin & Strauss, 2008). Indeed, in this study a case was identified that did not completely fit with the patterns in the theory and is considered to be a possible negative case.

Data Collection

Data collection consisted of doing interviews with parents and professionals and obtaining information about public policies and programs concerning smoking that had occurred contemporaneously and were relevant

locally. I conducted all of the interviews. They were digitally-recorded and then transcribed verbatim to form the text for data analysis.

Interviews. The interviews were carried out with the parents to address the overall research question of how they approached the topic of smoking with their children, as well as to address the specific questions regarding the meaning that they applied to smoking behaviour among children, the local policy and program context concerning smoking that may have influenced their approach, approaches of mothers and fathers, and approaches of smoking and non-smoking parents. Broad, open-ended questions were used to permit the parents to reveal their perspectives, for instance, "Would you please tell me about your thoughts on children smoking?", "What do you see as factors that influence children to smoke (to not smoke)?", "How has the topic of smoking come up?", "Can you think of a specific time when your child made mention of smoking or asked questions about it? Would you describe the situation for me?", and "What advice would you give to other parents about approaching the topic of smoking with their children?" An interview guide was used to help gather detail (see Appendix E, pp. 346). As the data collection process progressed, information from preceding interviews was used to guide subsequent interviews to allow commonalities and variance to be drawn out. For instance, when it became apparent that there were similarities and differences among parents based on their smoking status, a question such as this was asked, "How does being a former smoker affect the approach you take with your child?" When it became apparent that parents may talk differently to younger versus older children, a question such as this was asked, "What are your

thoughts on what is an appropriate approach to use in addressing smoking with children of different ages (e.g., young school-age children compared with older school-age children or adolescents)?"

Socio-demographic information also was obtained during the interviews (see Appendix F, pp. 350). The information was elicited at the beginning of each interview so that I was familiar with the parent's background and the family membership and could situate and particularize the interview questions about parental approach. During the overall data collection process, the socio-demographic data also permitted me to see what characteristics were being represented so that I could pay attention to ensuring that there was diversity in the sample.

Most parents were interviewed only once. All initial interviews were carried out in person except for one, which was carried out by telephone for parent convenience. Most often the interviews were conducted in private in an office at a university or at the parent's home. A few were carried out at participants' places of work or in coffee shops in secluded locations. When both parents of a child participated in the study, they were interviewed separately. The interviews with parents ranged in length from about 30 to 60 minutes. Four of the parents who were interviewed early in the study were interviewed a second time for the purpose of adding more detail to and clarifying points in the first interviews. One of those second interviews was carried out in person and three by telephone. Those interviews lasted about 20 minutes.

The interviews with the professionals were conducted to obtain information on the local policy and program context concerning tobacco use in which the parents were situated in approaching the topic of smoking with their children. It was thought that information from professionals would augment information about contemporaneous public smoking-related policies and programs gathered through other sources. The interviews were semi-structured and were conducted using an interview guide (see Appendix G, pp. 353). All were completed in person and privately. Most occurred at the respective workplaces of the participants. One occurred in an office at a university and one at a coffee shop. The interviews with the professionals were carried out concurrently with parent interviews during the first stage of parent recruitment. Those interviews ranged in length from about 25 to 40 minutes.

After each interview, I recorded in journal notes my impressions of it, any questions it had raised for me or things that I needed to consider in future interviews, any particular observations of the participant, any thoughts about the data, and any feelings it provoked for me personally. I used these insights to guide subsequent data collection and inform data analysis.

Information about contemporaneous public smoking-related policies and programs. Because of my long-term involvement, on a professional level, with local and national bodies that have mandates concerning smoking prevention and tobacco control, I was aware of contemporaneous initiatives that were relevant locally for the broader community and I had supporting documentation. Leading up to and during the study, I paid attention to media coverage concerning

smoking and observed for education campaigns. I collected relevant material and made notes about what I had found. I searched several Web sites to verify initiatives and to obtain documents pertaining to smoking. These included (a) Health Canada for legislation, national education campaigns, and *The Federal Tobacco Control Strategy*; (b) Newfoundland and Labrador Department of Health and Community Services for legislation, provincial education campaigns, and the provincial *Tobacco Reduction Strategy*; (c) Newfoundland and Labrador Alliance for the Control of Tobacco for education campaigns; (d) Lung Association regarding the *Smokers' Helpline*; (e) Newfoundland and Labrador Eastern School District for school policies relevant to smoking; and (f) Newfoundland and Labrador Department of Education for smoking education school curricula.

Data Analysis

The data analysis took three forms: (a) constructing theory from the parents' interviews, (b) generating themes from the professionals' interviews, and (c) describing the local context concerning smoking by reviewing the information gathered through documents and other media and identifying and delineating relevant policies and programs. I conducted the data analysis with consultation and guidance from my supervisors. All interviews were coded electronically using a word processing program. The interview transcripts were divided into two columns with the transcript text placed in the left column. Relevant text was highlighted and applicable codes were placed in the corresponding space in the right column. To facilitate management of the large amount of parent data, those interview transcripts also were entered into the computer software program for

qualitative data, NVivo 7 (Qualitative Solutions and Research International Pty Ltd). The program was used to organize and categorize the data for easy access to the codes and retrieval of the coded text. Analyses of the interview data to construct theory and generate themes were complex processes and are delineated in detail as follows.

Constructing theory. The procedure for constructing theory from the parent data was based on the approach of Strauss and Corbin (1998) and involved coding with constant comparative analysis, theoretical sampling, memo writing, and diagramming. Constructing theory refers to the act of developing "an explanatory scheme that systematically integrates various concepts through statements of relationship" (p. 25). After each interview, I listened to the recording so that I could get an overall impression of the parent's story and think about how that particular story was similar to or different from others carried out up to that time. After each interview was transcribed, I listened to it again while reading the transcript to ensure accuracy before beginning the process of coding.

There were three steps in the coding procedure. Although these steps suggest a sequence, in reality they are integrated and I moved back and forth between the types of coding throughout the entire analysis process. In the first step, I used open coding, often referred to as substantive coding, to identify concepts in the data and their properties and dimensions (Strauss & Corbin, 1998). Initially, open coding involved a line-by-line examination of the data whereby it was broken down phrase by phrase, scrutinized closely, and compared incident to incident (through constant comparative analysis) for similarities and

differences both within and across interviews. Incidents that were conceptually similar were grouped into more abstract concepts called categories. Such intensive coding early in the data analysis process allowed me to concentrate closely on the data so as to identify what was there and avoid ascribing any preconceived ideas about it. As data collection and analysis progressed, it became possible to use more of a sentence-by-sentence approach to further code for categories that already had been identified.

In the second step, I coded axially, which involved reassembling, in new ways, the data that were fragmented during open coding (Strauss & Corbin, 1998). The objective was to code intensively around single categories, link categories with categories, and link categories with their subcategories. To integrate structure and process I used the coding paradigm as suggested by Strauss and Corbin. The basic components of the paradigm are conditions, actions and interactions, and outcomes. They answer the questions who, when, where, why, how, and with what consequences. According to Strauss (1987), use of the paradigm is essential for completeness in coding. The result is precise and comprehensive explanations of the phenomenon under study (Strauss & Corbin, 1998). In this study, axial coding yielded the action and different types of interaction that the parents took with their children concerning the topic of smoking, the conditions that influenced their action and interaction, and the outcomes that resulted for them as a consequence of their action and interaction.

In the third step, I used selective coding to integrate and refine categories and abstract a central category. The central category was identified by applying

several strategies as suggested by Strauss and Corbin (1998): (a) asking myself the questions, "What is the problem these parents are dealing with?" and "What are they doing about it?" (b) reviewing the categories repeatedly while thinking inductively, "What concept captures these?" (c) writing memos to help me think about the category; (d) drawing diagrams to help me think about the logic of relationships between categories; and (e) reading entire interviews again while thinking, "What keeps coming through in the parents' stories?" The importance of identifying a central category is that it pulls together the main categories to form an explanatory whole, or theory, while accounting for variation among the categories. Such an explanatory scheme to understand how parents approach the topic of smoking with their children would be considered a substantive theory. In this study, it was not until the end of data collection and analysis, when all the other categories were fully described and explained, that the central category was confirmed, that is, a category that clearly represented the essence of the findings.

The words I chose for code labels during the three levels of coding were *in vivo*, as much as possible, which means that the direct language of the participants was used. I generated other code labels from the substantive data. To ensure that the words chosen best fit the data, I often found it necessary to retrieve and reflect on dictionary definitions. I kept a running list of dictionary definitions that I referred to when thinking about the data. At the completion of analysis I had accumulated some 70 words. During analysis, some code labels were changed to reflect greater precision in wording or better fit with the data. Some were combined and relabelled to a higher level of abstraction.

As data collection and analysis progressed, I used theoretical sampling "to maximize opportunities to discover variations among concepts and to densify categories in terms of their properties and dimensions" (Strauss &Corbin, 1998, p. 201). As concepts and relationships were identified in the data, I followed up on the analytic leads with subsequent parent participants. I also reviewed previous interviews to think about what I already had analyzed and to consider whether there was any fit of any new category with previously identified categories. The aim with data collection and analysis is to achieve theoretical saturation, that is, "the point in the research when all the concepts are well defined and explained" (Corbin & Strauss, 2008, p. 145). In this study I continued to collect data and theoretically sample until there was replication, no new information was arising during coding, and variation was accounted for. At that point theoretical saturation was considered to have been achieved.

During coding, I wrote many memos to facilitate the data analysis process. Often these were in point form and sometimes in paragraphs. The memos contained thoughts, insights, questions, and conceptual ideas that I had about the data. During open coding, I wrote a memo about each parent. These were simple memos that helped me explore the data, think about concepts and their properties and dimensions, and think about how the parents' stories were similar to or different from each other. I also reflected on my journal notes for any insight that could help me describe what was going on with that particular participant. As with selective coding where I wrote memos to aid in specifying the central category, during axial coding, I wrote memos to help me think about, specify, and

describe the conditions, interaction and action, and outcomes, and to think about and delineate relationships among those paradigm components. At that point, however, I still found it necessary to go back to the interview transcripts and read them to confirm my impressions about concepts and patterns in the data.

Over the course of analysis, some of my ideas in memos changed as a result of increasing insight into the data and consultation with my supervisors. Thoughts about the importance of categories and even their placement in the theoretical scheme changed, and original concepts were revised even up to the time of writing up the findings into the analytic story. Corbin and Strauss (2008) talked about "feeling right", which is a gut feeling about the findings. "It means that after being immersed in the data the researcher believes that the findings reflect the 'essence' of what participants are trying to convey, or represents one logical interpretation of data, as seen through the eyes of this particular analyst" (p. 47). It took many tries, with amending and reinterpreting, before the categories and their relationships became clear, I felt that I had attained the essence of what the parents had conveyed, and the analytic story was finalized and *felt right*.

In addition to written memos, I also used diagrams throughout the analytic process to help me sort out relationships between categories and subcategories, and among conditions, action, interaction, and outcomes. The diagrams I drew changed over time, becoming more elaborate and precise as data analysis progressed, and culminated in Figure 2, which represents the theoretical scheme derived from the parent data (see Chapter 4, Findings, p. 120).

Generating themes. Strauss and Corbin (1998) referred to the method of generating themes from qualitative data as *conceptual ordering*, which is the organization of data into distinct categories based on their characteristics and the use of description to delineate them. This may be likened to what others referred to as *analytic coding* to develop themes or categories (Morse & Richards, 2002) or *analysis* to identify key factors in data (Wolcott, 1994). The intent is that the product of conceptual ordering is well-developed themes that may have relationships among them but do not form an overarching explanatory scheme. In other words, the product is not at the level of a theory (Strauss & Corbin, 1998).

The procedures I used to generate themes from the professionals' interview data were similar, up to a point, to those used to construct theory and involved coding, making comparisons, writing memos, and diagramming. After each interview was transcribed, I listened to the digital recording while reading the transcript to ensure accuracy and to get an overall impression of what each professional discussed. I then used open coding, with a sentence-by-sentence approach to identify concepts and their properties. Concepts that were similar were combined and transformed into more general concepts, which were referred to as themes (otherwise known as categories).

To facilitate analysis, I wrote a memo for each interview with the professionals. These were simple, point-form memos to help me think about the concepts and themes. Diagrams were drawn and refined to help me visualize the themes and how they were connected and culminated in Figure 1 (see Chapter 4, Findings, p. 103).

The Scientific Rigor of the Study

As with other research methods, it is important that grounded theory research has scientific rigor, in other words, that it meets accepted standards for how research ought to be conducted and for scientific evidence (Charmaz, 2006). Various authors have identified criteria and strategies for evaluating rigor in qualitative research. Corbin and Strauss (1990, 2008) argued that the same evaluation criteria should not be applied across qualitative methodologies and that each requires its own in light of the canons and procedures of the specific methodology. Hence, they proposed particular criteria for evaluating research carried out using grounded theory methodology. I use their work to demonstrate how I endeavoured to achieve rigor in this study. Grounded theory research may be judged by adequacy in four areas.

The credibility of the data. Credibility is about trustworthiness and believability. Findings are credible when "they reflect participants', researchers', and readers' experiences with a phenomenon" (Corbin & Strauss, 2008, p. 302). Several strategies were engaged in this study to obtain credible data. Purposive sampling was used to ensure sample appropriateness. Diversity in sample characteristics, obtained through recruitment strategies, allowed for broad representation in the data. Interviews with open-ended questions were conducted with parents to obtain detailed data so as to identify salient characteristics of each parent's approach to the topic of smoking with his or her child(ren). Actual words from the parents were used in the category labels and analytic story and direct quotations from them were used to illustrate the categories that were derived from

the data. As suggested by grounded theory methodologists, the interpretive researcher must keep close to the research participants by including their voices in the study (Strauss & Corbin, 1994) and using their words and accounts in the process of analysis (Charmaz, 2006). "Providing ample verbatim material 'grounds' your abstract analysis and lays a foundation for making claims about it" (Charmaz, 2006, p. 82). Quotations were edited only to remove identifying information, redundant wording, or content that was not relevant to the particular category. Pseudonym initials, which were applied to the larger (multi-word) quotations in this study, show representation across participants.

The research process. This criterion refers to judgments about aspects of the research process that were applied in the study (Corbin & Strauss, 1990). An essential feature of any qualitative study is that it has methodological congruence or consistency (Corbin & Strauss, 2008; Morse & Richards, 2002). Although the different qualitative methods may have some similar procedures, each has unique characteristics and produces distinctive findings. The researcher should be careful to avoid mixing methods and procedures to ensure that the data are appropriate for the research question(s) and the analysis is appropriate for the data and produces an appropriate product that is the best possible. In the case of grounded theory method the final product should be a fully developed theory. In this study the research questions, data collection strategies, and data analysis procedures fit with the grounded theory method. In particular, to enable theory construction, I used open, axial, and selective coding, constant comparative analysis, memo writing, and diagrams, and achieved theoretical saturation.

During data analysis, it is important for the researcher to be responsive to the data, that is, "willing to be open to new ideas", and think about things in creative ways "in order to get at the essence or meaning of what participants are telling us" (Corbin & Strauss, 2008, p. 304). As Morse and colleagues put it, the researcher should be willing to relinquish any ideas or categories that are poorly supported (Morse, et al., 2002; Morse & Richards, 2002). Testing concepts and their relationships with individuals who have knowledge and experience in the research method and substantive area may lead to new insight (Corbin & Strauss, 1990). I consulted with my supervisors on the categories and relationships that I had generated from the data and used their feedback to ensure that the findings fit with the data and made logical sense.

During data analysis, it also is important to have a balance between objectivity and theoretical sensitivity (Strauss & Corbin, 1998). Both are important to interpreting the data. Objectivity means listening to and hearing what participants have to say and being able to represent their stories. However, complete objectivity is not possible and there is an element of subjectivity in all research. Investigators need to be aware of their subjectivity and reflect on it in an effort to control its intrusion into the data analysis and avoid imposing personal beliefs and assumptions. Theoretical sensitivity refers to the ability to perceive the subtleties and connotations in the data and to see the relationships among the categories. In short, sensitivity is having insight into the data. It is through immersion in the data, as well as one's prior knowledge and experience, including professional and personal, that one becomes sensitive to what is in the data. In

other words, those prepare the researcher to understand. It is through awareness and acknowledgement of one's background knowledge and perspective that one is able to see the data without prejudging it or imposing predetermined explanations on it.

I engaged in several strategies to address objectivity and theoretical sensitivity. Prior to beginning the study, I recorded in my research journal my personal assumptions about youth smoking and parental influence, thus making them explicit so that I could avoid imposing them during the data analysis. I also reflected on my research perspective and preference for an interpretive approach. In preparing for the study, I had reviewed relevant literature for background information about the problem, and to help me define the research questions and determine the best research methodology. I did not return to that literature during the study or data analysis. Although my background knowledge of and professional experience in the field stimulated my thinking about the data, it did not drive the analysis or force interpretation. I worked directly with the data and compared what I was thinking to what I actually was seeing in the data. The technique of constant comparative analysis ensured that I never lost sight of the data but remained grounded in it. Once I had gathered an understanding from the data and had constructed the theory, I returned to the literature and used it as a resource to compare and contrast what I had found. Thus, the literature was used at that point to help me see the significance and relevance of the theory.

In grounded theory method, it is important for the researcher to be able to show how the findings were derived. Memos and diagrams reflect the analyst's

thinking and reveal the products of the data analysis (Strauss & Crobin, 1998). In this study, the memos and diagrams yielded provide an audit trail, that is, a record of the analysis and how I arrived at my interpretations.

The empirical grounding of the findings. This criterion refers to the extent to which concepts are generated from the data, well developed, and linked; variation is built into the theory; conditions and consequences are examined; and process is taken into account (Corbin & Strauss, 1990). In this study, the empirical grounding of the findings is evident in the research products, which are categories characterized by properties and their dimensions, relationships among the categories, variation within and among categories, conditions, action and interaction, outcomes, a central category, and process. In this study, support for the finalized theory was obtained by comparing it to the raw data, as suggested by Strauss and Corbin (1998). That is, I went back to the parent interviews and reviewed them for the established categories and relationships among them.

The value and significance of the theory. A theory has value and significance if it conveys understanding, contributes new knowledge or further knowledge to what already is known about the phenomenon, and is useful (Corbin & Strauss, 1990, 2008). The theory created in this study addresses a knowledge deficit regarding parental communication with children about smoking and supports and extends particulars of what already was known. The understanding gained may be used in health promotion practice.

The Study Ethics

Prior to commencing this study, the research proposal was reviewed and approved by two affiliated ethics review boards. The following considerations were addressed to protect the rights and safety of those who participated in the study.

Protection of participant identity. To protect identity, all participants were assigned a code number for the transcripts, journal notes, memos, and socio-demographic data records. An effort was made to make the transcripts anonymous by removing personally identifying information. The digital recordings of the interviews were transcribed by a stenographer who took an oath of confidentiality prior to access to the data. All paper copies of the data and the digital recordings were stored in a locked filing cabinet in my office at a university and will be kept under my guardianship for seven years from the time of completion of the study, after which they will be destroyed. Likewise, consent forms will be kept but are stored in a separate locked filing cabinet. Participant contact information (telephone numbers or email addresses, or both) was kept during the study for follow-up contact but was stored separately from other identifying information and has since been destroyed. During the study, electronic copies of the transcripts and the NVivo program with the transcript data were stored on a password protected computer. The electronic data has since been copied to computer disks and removed from the computer. The computer disks are stored with the paper copies of the data and also will be destroyed after seven years. All participant quotations, which are used in this report and which may be used in

future publications, have been made anonymous by removing any potentially identifying information. Pseudonym initials have been assigned to the larger quotations. Demographic data are reported only as group data.

Informed consent. Upon initial contact, I explained the study to each potential participant. The explanation included information about the study purpose, study procedures, nature of participation and expected duration, risks and benefits, and rights as a research participant. Prior to being interviewed, each participant was provided with an information handout on the study and was given an opportunity to read it, ask questions, and discuss the study with me. Hence, the participants were informed concerning the study before giving written consent. The two research ethics boards required that the reading level for informed consent be less than grade 9. Thus, the information handout was written at a 7.4 Flesch-Kincaid grade level for parents (see Appendix H, pp. 355). Because it was assumed that professionals would have a higher educational level than the general population, a Flesch-Kincaid grade level of 8 was applied to the information handout for professionals (see Appendix I, pp. 360). The consent form, which accompanied the information handout, was written at a 7.7 Flesch-Kincaid grade level for all participants. The grade levels for the informed consent materials were higher than that achieved for the recruitment brochures and posters (i.e., a 6.5 level) because of the greater detail and specified content that are required for informed consent.

Risks and benefits. There were no anticipated risks to participants in this study. During the interviews, I was sensitive to parent feelings and was careful

with my questions and responses to avoid leaving them with any feelings of inadequacy about their approaches with their children. The parents were reimbursed for their expenses which amounted to travel and parking costs for the interviews. After some parents already had participated in the study, permission was sought and obtained from the two ethics boards to offer parents a small gift incentive in an effort to increase sample size and diversity. Hence, subsequent parent participants were given a $30.00 food gift certificate at the interview for use at a local supermarket. This was not considered to be an undue inducement as the gift was small in value and the study was viewed by the ethics boards as being *no more than minimal risk.* At the end of the study an attempt was made, through telephone, email, or postal address, to contact all participants to let them know that the study was completed and to offer them feedback on the findings. The majority of parents were reached. For a few, their contact information had changed and so I was unable to reach them. A further few did not respond to my messages. Any of those reached, who had not received the $30.00 gift because they had been recruited into the study prior to the implementation of the gift, were forwarded it at that time. All parents who had responded to my email or telephone messages and all others for whom I had a postal address were forwarded a letter, to thank them for participating in the study, and a copy of the booklet *Help Your Child Stay Smoke-Free: A Guide to Protecting Your Child Against Tobacco Use*, which was published by Health Canada in 2008 as a resource for parents.

Summary

This study was carried out using the grounded theory method of Strauss and Corbin (1998). The purposive sample consisted of 38 mothers and fathers who had at least one school-age child, ranging from 5 to 12 years old, and 9 professionals, including nurses, teachers, and employees of NGOs, whose work involved children or smoking prevention. All participants were self-selected for participation in the study.

The data consisted of audio-recorded and transcribed interviews with parents and professionals and information obtained, through documents and other media, about smoking-specific public policies and programs that were relevant locally. The data from the parents were analyzed to construct a theory by using coding with constant comparative analysis, theoretical sampling, memo writing, and diagramming. Data collection and analysis continued until theoretical saturation was considered to have been achieved. The data from the professionals were analyzed conceptually to generate themes. The information gathered through documents and other media was used to describe the local policy and program context concerning smoking.

CHAPTER 4

STUDY FINDINGS

This study was carried out to understand how parents approach the topic of smoking with their children. To enhance understanding and facilitate interpretation, it is important to know the situational context for smoking in which this phenomenon occurred. To that end, information was gathered, through documents and other media, about public smoking-related policies and programs that had occurred contemporaneously and were relevant locally. Although the intent of the interviews with the professionals was to obtain information on the local policy and program context concerning smoking to augment the information gathered otherwise, the professionals shared their perspectives on smoking prevention more broadly. Thus, the study findings consist of three main components as detailed in the following sections: (a) a description of the local policy and program context concerning smoking; (b) the professionals' perspectives, which are represented by the theme *Smoking prevention requires a multipronged approach involving parents, school, and society*; and (c) the theory that was constructed to explain parents' approaches concerning smoking and is referred to as *Dealing with a latent danger: Parents communicating with their school-age preadolescent children about smoking*. In addition, a comparison is provided of the similarities and differences between professionals' perspectives and parents' perspectives and practices concerning youth smoking prevention.

The Local Policy and Program Context for Smoking

Considerable attention has been paid to smoking in recent years through federal and provincial legislation, other public policies, and smoking prevention and cessation education. Such initiatives, beginning in the 1990s, have influenced the social context for smoking in general and for youth smoking in particular through increased public awareness of the health risks and the importance of youth smoking prevention, decreased exposure to the behaviour, decreased access of youths to tobacco products, and decreased normalcy of the behaviour (Health Canada, 2002; Health Canada, 2006a; USDHHS, 2004a). The combined result of these efforts is a substantially reduced smoking rate. In the general population of Canadians the rate fell from a high of 29% in the 1990s to 18% since 2005. In the 15 to 19 year old age group it fell from a high of 28% in the 1990s to 15% since 2005. These statistics are similar provincially for Newfoundland and Labrador (Health Canada, 2007d, 2009a; Human Resources and Skills Development Canada, 2010; Pederson, 1993).

Prominent public policy initiatives that have taken place recently and are relevant locally and contemporaneous smoking education initiatives that were in place locally at the time of this study are described as follows. Some of the initiatives were specific to smoking prevention and some were specific to other aspects of tobacco control, namely ETS and smoking cessation.

1. The provincial *Tobacco Control Act* (1993), which came into force in 1994, made it an offence in Newfoundland and Labrador for a retailer or other

person to sell or provide tobacco to a person under the age of 19 years. Prior to that, the legal age limit was 16 years.

2. The federal *Tobacco Act* (1997) placed significant restrictions on promotion of tobacco products in Canada. Specifically, the legislation restricted the types of location and media for advertising and prohibited lifestyle advertising and advertising that could be understood as appealing to young persons. It also provided for the Tobacco Products Information Regulations, which came into effect in 2000 (Health Canada, 2009b). The Regulations required that graphic warnings be displayed on tobacco packaging, along with information on emission levels of toxic chemicals, and health information on the hazards of tobacco use or tips on quitting smoking.

3. The provincial *Smoke-Free Environment Act* (1993), which came into force in 1994, prohibited smoking in certain enclosed public places and indoor or other enclosed workplaces in Newfoundland and Labrador. However, it allowed smoking areas or smoking rooms to be designated in most public places and workplaces.

4. The provincial *Smoke-Free Environment Act* (2005) was an effort to tighten up the legislation so that smoking was prohibited in all indoor public places in Newfoundland and Labrador and outdoor decks and patios licensed to serve food or liquor. Designated smoking areas and rooms were no longer permitted in public places.

5. *Smoke-free school properties* policies, introduced by all school boards in Newfoundland and Labrador in 2006, banned smoking on school properties in an effort to make all school facilities and grounds smoke-free (e.g., Eastern School District, 2009).

6. *School smoking prevention education* had been included in curriculum guides for Newfoundland and Labrador since the mid 1990s. Comprehensive learning objectives for smoking content were delineated for grades 4, 6, and 7. An elective course on healthy living for high school students, which was introduced in 2002, included topics on substance use and abuse (Newfoundland and Labrador Department of Education, 2009a, 2009b, 2009c).

7. *Public education about smoking* included both national and provincial initiatives. At the national level there were a number of social marketing and mass media campaigns, which were implemented by Health Canada during the period of 2002 to 2007. These included various combinations of television, radio, and cinema advertisements and print resources directed toward increasing public awareness about the health dangers of smoking and ETS and the importance of smoking cessation. Examples are (a) *target* (about second-hand smoke and directed to adults), (b) *s.s.d.* (about *second-hand smoke diseases* and directed to youths), (c) *Bob* (about smoking cessation and directed to adults), (d) *Barb Tarbox* (about health effects of smoking), (e) *Heather Crowe* (about ETS in the workplace), and (f) *Make Your Home and Car Smoke-Free* (about protecting children from second-hand smoke) (e.g., Health Canada, 2008d).

At the provincial level public education included several mass media campaigns and the institution of a helpline for smokers. The mass media campaigns were implemented during the period of 2000 to 2007 by the Alliance for the Control of Tobacco, a provincial advocacy coalition. The campaigns included various combinations of television, radio, and cinema advertisements and print resources. They were directed toward preventing smoking, in particular youth smoking, and increasing awareness of the health effects of ETS and the health benefits of not smoking and being in a smoke-free environment. Examples are (a) *Smoking Sucks* and *You're a Target: Don't Let 'Em Get You* (about smoking prevention and directed to teens), (b) *Be Free, Smoke-Free* (about living smoke-free and directed to teens, adults, and pregnant women), (c) *Let's Shut the Last Door* and *Second-Hand Smoke: It Kills* (about ETS), and (d) *Enjoy Newfoundland and Labrador* (about living in a smoke-free environment) (e.g., Alliance for the Control of Tobacco, 2010). For some campaigns print materials were distributed to schools to be given to the students (e.g., *You're a Target* and including *Smoking Poisons You [S.P.Y.])*. The *Smokers' Helpline* and supporting website, which were begun in 2000 by the Lung Association and have been in continuous existence, offered smoking cessation resources and counselling services to the people of Newfoundland and Labrador. The Smokers' Helpline was widely promoted through television and radio advertisements and print materials; for example, *We Care* and *It's Your Call*, which were television advertisements.

The Professionals' Perspectives

Characteristics of the Professionals

The professionals who participated in this study consisted of 2 elementary school teachers, 2 public health nurses, and 5 employees of NGOs that had smoking prevention as a mandate. Both teachers had a number of years experience in teaching primary and elementary school children. The two nurses had extensive public health experience. They had been involved in providing smoking health education to youths and others. The professionals from the NGOs had various academic backgrounds including education, arts, and health promotion. Their work involved various combinations of antismoking advocacy, antismoking social marketing, smoking prevention education, and smoking cessation counselling.

Smoking Prevention Requires a Multipronged Approach Involving Parents, School, and Society

The professionals' view was that smoking prevention during youth requires strong and sustained effort by three key players, which are parents, school, and society in general. Although each player can make a contribution, it is the link among the players and the combined effort that lead to the greatest effect. Parents have the main responsibility for educating their children about smoking. Schools have a responsibility to reinforce the antismoking message. The efforts of parents and schools ideally are mutually supportive. Society has a responsibility to support both parents and schools through social policy. Provision of resources for parents is important. "... parents work together with teachers and I think

society is responsible as well....” (HT) The professionals’ perspectives are illustrated in Figure 1 and described as follows.

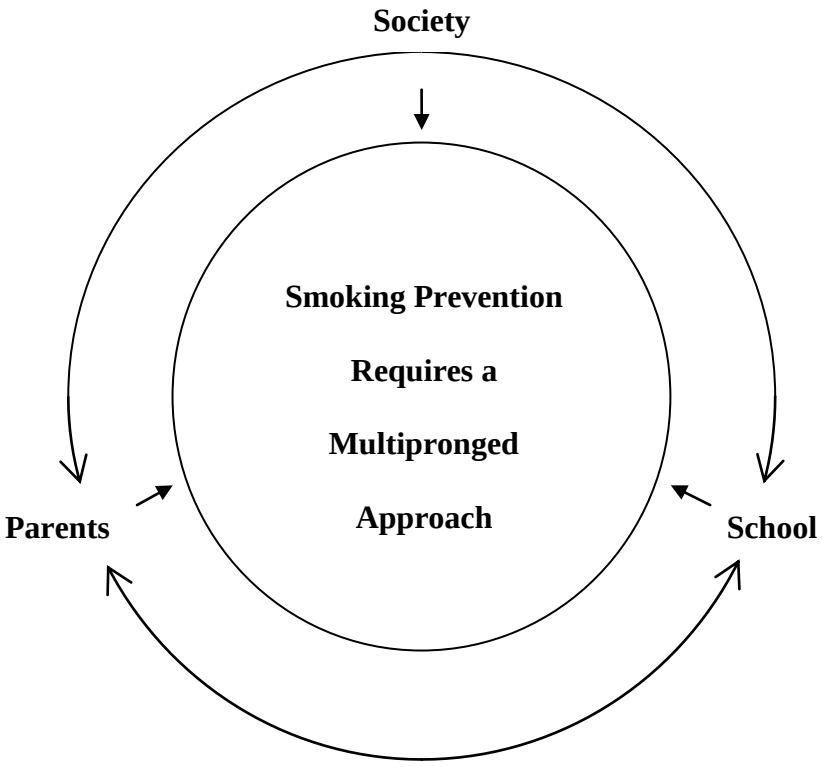

Figure 1. The multipronged approach required for smoking prevention during youth as perceived by professionals in the field. Smoking prevention requires the efforts of three key players: parents, school, and society. The efforts of parents and school ideally are mutually supportive. Society has a responsibility to support both parents and schools through social policy. Provision of resources for parents also is important.

Parents have the main responsibility for educating their children about smoking. The professionals thought that parents are a young child’s most important “influence” and smoking prevention education should come from them, first and foremost. Although they did not have direct knowledge, the public health nurses and NGO professionals also thought that many parents may not address

smoking, to any extent, with their young children. They surmised that parents may fail to address smoking early for any of several reasons including that they do not know the facts about youth smoking; do not view it as a relevant issue for young children; think that it is being dealt with in school; and simply do not "feel equipped" to address it or know what approach to take, which especially may be the case for parents who smoke.

> .... I don't think they're thinking about it with the really young children. It's just not one of those present problems. It's something way out there in the distance somewhere.... when parents are scared that their children are now coming into the spot where they are [likely to smoke] that may be when you get them asking.... (QC)
>
> It's one of those situations where parents prefer not to talk about it. They think the school is going to do it.... They're going to learn it in school, that's all that matters. And, I really firmly believe that when it comes to tobacco for sure. (KW)
>
> I think too, parents may be unaware ... just from what I've read and what I've heard, parents are not sure I think when, at what age to approach the subject.... Lack of communication is a big barrier [to smoking prevention]. A lot of, I guess, parents don't necessarily know how to talk to their kids.... they don't know how to tell their kids how [to] say no to a peer group or to someone who's pressuring you to try a cigarette ... parents don't know how to tell their kids to do it [resist peer pressure]. (NA)
>
> .... If a parent is smoking they tend to really try to minimize it. They don't want to talk about it. They feel guilty about it.... I can't remember anyone ever actually saying help me talk to my child. I'm a smoker and help me counteract that.... They want to put it to the side cause it is not something they're proud of.... (QC)

These professionals had made the observation that although their organizations had services and resources concerning smoking, rarely had parents sought help to proactively talk with their children about the behaviour. This supported their view that parents may not be dealing with the issue. "... to tell you

the truth it's not something that they ask about. They may ask you for lots of other stuff but it's not smoking...." (QC)

> In 18 years, I don't remember ever having been contacted by a parent to say what resources [do you have] ... I have young children and what resources are available for me to educate them on the risks of smoking. I've never had those questions. (MY)

When parents sought help, it usually was because they had discovered that their children already were smoking and they wanted to know what to do to encourage and assist them to quit. "We do have some parents ... who are non-smokers or smokers seeking information because they know their kids smoke. What can they do to help their kids. So we do have them sometimes calling about it." (NA) Parents also may have made contact when they needed resources about smoking to assist their children with school projects on the topic.

Whether or not parents are involved in smoking prevention, the nurses and NGO professionals had suggestions for an enhanced approach. They thought that parents could have an effect and one that is long-lasting through using an approach that entails both talking with their children and displaying behaviour that is consistent with an antismoking message. Among them, they identified several strategies for talking with children about smoking including start at an early age, bring up the topic often, and use an "open communication" style, a "casual" approach, and age-appropriate messaging. Some offered suggestions regarding specific content for the message.

Parents should start talking with their children as soon as the children are old enough to understand things about smoking, certainly by preschool, and

continue to talk about smoking frequently throughout childhood without overdoing it or as one professional said, “without smothering the child”. (QC) “I really think the earlier the intervention the better ... like preschoolers ... [if] they’re taught about it, the negative things about smoking ... [they] just grow up knowing that.” (MY) “.... bring it up often. That’s what our resources say.... it’s okay to keep stating the facts and encouraging kids not to smoke ... [it] really does make a difference.... it really goes a long way.” (NZ)

> .... And I think that can happen right from the time that they’re very little and they’re able to understand. I would think even a toddler can get some message around it and then of course [it] needs to be constantly reinforced... (QC)

Parents should use open communication and engage their children in discussion about smoking. “I think we have to draw the children out too to talk about it....” (QC) “I think the most important thing for parents is to have open dialogue with their child and not be afraid to speak to [the] child about the issue.” (SE) Telling children not to smoke or using an authoritarian approach may not work and may backfire if children choose to rebel against parental authority, which could happen as they get older. “I don’t believe that the best approach is saying, you shouldn’t smoke....” (TF) “I think keeping that open dialogue because I think when you [children] get into those teenage years, you want to rebel and you want to do your own thing and you want to discover who you are ...” (SE)

> ... not attacking them about the negatives of it because often times I think some of the kids will want to rebel against that. You said it’s no good, but really is it? So just try and get their opinions on it because I think kids

> form an opinion rather quickly of something. So, if they see people smoking they're obviously going to be curious and want to know what that is ... maybe the smell from a smoker is enough to kinda turn them off a little bit.... work with them to get them to see the true effects of smoking and the danger of smoking. I don't know if you'd need to go out and preach to them as such.... If you make a child, even a 5-year old, feel important and feel that what they're contributing to a conversation or to a learning is valuable, then I think they learn better or they learn to react the right way.... Yea, I think, just going at it positively and not taking a lecture style, scolding type approach. (SE)

> .... not making it a forbidden fruit. Because making anything a forbidden fruit is just not a good idea. Especially once the child hits grade 7 and when you have a smoking population starting at about age 12, that's puberty. When you tell a pubescent child or a pre-pubescent child they cannot do something, they are going to go and do it. (KW)

Parents should use a "casual" approach, which involves taking advantage of everyday opportunities or as one professional said, "teachable moments", to raise the topic and convey "key messages". It is not necessary to have a scheduled or formal discussion. "... when the opportunity arises take advantage of it and ... talk about the issue of smoking ..." (TF) "Bring it up a lot in casual conversation.... It's okay to talk about it a lot if it's in casual conversation." (NZ)

> I think using the teachable moments with children all along; integrating it into their everyday life. Not sitting down and having a special session, now we're going to talk about why you shouldn't smoke. Just, you know, using all the times that parents ... have to put in the key messages about not smoking.... and then of course [it] needs to be constantly reinforced at those teachable moment times. (QC)

> For example, they see an ad on TV and the Canadian Cancer Society says you shouldn't smoke and the child is there sitting watching the TV. [the parent] could ask them, well what do you think of that? What's your understanding from that? And I think that's a great way to understand and then deal with, if the child is aware of it and how much do they know about it. So when the opportunity arises ... just ask them questions.... Children, although they're small, yes, they still have their own understandings of the world and so it is important to ask them, you know, their viewpoints and then take that and from that educate them if need

> be.... when the opportunity arises just asking them, what do you think about all of this? I think that would be a great way to engage. That's the advice I would give to parents especially at the younger ages. Don't feel you need to sit down with your child, like with children and sex and that whole issue. Like, okay, when am I going to sit down with my child? It's not only about sitting down with your child. It's taking those opportunities when you see a certain thing on TV or you hear something on the radio or you see an ad as you're driving by a billboard or whatever. It's more so about taking a hold of those opportunities when they arise and talking about the issue. And then it's less threatening to the parent too. You don't have to actually sit in front of them one-on-one. (TF)

The message about smoking should be age appropriate. ".... I think you can give the key messages all along. But, you build on it depending on their developmental level." (QC) Young children need only a simple message about the health

> ... benefits of not smoking. Put it in a positive light ... like if you don't smoke then you can be more healthy and do more fun activities ... You can run and play longer and all that. So put kind of a positive spin on it. (NZ)

Older children, preadolescents and adolescents, need more detail about the health consequences. They are better able to cope with "candid" messages about health effects or messages with "shock value' than are younger children who could become "scared". (MY) Older children need to know about the factors that influence children to initiate smoking, especially peer pressure, and be given guidance on how to resist it. ".... the advice that you [parents] give them, when they're in a social situation they remember, well, mom said this is how I could say no to peer pressure ..." (NZ) They need to understand about addiction and how difficult it is to quit smoking once begun. Parents who smoke should talk with their children about their experience with smoking and the addiction. They should

make it clear to their children that they are aware of the "contradiction" that they are living and would like to quit smoking. "Being open with your kids, being honest with them. Even discussing your experiences with it. If whether you're a smoker and you're trying to quit and how difficult that challenge is to meet...." (NA)

> And I think it's really important too for the smoking parent to be saying I'm addicted to this.... I think it's really important for parents who do smoke to say this is a drug.... and this is something that I am desperate to stop ... and I'm going to stop it because it's really important to me. Or, even if they don't, just say I'm addicted and I'm having trouble. And, that's why I'm doing it away from you because I really don't want you to be influenced by that. That message alone rather than it's my choice and I just want to and I really like it and ... I need a cigarette because I need to relax and all of those other little messages that parents can send to children about why they are smoking. (KW)

Parents also should show that smoking is unhealthy and unacceptable through their actions, for example, having non-smoking homes and vehicles. This especially is important in homes where there is a parent who smokes. "How things are practiced in the home.... You can say all you can but the practice is really what sends the message." (TF)

> ... it's all in how it's handled. If a parent is smoking and they're allowed to smoke in the house wherever they want, while doing whatever they want, that's a totally different message that you're giving your kids than you have a parent that's smoking but they have to go outdoors.... They have to make sure that there are no cigarettes around the house.... Even if it's a blizzard outside, they're still not allowed to smoke in the house. They have to go outside. They're banished sort of thing. That's a totally different message that you're giving your kids rather than here we are in the house. You're in the smoke. I'm in the smoke. It's fine. It's okay. So I think, you know, designating a smoke-free home and a smoke-free car especially ... sends a message to kids that, yea, dad does this but it's not a good thing. And, not only is it not a good thing but mom doesn't like it and he's not allowed to do it around me. And, he's not allowed to do it

> around mom.... So, it's that whole impression that you're giving.... It's how you place it. You can either place it as normal or you can place it as abhorrent and away from us and not near us.... (KW)

Schools have a responsibility to reinforce the antismoking message.

The professionals thought that schools have an important "role to play" (HT) in smoking prevention education, but without parental support efforts may not be as successful as is possible. They thought that the relationship between parents and the school should be a two way process with parents setting the foundation for smoking prevention and schools reinforcing it.

> I think it should come from both. I think it needs to come from home first and for the school to reinforce it. Like with everything, I mean you teach your child their letters before they [go] to school and of course [teachers] reinforce that. Most parents do. Not everybody does but I think it needs to come from home. [Teachers] can only play the role so far.... (GS)

In turn, parents need to be tuned in to what their children are learning in school and continue to strengthen the message at home. ".... parents need to be on side as well.... I think parents and teachers should be working together ... which is ideal." (HT)

> .... [parents should] be aware of what they [their children] are actually being taught within the school system ... speak to them about that. Talk to them about those particular things they're learning and again ask them, what's your understanding? Because, it's not always about you telling them more. [It's] them telling you.... (TF)

Although they thought that smoking prevention education needs to come from home first, professionals recognized that that may not necessarily be the case and for children who do not receive it at home education at school is an essential alternative. ".... if it's not being done at home, then they're definitely

going to get it from school." (GS) However, their sense was that smoking prevention education was not as strong in schools as it could be. The teachers confirmed that smoking prevention education was a component of the elementary but not primary school curricula and thought that generally it was limited to a topic in the health curricula of grades 4 and 6. Sometimes it also was covered by students in their individual school projects. They acknowledged, however, that smoking may not necessarily be a priority for instruction and, therefore, may not receive much attention. Their impression was that pressure to complete objectives in core subjects and teacher preference often determine to what extent smoking is covered in elementary school.

Professionals thought that although more emphasis may be placed on smoking prevention education in junior high and high school, without earlier work that may be a late point as children may start smoking early. They believed that the earlier it is introduced in school, the better. It should be "integrated" in the curriculum, throughout the grades. It should not be isolated, occasional, random presentations on the topic.

> There's the education piece within their own school ... If it's something that is new to them, it is not going to have a lasting impression as if, for example, it starts from day one.... it needs to be repeated.... start at a very early age and bring it through.... I think that the message needs to be throughout the entire school process, so kindergarten right through grade twelve. (TF)

> ... curriculum, I think that that's an absolute place to thread the message through. Having one session on smoking ... often doesn't change a whole lot of people's minds ... by threading the message through in various subjects, people tend to retain it.... I think it's an excellent place to thread the message through. Not a parachute in and parachute out... (MY)

The teachers raised concern about the possibility of smoking prevention education causing emotional reactions, such as anxiety or fear, in children who have family members, especially parents, who smoke. For those children smoking can be a "sensitive topic" and educators need to be "delicate" in their approach.

> I find as an educator, I have to be very careful how I approach it because the students who have parents that smoke then can be easily hurt or offended or even scared for the parents' safety and health. I have to be cautious about that ... so that's a factor for an educator to consider. (HT)

Professionals agreed that to prevent undue concern among children, the focus of education in the early grades should be on "health in general" (MY), not the serious illnesses. They thought that the best approach is to emphasize overall healthy living, with non-smoking being one thing among others that makes people more healthy.

> Well I think tying it into healthy living. Keeping our bodies healthy. What do we need to be healthy? We need clean air. We need fresh air. We need clean hands. We need nutrition, rest, sleep, exercise, all [of] that. Making that a part of the package. And, clean air, well if you're smoking you're obviously bringing in air that's not clean. (HT)

> The main thing I think is focusing on the health. Making it a part of a healthy lifestyle ... It becomes a way of life. It becomes a part of being healthy. Physical activity is a part of being healthy. Non-smoking is a part of being healthy. So I think if it's kind of taken under that umbrella, it's not going to be as frightening. But, also I think we have an opportunity with children to say some factual things like about the ... coughs and about the bad smell and about the dirty teeth and all that. I think those are the kinds of things that I don't think [are] frightening... they're observations.... (MY)

Professionals were hopeful that with the generally increased awareness in society of the need to promote active and healthy living, early smoking prevention education in school will receive more attention. Some thought that it was

beginning to filter down and there already were efforts to increase messaging about smoking in the primary and elementary grades.

> They [School Board] have a new policy out now, just this year, which is [about] being active, healthy living, healthy eating, and no smoking. So it's now something that we're actually taking more of an approach [on]. I mean we always said, you know, it's wrong and things like that but it's now becoming more of an issue.... (GS)

Society needs to be a supportive environment. The professionals thought that not only are interventions by parents and school vital, but for greatest impact on smoking prevention among youths a "supportive environment" at the societal level also is essential. Smoking prevention requires a "community effort", a "coordinated voice" involving all three players, so that the message that is conveyed is prominent and consistent across sources. ".... if [antismoking] messages are everywhere then that helps to instil those messages they have at home." (TF)

The professionals thought that the recent legislative and other social policies to reduce smoking among youths were helpful. The NGO professionals specified that more needs to be done as youths still were accessing cigarettes and still were being exposed to pro-smoking messages from sources such as movies, tobacco industry marketing, and point of sale promotion of tobacco products. They knew that the prevalence rate of smoking among youths still was high. ".... it isn't as normal as it used to be, but it is still there and is still very prevalent when you look at ... how many kids are actually still smoking." (KW)

> I think the pressures to smoke are maybe not as great as what they were 5 years ago, 10 years ago but that pressure is still there. I mean, you know

> that the tobacco industry does target children. They don't admit it, but they do. So I think we need to counteract the tactics they take to make smoking cool and attractive ... (SE)

> Sometimes you need more, you really need more strict legislation.... We still have all of these social sources of tobacco. So you've got the power walls. You've got the signs. You've got smoking on TV. You've got smoking in movies. You still have this societal idea that it's okay. You know, there was a study done in the States that said that 3 year olds recognized Joe Camel before they recognized Mickey Mouse and Ronald MacDonald. You know, there's a problem when that's happening. (KW)

In addition to stricter social policies to curb such influences, which would validate and strengthen messages provided by parents and teachers, parents also need direct support. The nursing and NGO professionals' impression was that there were few if any resources on smoking that were directed specifically to parents. They thought that parents would benefit from having resources that informed them about youth smoking and that they could use to educate their children about the behaviour. ".... I really think educating parents is where we have go and then that will transfer to the children." (MY)

> "... I think if they know more about it they are more inclined to tell their children about it. So I think maybe an education process.... from a sort of help them to help their children kind of thing.... Talk about the facts about children and smoking and although we've done this, there's still the risk and, you know, most concerned parents will want to know more about how they can help their children.... (TF)

Resources, which could be in the form of lay literature and electronic media, could be available through existing providers such as public health nursing and other agencies in the community. Some thought that because parents tend not to seek out help for smoking prevention, it would be important for providers to promote the resources through a "wide-spread campaign"; for example, through

"schools, maybe at curriculum night", (MY) since schools have "the biggest link to parents". (TF) Specifically, a resource on youth smoking could be distributed to all parents. As one professional suggested, perhaps the Department of Health could create something

> that can be sent out to all parents.... maybe there can be something done through public health or in the schools that can get the ball rolling with parents to discuss this. Something that can be sent home through the school that the kids can give to their [parents] ... that can just get things started. That might be a way to open up the door.... It's almost like they have to be pushed. (NA)

Summary

The perspectives of the professionals in this study was that smoking prevention for youth requires a multipronged approach, with parents, school, and society in general contributing. They thought that parents have the main responsibility for educating their children about smoking. Schools have a responsibility to reinforce the antismoking message and society has a responsibility to support both schools and parents through social policy and the provision of resources for parents. Nursing and NGO professionals' were of the opinion that parents should intervene by discussing smoking with their children and having smoke-free homes and vehicles and they offered suggestions for talking with children about smoking. The findings from the professionals have implications for interventions with parents about smoking prevention for children, which are discussed in Chapter 6.

The Theory

Characteristics of the Parents

There were 28 mothers and 10 fathers who participated in this study including 6 mother-father pairs. Five of the pairs lived together with their children. One mother and father were not living together. The parents had anywhere from 1 to 4 children, with half (n = 19) having 2 children. The children were living with or had lived with the parent participant. Seventeen of the parents, consisting of 11 mothers and 6 fathers, were former smokers. Twelve parents, all of whom were mothers, had never smoked. Nine parents, including 5 mothers and 4 fathers, currently smoked. Most of the parents (n = 28) were living with a spouse or partner and 10 were single. A large number of the parents (n = 30) had at least some university or college education, and 17 of those were university or college graduates. Eight parents had high school education or less. Household income brackets were more evenly distributed among the parents. Of the 37 who reported income, there were 12, 13, and 12 in high, middle, and low income level, respectively. Occupations varied from the professions (e.g., finance and administrative) to skilled trades and unskilled sales and services. All of the 10 stay-at-home parents were mothers. Five mothers and fathers were not employed for various reasons. The characteristics of the parent participants are presented in Table 1 (p. 117).

Table 1

Parent Characteristics

Characteristics		n[a]
Parent	Mother	28
	Father	10
Marital Status	Single	10
	Spouse or partner	28
Household income[b]	Low	12
	Middle	13
	High	12
Education	Less than high school	5
	High school graduate	3
	Some university or college	13
	University or college graduate	13
	Master degree or higher	4
Occupation[c]	Business, finance, administrative	3
	Applied sciences, technology	1
	Health	3
	Education, law	5
	Art, culture	4
	Services, sales	5
	Trades	2
	Stay-at-home parent	10
	Unemployed, disabled, student	5
Smoking status	Current smoker	9
	Former smoker	17
	Never Smoker	12

Note. [a]N = 38
[b]Household income - n = 37, missing data for n = 1.
Low $\leq$ \$29,000; Middle \$30,000 - 89,000; High $\geq$ 90,000.
[c]Occupation - Classification adapted from *National Occupational Classification: Statistics (NOC-S) 2006,* Statistics Canada. Retrieved from http://www.statcan.gc.ca/subjects-sujets/standard-norme/soc-cnp/2006/noc2006-cnp2006-menu-eng.htm

An Overview of the Theory

The theory, which explains the parents' approaches concerning smoking, is comprised of four essential components: (a) the central category, representing the problem for parents and their response to it; (b) action and interaction strategies, representing how parents responded; (c) conditions, representing factors that influenced parents to respond and respond as they did; and (d) outcomes, representing the consequences for parents as a result of their action and interaction. See Figure 2 (p. 120) for a model of the theory.

The central category *Dealing with a latent danger: Parents communicating with their children about smoking* explains the essence of this research. Hence, it also is used in the formal title of the theory. The problem for parents was that their children could begin to smoke. Their response was to communicate with their children by way of action and verbal interaction.

Parents' action consisted of having a *no-smoking rule* to protect their children from second-hand smoke and to limit their exposure to smoking. Although they had a rule, some had a stricter rule than did others. The rule concerned their homes and vehicles mainly, but for many it also included preventing or limiting exposure in other settings.

Parents interacted verbally with their children about smoking by using one or another of the following approaches: (a) discussing smoking with their children by intentionally taking advantage of opportunities, (b) telling their children about the health effects of smoking and their opposition to it by responding on the-spur-

of-the moment if their attention was drawn to the issue by external cues, or (c) acknowledging to their children the negative effects of smoking by responding only when their children brought it up. These approaches were composed of two aspects: (a) interaction style, which refers to the manner in which the parents interacted with their children and is represented by the phrases *discussing smoking with their children*, *telling their children about the health effects of smoking and their opposition to it*, and *acknowledging to their children the negative effects of smoking*; and (b) interaction method, which refers to what the parents did to interact with their children and is represented by the phrases *intentionally taking advantage of opportunities*, *responding on the spur-of-the-moment if their attention was drawn to the issue by external cues*, and *responding only when their children brought it up*.

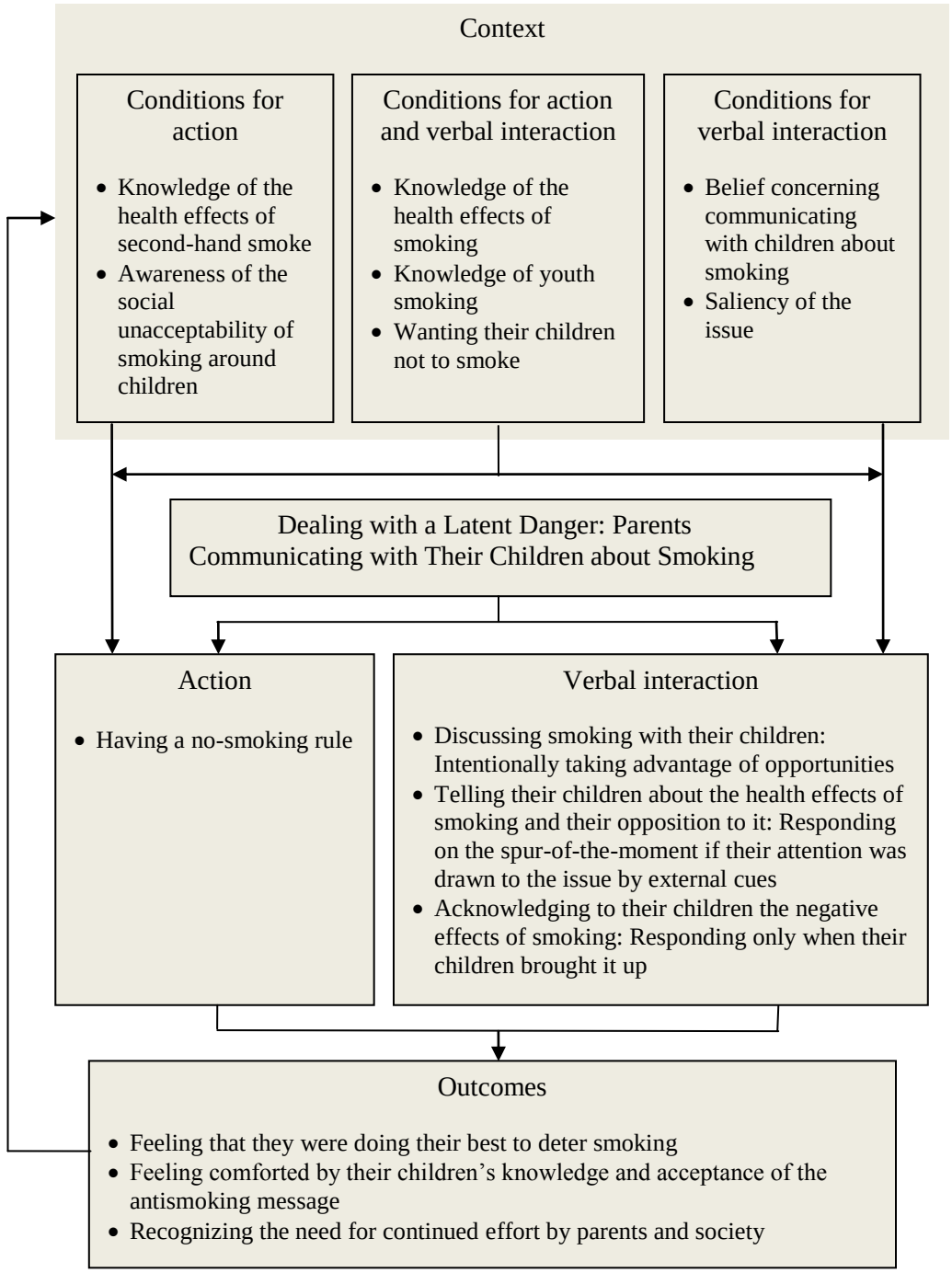

Figure 2. A theoretical model of the process that parents used in communicating with their children about smoking. Action and verbal interaction were influenced by conditions and resulted in outcomes for the parents. The outcomes fed back and contributed to the context for the parents' continuing action and interaction to deal with the latent danger.

There were five conditions that influenced parents to respond to the issue of smoking. These may be classified as *shared* conditions, in that the parents had them in common, and are (a) knowledge of the health effects of second-hand smoke, (b) awareness of the social unacceptability of smoking around children, (c) knowledge of the health effects of smoking, (d) knowledge of youth smoking, and (e) wanting their children not to smoke (see Table 2, p. 123). The first two of those conditions were related specifically to parents' action, that is, having a no-smoking rule. Although the last three were more directly related to parents' verbal interaction, they also affected parents' action. Knowledge of the health effects of smoking, knowledge of youth smoking, and wanting their children not to smoke influenced parents to have a no-smoking rule to reduce exposure of their children to the behaviour, hence, potentially reducing what they thought was a negative factor for youth smoking (see Figure 2, p. 120).

There were two other conditions and these varied by the parents' verbal interaction approach (see Table 2, p. 123). In other words, these conditions influenced parents to respond as they did and are (a) belief concerning communicating with children about smoking and (b) saliency of the issue. Parents who believed that it is important to *use open dialogue to impart facts when opportunities arise* and for whom *smoking was foremost in their minds* discussed smoking with their children by intentionally taking advantage of opportunities. Parents who believed that it is important to *hit home the message when the issue arises* and for whom *smoking was in the back of their minds* told their children about the health effects of smoking and their opposition to it by responding on the

spur-of-the-moment if their attention was drawn to the issue by external cues. Parents who believed that it is important to *be supportive of the message when it comes up* and for whom *smoking was not on their minds* acknowledged to their children the negative effects of smoking by responding only when their children brought it up.

Although the conditions that influenced parents' verbal interaction are presented as separate entities (see Figure 2, p. 120), there is, in fact, relationships among some of them. Knowledge of the health effects of smoking influenced parents to want their children not to smoke and for some parents this knowledge contributed to the saliency of the issue. Further, their knowledge of the health effects of smoking combined with their knowledge of youth smoking, which heightened their awareness of the vulnerability of children to smoking, gave them increased reason for action and interaction.

Table 2

Conditions for Parental Action and Verbal Interaction

<table>
<tr><td colspan="2"><u>Conditions for action and verbal interaction that were shared by parents</u>

• Knowledge of the health effects of second-hand smoke
• Awareness of the social unacceptability of smoking around children
• Knowledge of the health effects of smoking
• Knowledge of youth smoking
• Wanting their children not to smoke</td></tr>
<tr><td colspan="2"><u>Conditions that varied by parental verbal interaction approach</u></td></tr>
<tr><td>Interaction approach</td><td>Condition</td></tr>
<tr><td>Discussing smoking with their children: Intentionally taking advantage of opportunities</td><td>• Belief concerning communicating with children about smoking: Use open dialogue to impart the facts when opportunities arise

• Saliency of the issue: Smoking was foremost in parents’ minds</td></tr>
<tr><td>Telling their children about the health effects of smoking and their opposition to it: Responding on the spur-of-the-moment if their attention was drawn to the issue by external cues</td><td>• Belief concerning communicating with children about smoking: Hit home the message when the issue arises

• Saliency of the issue: Smoking was in the back of parents’ minds</td></tr>
<tr><td>Acknowledging to their children the negative effects of smoking: Responding only when their children brought it up</td><td>• Belief concerning communicating with children about smoking: Be supportive of the message when it comes up

• Saliency of the issue: Smoking was not on parents’ minds</td></tr>
</table>

There were three main, overarching outcomes for parents that reflect how they felt and what they thought as a result of their action toward smoking and verbal interaction with their children about the behaviour. These were (a) feeling that they were doing their best to deter smoking, (b) feeling comforted by their children's knowledge and acceptance of the antismoking message, and (c) recognizing the need for continued effort by parents and society (see Table 3, p. 126). The outcomes are not static endpoints but represent dynamic internal processes. Feeling that they were doing their best to deter smoking, feeling comforted by their children's knowledge and acceptance of the antismoking message, and recognizing the need for continued effort by parents fed back and became a part of the ongoing context for the parents' continuing action and interaction to deal with the latent danger (see Figure 2, p. 120).

For two of the outcomes, there was variation according to the overall approach that parents had taken with their children (see Table 3, p. 126). With respect to *feeling that they were doing their best to deter smoking*, those whose approach involved having a no-smoking rule and discussing smoking with their children by intentionally taking advantage of opportunities felt that they *had given their children a good foundation to make the right choice if confronted with the behaviour in the future*. Those whose approach involved having a no-smoking rule and telling their children about the health effects of smoking and their opposition to it by responding on the spur-of-the-moment if their attention was drawn to the issue by external cues felt that they *had given their children a strong message to discourage smoking*. Those whose approach involved having a no-

smoking rule and acknowledging to their children the negative effects of smoking by responding only when their children brought it up felt that they *had reinforced the antismoking message*. With respect to *recognizing the need for continued effort by parents and society,* those whose approach involved having a no-smoking rule and discussing smoking with their children by intentionally taking advantage of opportunities felt that they needed to *maintain open communication about smoking*. Those whose approach involved having a no-smoking rule and telling their children about the health effects of smoking and their opposition to it by responding on the spur-of-the-moment if their attention was drawn to the issue by external cues felt that they needed to *continue to be vigilant as their children get older in order to curb any tendency to smoke.* Those whose approach involved having a no-smoking rule and acknowledging the negative effects of smoking by responding only when their children brought it up felt that they would need to *step up their effort as their children become adolescents*.

For two of the outcomes, there also was variation in what was experienced by parents (see Table 3, p. 126). Although parents *felt that they were doing their best to deter smoking*, some, across all verbal interaction approaches, *questioned what they were doing*. Similarly, although parents were *feeling comforted by their children's knowledge and acceptance of the antismoking message*, some of those whose verbal interaction approach involved discussing smoking with their children by intentionally taking advantage of opportunities were *concerned about their children's response*.

Table 3

Parent Outcomes for Action and Verbal Interaction

Approach	Outcome
Discussing smoking with their children: Intentionally taking advantage of opportunities Having a no-smoking rule	1. Feeling that they were doing their best to deter smoking - Had given their children a good foundation to make the right choice if confronted with the behaviour in the future • Questioning what they were doing 2. Feeling comforted by their children's knowledge and acceptance of the antismoking message • Concerned about their children's response 3. Recognizing the need for continued effort by parents and society • Parents have a continuing responsibility to do what they can to deter smoking: Parent needs to maintain open communication about smoking • Society needs to take more responsibility for preventing smoking among children
Telling their children about the health effects of smoking and their opposition to it: Responding on the spur-of-the-moment if their attention was drawn to the issue by external cues Having a no-smoking rule	1. Feeling that they were doing their best to deter smoking - H ad given their children a strong message to discourage smoking • Questioning what they were doing 2. Feeling comforted by their children's knowledge and acceptance of the antismoking message 3. Recognizing the need for continued effort by parents and society • Parents have a continuing responsibility to do what they can to deter smoking: Parent needs to continue to be vigilant as children get older in order to curb any tendency to smoke • Society needs to take more responsibility for preventing smoking among children
Acknowledging to their children the negative effects of smoking: Responding only when their children brought it up Having a no-smoking rule	1. Feeling that they were doing their best to deter smoking - Had reinforced the antismoking message • Questioning what they were doing 2. Feeling comforted by their children's knowledge and acceptance of the antismoking message 3. Recognizing the need for continued effort by parents and society • Parents have a continuing responsibility to do what they can to deter smoking: Parent needs to step up effort as children become adolescents • Society needs to take more responsibility for preventing smoking among children

There was one parent in this study whose approach with his child about smoking does not completely fit the theory. Because it is unclear as to whether his approach represents a true negative case, it has been labelled a possible negative case. Some aspects of his approach are similar to that of other parents in the study and some are different.

Further description of the theory and possible negative case is provided in the following sections of this Chapter. The categories that make up the theory are delineated according to properties and variation within the properties. Properties are characteristics that give specificity to and define and describe categories (Corbin & Strauss, 2008). In keeping with the logic of the theory and for clear sequencing, the theory components with corresponding categories are presented in the following order (a) central category, (b) shared conditions, (c) action, (d) verbal interaction approaches and related specific conditions, (e) outcomes, and (f) context for continuing action and interaction.

Dealing With a Latent Danger: Parents Communicating With Their School-Age Preadolescent Children About Smoking

Central category. The central category *Dealing with a latent danger: Parents communicating with their children about smoking* reflects the meaning that parents applied to youth smoking relative to their children. They perceived it to be a latent danger. Their children were not smoking at that point in time but the possibility was there for them to begin in the future. As one parent said, “You’re dealing with a threat that’s not immediate ....” (OA) Although some thought of it as more of a remote possibility because of their children’s negative reaction to

smoking, they had a lingering uncertainty. For instance, these parents revealed their misgivings.

> I would be surprised. That would be my initial reaction to it because right now she has a real aversion to smoke.... I don't think that at this point… she would definitely not do [it]. Now like when she's a teenager it's going to be a different… you know, you just don't know.... (AM)

> She keeps on, like I said, about smoking and stuff so I think anything like, you know, to keep you healthy and stuff, I think she's going to be on the side to say no that's bad for you. I'm hoping she's going to be like that.... That's, that's my feeling now on how she's going to behave as she's getting older.... I'm hoping that she is going to be a leader not a follower.... I know they're going to try things, you know, as they get older, I know. I pray to God they don't try smoking but I mean they may. I hope they don't but they may, you know. So, I'm not like stupid to things like that. I mean, you know, they're normal, they're kids, you know.... (ET)

> My little girl is what, 11, and right now, I mean, I wouldn't think it would be a problem for her, but give her a couple of years now ... I mean, it's not something you want.... Even if you're after talking to your child and you think they're not going to try it, if all their friends are, then you got to wonder if she's going to want to try it too just because everybody else is trying it. (HW)

Other parents thought that the possibility of their children beginning to smoke was more likely.

> I wouldn't be surprised. Even at this age, I wouldn't be surprised. No, God knows there's lots of examples and morbid curiosity in kids is a really powerful influence. It hurts people but it won't hurt me. Or, I bet I could do it.... (OA)

> Yes, I would be hurt but I wouldn't be surprised knowing that children are children and they're going to try different things, right.... My own thought is that you can't be like an ostrich and put your head in the sand.... You'll just be fooling yourself because then you're going to find out they're smoking, right, or found cigarettes in their pocket and, you know ... I know because you did it yourself, you know. (FU)

> I think that she will definitely try it. I think she will, like myself and like any young person growing up. I think people try it but I think it's peer pressure, right. (OD)

This story illustrates the source of a mother's doubt.

> When she was about 6 or 7 she said, 'When I get older I'm going to smoke' and I looked at her and said, '[daughter], it's not good. It can do a lot of damage to your lungs'. I said, 'It can give you cancer'. I said, 'It's not a good habit to have'. 'But', she said, 'daddy does smoking'. I said, 'Yea, but daddy tells you everyday how he feels towards smoking. It's just a nasty habit'. And, he tells them that he don't like smoking, right. But, it's just a habit that.... And I said to her, 'Why would you [say that]?' 'I don't know', she said, 'mom'. She said, 'Just wondering what it would be like if I smoked when I got older'. I'm like, 'It's not a good habit'.... Now that she's 8, she says it is yucky. But, I mean, there's always a doubt in my mind. Is she going to smoke when she gets older?

Because smoking was possible, parents communicated with their children by way of action and verbal interaction to deter the behaviour from emerging.

> I think I do worry a bit. One of … [husband's] nephews smokes and they [her children] really idolized him for a while and I was a little bit wary and I was trying to make sure he didn't smoke in front of them and stuff. (PB)

> Now my children ... I don't want them seeing it. I grew up in a home where there was smoking. I would steal the cigarettes from my parents so I really don't want them near it or around it or anything cause I'm afraid that they'll normalize it and, and pick it up. (LA)

> It probably will be an eventual thing but hopefully ... discussion around smoking as he's growing up. Like, we bring it up. He sees people we talk about it. So, hopefully we would have set enough of a foundation that it is not healthy and people who get into it they are in trouble because it is an addiction. (DP)

> It's no good, I don't think ignoring it.... It's something they're going to see, they're going to likely, probably, experience. Most children are likely going to try a cigarette. It's not something you can pretend is not going to happen.... hopefully they don't, but it's likely they do. So ... talk to them. I have. Like I said, I've talked to my girls at a very young age. And, parents are the most important influence they have. (IX)

> What I find is it's your responsibility at that age what youngsters do and when they're 18 or whatever like you hope you've done your job and they learned from it. That's all you can do, right. (AP)

Although parents took action by having a no-smoking rule, some had a more stringent rule than did others. Similarly, although parents verbally interacted with their children about smoking they varied in style and method, which resulted in differences in the quality and extent of interaction.

Shared conditions. The five shared conditions that influenced parents to respond to the issue of smoking are (a) knowledge of the health effects of second-hand smoke, (b) awareness of the social unacceptability of smoking around children, (c) knowledge of the health effects of smoking, (d) knowledge of youth smoking, and (e) wanting their children not to smoke (see Table 2, p. 123). The first two were related specifically to the parents' action of having a no-smoking rule. The other three, although more directly related to the parents' verbal interaction, also influenced their action by giving them reason to reduce exposure of their children to the behaviour (see Figure 2, p. 120).

Knowledge of the health effects of second-hand smoke. Parents, to one extent or another, knew that second-hand smoke can affect health, and that knowledge was the main impetus for their no-smoking rule. For instance, a mother said, "I know the benefit of not putting my children into second-hand smoke....". (BQ) Another mother stated, ".... second-hand smoke kills too". (YK) In commenting on his rationale for smoking outside, a father conveyed, "It's bad

enough that I'm polluting my lungs. Why would I want to pollute my child's". (DS)

Awareness of the social unacceptability of smoking around children.

Parents knew that smoking restrictions and bans had become the norm, and having a no-smoking rule reflected their awareness that not smoking around children was the societal expectation. They recognized that smoking was much more common when they were growing up and smoking around others was "socially acceptable" but had become "socially unacceptable" in recent years. "**....** Everywhere you went you could smoke when I was growing up...." (XJ) ".... You'd go to anyone's house, it wasn't a question of 'Can I?' 'Would you mind if I smoked?' Everybody smoked and it was automatically acceptable that people smoked.... " (EQ) "It's a different world [now]." (LX) "You're not allowed to smoke anywhere." (ET) "It's almost like it's ostracized now and it's certainly not the in-thing to do or be." (CO) "... parents are more aware of, if they do choose to smoke, not to smoke around their children. I remember when I was small, everyone smoked around us. That was just normal and no one really thought anything of it...." (LX)

> I often think back to when I was a child and watching TV in my house. At a certain time of day the sun used to come in through the curtains, and my mother would be sat down just [smoking] away and she was almost like a chain smoker and you'd see that smoke just billowing across that ray of light coming in. If you were sat down with your mother you'd see that smoke, just like a wall, like a wall of smoke. I'll never forget it. And, you know, that was an everyday occurrence. And, if you were going anywhere in the car it was an everyday occurrence. It was, you know. I got nothing against my mother and I love her dearly but, you know, she wasn't educated to the fact, I guess. Back then there was just no education. (FU)

Knowledge of the health effects of smoking. Parents had knowledge of the health consequences of smoking. Whether through direct personal experience as a smoker or former smoker, knowledge as a result of having relatives or friends who smoked, or knowledge acquired more generally, parents knew that smoking is a serious addiction and causes serious illnesses. Their knowledge was the main reason for their verbal interaction with their children and also influenced them to act, through having a no-smoking rule, to reduce their children's exposure to the behaviour.

Smoking is a serious addiction. Although parents believed that smoking is an addiction, some held stronger views about it than did others. Parents with stronger views compared nicotine to other addictive substances and considered it to be a "drug" that is as potent as illicit drugs and alcohol. "I mean it has to be looked at as an addiction like drugs, in the same, obviously the same seriousness because it's harder to break at times, or like alcoholism." (UG) "I consider smoking to be every bit as bad as doing drugs because the consequences can be just as devastating…. I consider it a drug. It's right up there with marijuana, alcohol, crack cocaine, crystal meth…." (VH) "It's got to be in order to take that physical control over you." (FU) To support his belief, a father talked about how, through his line of work, he had met a number of individuals who were or had been addicted to heroin.

> They had all been heroin addicts for probably, anywhere from 4 years to 15. They all smoked. They had all quit both of them at various points in their lives. All of them said it was harder to quit smoking than it was to quit heroin. They would rather, any day, if they had to choose, quit heroin before they would quit smoking. (OA)

To illustrate how strongly they felt about the addiction, some parents indicated that they would prefer to see their children "smoke a marijuana joint" (CO) or drink "a bottle of beer" (EQ) than smoke a cigarette.

The formerly and currently smoking parents had firsthand knowledge of addiction. They especially knew how easy it is to start smoking and how quickly one becomes addicted.

> Being a former smoker, I know that it's easy to get caught up in the web.... for years after I started smoking I really wanted to give it up. I just couldn't, it was so addictive.... it's a pretty bad addiction when you get hooked on them. And it doesn't take very long to get hooked and you go from that pleasurable first puff, what we used to call in our days, a baccy [tobacco] buzz, to not getting baccy buzzes at all and then you just need the cigarette.... (XJ)

Although some former smokers thought that they had overcome their addiction without too much difficulty, others described it as an immense difficulty, a real "battle".

> I remember getting up... out of bed 3 o'clock in the morning and going up to the back window and having a cigarette or going down over the stairs and going outside and I used to think to myself, you know, you'd almost tear the house down to get out to have a cigarette but once you had two or three puffs of it, the realization of what you're doing would come to you. But before that it wouldn't matter, you'd knock a house down. That's the way I was. I'd knock a house down to get to it.... Now it could be a raging snowstorm out[side].... (FU)

> You're playing tug-of-war with yourself 24/7.... It was, you know, just a constant, constant, constant tearing at you. Even though you knew all the facts, it didn't matter. You could show me a lung. You could take somebody's lung out and put it on the table and I'd look at it and say my God how, I can't believe somebody does that. And, I'd turn around and go around the corner and have a cigarette. You know. So that's why I really believe that it's, a serious, serious addiction. Because if you've seen TV shows and you see somebody that's on drugs and they're denying it to the hilt and then they'll go around the corner and do the exact thing that

> they're denying and it's not different with cigarettes. It's just as serious, you know. (FU)

A number of the formerly smoking parents had quit smoking either because they had children or were planning to have children and wanted to protect their children from the exposure, but they felt that likely they still would be smoking if not for that because of how seriously addicted they had been. "I quit for my kids. I quit because I was having children. Other than that, I think I would still be a smoker." (OA)

> And to be quite honest with you, if I hadn't gotten pregnant when I did I might still be smoking because I always said when I got pregnant I was going to quit smoking. And, I really did think that once I had my baby I might smoke again; not around my baby but like outside, go outside or whatever.... And like I said I always thought I might pick it up again because, I mean, I'd smoke like two packs a day when I was young. (ET)

For some formerly smoking parents knowledge of the addictiveness of smoking was reinforced by their experience of periodically still getting a craving, which was brought on by such provocation as seeing someone smoking or smelling tobacco smoke, even after having been quit for a number of years. This father had been quit for 6 years.

> I still crave cigarettes.... I mean there are certain times now.... the smell of tobacco being exhaled... sometimes it will strike you and it'll give you like a buzz, like a craving.... if I smell it, if I was driving down the road, it'll strike me as, Wow! Wouldn't you like to have one of those. (FU)

This mother had been quit for 12 years.

> I find it difficult. I still do. I find it difficult when I'm around people who smoke. It's not gone.... The craving is still there, the desire to smoke is still there. There's only a couple of people who I have contact with on a

> regular basis, family, who still smoke. But it is. I still find it difficult.... the smell of a cigarette, there's something about it, you know, like smelling wood smoke in the fall. There's just something about it ... I enjoyed my cigarette.... I really enjoyed having one. So, those memories are there.... You smell it and it just brings back all those memories. (RD)

The parents who currently smoked acknowledged their addiction and wished that they had never started smoking. "If I had my time back I would never have smoked...." (YK) A father who had started at 10 years of age commented, "Like I wish I had learned, had listened to my mother at that age.... If I had to know then ... at 10 what this would be like, man I wouldn't have smoked...." (AP) Most had tried quitting in the past. Some had tried repeatedly but could not stay quit despite their best efforts.

> ... I know what smoking does to you and how hard it is to quit. Like I'm after trying umpteen times.... I just cannot quit. I'm after trying the patch and the gum and, but I just become so irritable that I actually find it hard to be a good mom when I don't smoke. But when I get out and have that cigarette, I come in and I can clean up my house. I can play with my children, read stories. It's just, I'd be a totally different person when I don't smoke.... Once you get that craving it's just the worst thing in the world. I can actually sit down and cry some days.... I just can't help myself. I just get the shakes and I just start crying and I just get really emotional and just got to have a cigarette.... (YK)

> I think that is why [son] had asthma when he was born. It was because I smoked while I was pregnant.... And like I'm, I feel so guilty about that. But, I still can't quit. It's got such a hold on me and the same with my parents [who smoke]. (YK)

Most of the parents who had never smoked themselves had friends or close relatives, in particular their own parents and siblings, who were or had been strongly addicted to tobacco. Some had witnessed relatives "struggle" to quit. Others had witnessed relatives continue to smoke even when they had smoking-

related illness and had been advised by their physicians to quit. Referring to her father-in-law, a mother said, "... [he] has had several heart attacks and still smokes like a tilt". (CO)

> ... my father smoked like a tilt. He smoked like a tub of tobacco… In 3 or 4 days, he'd have the tub gone and my father started smoking when he was 12 and he's almost 80. And, he only quit smoking two years ago and it was only because the doctor told him he had to. He had two heart attacks and he says he is quit now but it's on my mind, *has he?* I think he's sneaking them.... (CR)

Another mother described the hold that smoking had on her mother even after she had lost a leg to vascular disease because of it,

> ... her surgeon would break cigarettes in front of her and she would still smoke... even though she was told there was a risk of her losing her second leg, she would still smoke, do you know what I mean. Like there was, you couldn't get through. And, if you criticized her for it or tried to offer incentives or, you know, somehow modify the behaviour, she would simply say let me die happy. (RG)

These parents believed that once started, smoking is tenacious to the point of being "irrational". It clearly becomes "really entrenched".

Smoking causes serious illnesses. Many of the parents had family members or friends who had smoking-related illness. One mother talked about how her father, who was only 55 years of age, was "… very unhealthy [due to] his smoking". (LA) Some had close relatives who had died as a consequence of such illnesses including lung cancer, cardiovascular disease, and chronic obstructive pulmonary disease (COPD). Parents who currently smoked thought that their health was being affected. "That's [health effects] starting to catch up. I'm 36 but I know it's catching up…." (WI) One father summed it up like this, "I don't think

I've met any smokers who just smoke and don't really know what's going on with this smoking in their body…." (KZ) Although not experiencing frank illness at the time, some of those who smoked, in fact, were experiencing respiratory symptoms or felt out of shape. Similarly, some of the formerly smoking parents had personal knowledge of health effects as they had experienced symptoms when they were smoking. One parent talked about how much more healthy he was since quitting. "…. I can't believe what a difference it makes." (FU)

***Knowledge of youth smoking*.** Parents had good knowledge of the nature of youth smoking and factors that influence children to smoke. Whether through personal experience, knowledge because of relatives or friends, or knowledge acquired more generally, they knew that children are vulnerable to smoking. Hence, they took measures through having a no-smoking rule to reduce exposure to the behaviour and interacting verbally with their children to deter it.

Parents thought that smoking among youths was less common currently compared to when they were growing up, but they believed that many still take up the behaviour as they regularly saw youths smoking. They knew that it more commonly occurs in adolescence, but younger children also may try or even start smoking. One parent said that her sister tried it when she was just 5 years old and another said that her sister actually started to smoke at age 9. Some, themselves, including those who had tried cigarettes but had not become smokers, had attempted smoking when they were as young as 8 to 11 years old. Although some of the parents who were current or former smokers had not started to smoke regularly until they were older adolescents, others had started regular smoking

when they were early adolescents or even preadolescents. Commenting about how young he was when he started smoking, a father said, “I think I got caught smoking Camel cigarettes when I was 9 years old”. (AP) Some parents had seen smoking among preadolescents, even currently. One mother commented that she lived in a neighbourhood where smoking among youths was common and she had “seen kids out there 9 and 10 years old with cigarettes in their mouths.... My little girl, she was 11 years old last year and she had a little girl in her class that actually smoked”. (CR) Another mother noted, “It seems like now, you go out to the malls or whatever, they’re getting littler and littler and younger and younger and you see them all smoking and it’s so bizarre”. (GV)

Parents believed that children may begin to smoke for reasons such as exposure to other youths who smoke, role models who smoke (e.g., parents, siblings, and popular idols), and pro-smoking messages in society (visibility of smoking and tobacco products), and relatively easy access to tobacco products. However, smoking by peers and family members, in particular parents, generally was recognized as the most important.

> Parents are a child’s first teacher. So the child sees that their parent is smoking, they’re obviously going to think that that’s okay and that’s normal and there can’t be anything wrong with it because mom and dad do it. (JV)

Parents thought that exposure to peers who smoke induces children to smoke because of “peer pressure” in the form of encouragement to smoke or the need to “fit in” or “feel cool”. “.... Friends who smoke.... kids, you know, they just see the cool kids ... they’re the ones that smoke ... for some children, that is what

they perceive as cool. I guess it is another form of peer pressure...." (BN) Many of the parents could relate personally to peer pressure because they had experienced it themselves when they were growing up. As one formerly smoking father said,

> .... It put you in a higher bracket like as in being cool around the school.... It was kind of a peer thing, peer pressure thing cause a lot of kids did it at the time and even those that didn't do it as a regular basis did it occasionally. (XJ)

A formerly smoking mother talked at length about her experience with peer pressure,

> I was probably like the last one [to smoke]. I mean, everyone smoked but me. And, everyone knew not to ask me cause I didn't want to. And, all it came down to just your friends constantly, constantly every day, every time you're out with them, just have one, just have one. And you say no and then eventually after every day you just got sick of them bugging you and you say fine, okay. And, you have one which sounds really stupid now. But, you know, when you're 13 or 14, or 14 or 15 whatever, your friends seem like they're more important to you sometimes and you don't get along with your parents or, you know, mom's mom. Cause, I mean the first time I smoked, I didn't even like it. So, how I came to do it again I don't know. Cause I mean I thought it was really disgusting. Of course, when you get enough peer pressure.... Cause I know for me that was a big thing. I really didn't want to but then I still ended up doing it anyways. (HW)

Similarly, many of the parents who formerly or currently smoked could relate personally to the negative influence of family members who smoked. Those parents had direct knowledge as a result of having grown up with smoking relatives, especially their own parents.

> Both of my parents smoked so like the way I always looked at it, if they said anything to me, I'd say sure you're doing it, you know. Cause kids, they're smart. They know what you are doing, right. So, that is what I would have said like when I was younger, like. (MB)

Some thought that their parents' smoking had been the key, or "root", cause of their own smoking. "For me it was my parents.... My dad was a heavy smoker but all of his brothers and sisters are smokers and a lot of my cousins have become smokers...." (WI)

> Probably like, even just anybody in the family when they see people smoking they probably just want to try it to see what it's like. That's what happened to me. I [saw] my parents smoking and then my mom used to keep her cigarettes underneath her bed every night and one morning I just went in and took one and went to school with it and then I lit up. So, I think that parents have a lot to do with it… (YK)

Currently smoking parents acknowledged that their smoking was a negative influence for their own children. As one parent who grew up with smoking parents said, "And then for them [his children] to grow up and see [him smoke], it's like a circle. It just goes round and round". (AP)

> ... growing up for me, I saw my parents smoke, figured it was okay, so I tried. Then I got hooked, been smoking ever since basically. But definitely parents play a humungous role in how their kids react and what their kids do. If they see their parents, like I said, smoking, could be drinking, could be anything, if they see the parent doing it obviously they're going to think it's okay and they're going to try it. If mom and dad can do it, why can't I, basically.... (DS)

> Like I said I was hoping that I'd be quit before he'd [son] even know what a cigarette is, but I'm not…. I need to quit. That's the best route to take…. (DS)

Wanting their children not to smoke. Because of the health effects of smoking, the parents wanted their children not to smoke. As one formerly smoking mother said, "It's not something you want. I mean, even if you smoke yourself you don't want your child to smoke. It's not good, it's not healthy and

hopefully, hopefully they won't". (HW) Similarly, a mother who currently smoked commented,

> It's health-wise. I mean that is the main concern with it. It is not healthy to be smoking. It is not healthy to be around smoking either, right.... It causes heart problems, breathing and then you get out of shape.... (TH)

Their knowledge of the health effects of smoking combined with their knowledge of youth smoking, which made them realize that it was possible for their children to begin smoking, and their desire for their children not to smoke caused them to address the matter through action and verbal interaction.

Parental action: Having a no-smoking rule. Parents engaged in action against smoking by *having a no-smoking rule*. Their main intent was to protect their children from second-hand smoke but they also wanted to limit exposure of their children to smoking. The rule was applied predominantly to their homes and vehicles, but some parents also applied the rule to other settings. The rule was consistent with and lent support to the message they conveyed through their verbal interaction that smoking is unhealthy.

> Yea, well it's a good example that it's [smoking is] outside cause they knows, youngsters knows. They sees the commercials. Like, one time we did smoke in the house and gees boy, you know it sticks to…. They knows. They're not stupid right. So, we can't say well no it don't boy. That's a lie. Cause then you're confusing the message then right. So we smoke outside.... (AP)

Although the strictness of the rule varied among parents from stringent to less stringent, there did not appear to be a pattern in stringency based on smoking status or socio-demographic characteristics.

Many parents had a stringent rule. These included parents from all three categories of smoking status (i.e., never, formerly, and currently smoked) and parents from all three patterns of verbal interaction (i.e., discussing smoking with their children by intentionally taking advantage of opportunities, telling their children about the health effects of smoking and their opposition to it by responding on the spur-of-the-moment if their attention was drawn to the issue by external cues, and acknowledging to their children the negative effects of smoking by responding only when their children brought it up). These parents were strongly opposed to any exposure of their children to smoking. In addition to an increased health risk from second-hand smoke, they believed that exposure to cigarettes and smoking is an important factor that influences children to smoke. ".... I think that if you have more exposure to it, you're probably more inclined to pick it up." (BQ) While acknowledging his own negative role modeling, a currently smoking father said, ".... If kids didn't see smokes, they wouldn't know what they are and they wouldn't smoke. They wouldn't be tempted to try it". (DS) A formerly smoking father's view was that his children had "a head start because we're not smoking in the house and we're not smoking around them. So, you got one side of it capped off there". (FU) Similarly, a mother who had never smoked commented, "If you have family members that do smoke, don't have your child in their presence while they're smoking because that's not sending a good message...." (IU) The parents felt that exposure causes children to "normalize" the behaviour. "… maybe if it was an accepted norm in their house then, you know, they would more than likely pick it up." (DP) It "gives them the message

that it is okay to do so"; (JV) whereas, a strict no-smoking rule demonstrates that it is not an "acceptable" behaviour.

For some of these parents, their negative feelings as a result of having grown up in smoke contributed to their strong views. They talked about how when they were children there were no restrictions on smoking in their homes and vehicles, which were smoke-filled continuously. They could not escape second-hand smoke and often felt physically ill because of it. They did not want that for their children. As a mother, whose husband also smoked, related,

> ... we don't smoke in the car with the kids. We smoke outdoors. We take turns going out for a cigarette cause we don't agree about smoking around your kids.... Years ago.... I remember sitting in the back of the car and my mom and dad in the front of the car puffing away and I'd be in the back coughing my head off, you know. It was just awful. I can't imagine doing that to them [her children]. Or, I'd be sitting on my parents' laps and they'd be smoking away on a cigarette…. (YK)

Some parents had children who had been diagnosed with asthma. These parents were even more concerned about exposure because they knew that like direct smoking, second-hand smoke also can make asthma worse. As one mother said, "Even if she wasn't, I'd still be antismoking but [I am] that much more now that I know that she's an asthmatic". (IU)

The parents' strong views about exposure to second-hand smoke and smoking were reflected in their rule. They did not allow smoking whatsoever in their homes and vehicles. Referring to her rationale for not allowing smoking in her home, a mother said, "I do have certain rules and one of them is that you can't smoke in the house. You don't pull fire alarms. You don't do things that are not

safe, and smoking is not safe". (RG) Another mother said she'd be "horrified" if someone came to her house and lit up a cigarette. The smoking parents always smoked outside and tried to do so inconspicuously so as to not draw their children's attention to it.

> First and foremost it's not allowed in my home. If I want to have one, like I said, snow, rain whatever, I will go on outside and do my business.... I do go out by the door but I mean I don't announce and say, I'm going out to have a cigarette now. I kind of sneak out and do my thing and kind of sneak back in. I try to not let her even see me do it if I can. Like she knows that I do [smoke]. Like, I mean, if somebody asked her if I did she wouldn't say no but can she say [I] see her do it all the time? She'd definitely have to say no there. (GV)

> Like if I go outside for a cigarette I'll make sure I'm not in view of the kids or if I'm in front of a window I'll make sure the blinds are closed so they can't see me. Like they know what I'm doing but I don't need [to be], you know, playing with them through a window while having a cigarette. (KZ)

The parents also made a point of not exposing their children to either smoke or smoking in places outside their homes. They were strongly opposed to smoking in public places, especially areas that were visible and accessible to children.

> One thing that I personally don't like even, and I'm a smoker, is there are some smoking sections that are more or less in your face, like right in front of entrance ways and whatnot. You can't really get by that, you know what I mean. Like it's there, you have to get by it to go into some buildings or whatnot and well if I'm taking my kids obviously they're going to see the smokers out there doing whatever. They could put the smoking sections in a bit more of a concealed place. Or, a little bit more out of the way of the public I guess would be a better idea in my mind at least. (KZ)

They avoided smoking areas in public places and required non-smoking accommodations outside of their homes.

> ... We've always had non-smoking and made an issue of having a non-smoking [hotel] room.... So, it was always made a point that we had non-smoking, and they realized that, I think, from early on that we wouldn't sit there [smoking section].... (ZL)

Further, they "wouldn't bring [their children] knowingly to a smoking home…." (LX) or required that smoking not occur while their children were present. A mother said,

> We won't even go to like activities that the family has if people are going to be smoking and everybody knows that.... [Grandparents] go outside now, like, on account of the kids cause they know that I'm totally against it and I wouldn't bring them [the children] if I knew they were smoking in the house. I'm that against it.... (BQ)

Similar to the parents who had a more stringent rule, those who had a less stringent rule comprised parents from all three smoking status categories and parents from all three patterns of verbal interaction. These parents knew about the health effects of second-hand smoke, the social unacceptability of smoking in the presence of children, and the negative influence of modeling the behaviour and were in favour of the societal restrictions on smoking that had occurred in recent years. However, they were less inclined to insist on absolutely no exposure to ETS and smoking. For instance, some had only partial restrictions on smoking in that they allowed smoking or smoked themselves in their homes or vehicles when their children were not present. A mother said, "Like, if the [children] are not home, [husband will] smoke in the living room…. Or, he'll go out and open the window and smoke it out there…." (UG) Although parents who smoked did so outside when their children were home, they did not take extra precautions to conceal from their children what they were doing. Some of the parents had

instigated a rule to restrict smoking in their homes only since having a child become diagnosed with asthma.

> Yea, he was up to my moms. I went out one night and I went back to pick him up and the place was like coated [with smoke]. It was like a thick fog and I took him home and the next morning he got up and he was breathing kind of different than usual so I bought him down [to the hospital] and sure enough he took an asthma attack. From then on I took the smoking outside. (QF)

The parents also tended not to make an issue of environmental exposure beyond the societal measures that already were in place and tended not to be rigid about exposure in relatives' homes. Parents who had never smoked or had smoked formerly had a less stringent rule to accommodate a spouse or other relatives who smoked. As one mother indicated, she tolerated her husband smoking at their door but was not happy about it.

> He doesn't smoke in the house per se, outside of sitting on that chair and opening the door and blowing it out the door and even that is too much for me because I don't want it here at all.... (CO)

Parental verbal interaction. The parents interacted verbally with their children about smoking through using one of three approaches (a) discussing smoking with their children by intentionally taking advantage of opportunities, (b) telling their children about the health effects of smoking and their opposition to it by responding on the spur-of-the-moment if their attention was drawn to the issue by external cues, or (c) acknowledging to their children the negative effects of smoking by responding only when their children brought it up (see Figure 2, p. 120). These differed in terms of interaction style and interaction method but were marked by five underlying properties, or characteristics, which were (a) when the

interaction occurred, (b) purpose of the interaction, (c) intensity of the interaction, (d) character of the message, and (e) who interacted. The properties reflected the when, why, how, what, and who of the verbal interaction approaches. As well as demonstrating differences among approaches, the properties also revealed within-category variation within approach. The two conditions that influenced how parents interacted with their children also differed by approach. These were (a) belief concerning communicating with children about smoking and (b) saliency of the issue (see Table 2, p. 123).

Although it is difficult to tell whether any particular socio-demographic factor was associated with a particular verbal interaction approach, there seems to be a trend of relatively more mothers, parents who had a spouse or partner, and parents with any of higher household income, education, and occupational status located in the category *discussing smoking with their children by intentionally taking advantage of opportunities* than in the other two categories (see Appendix J, pp. 364-365). There were 20 mothers of 22 parents in that category compared with 4 of 9 and 4 of 6 in the other two categories. Almost half of the parents in that category had high household income compared to one parent each (1 of 9 and 1 of 6) in the other two categories. A large number of parents (20 of 22) in that category had at least some university or college education with 15 of those being college or university graduates. Only one parent in each of the other two categories (1 of 9 and 1 of 6) was a university or college graduate. More than half of the parents (13 of 22) in that category held jobs in the professions. In

comparison, a third (3 of 9) and no parents (0 of 6) in the other two categories held jobs in the professions.

With respect to smoking status, only 2 of 22 parents in the category *discussing smoking with their children by intentionally taking advantage of opportunities* currently smoked (see Table 4). This is in contrast to the higher proportion of smoking parents in the other two categories (4 of 9 and 3 of 6).

Table 4

Verbal Interaction Approach by Parent Smoking Status

Verbal interaction approach		Never smoked	Formerly smoked	Currently smoked
Verbal interaction	Discussing smoking with their children: Intentionally taking advantage of opportunities	10	10	2
	Telling their children about the health effects of smoking and their opposition to it: Responding on the spur-of-the-moment if their attention was drawn to the issue by external cues	2	3	4
	Acknowledging to their children the negative effects of smoking: Responding only when their children brought it up		3	3

Note. N = 38 but 37 parents engaged in verbal interaction. The one missing parent represents a possible negative case.

Discussing smoking with their children: Intentionally taking advantage of opportunities. The majority of parents interacted verbally with their children about smoking by discussing it with them. Their interaction style entailed open communication. They encouraged their children to talk about smoking, engaged them in discussion, and participated with them in a two-way exchange of ideas. Their method was to take advantage of everyday ordinary opportunities. "It's utilizing whatever comes up at the time.... Every now and then something triggers it and we talk about it." (AM) ".... it's not like I have a schedule that I put them on, [or] I talk about smoking on a regular basis...." (VH) "I look for a kind of teachable moment. I don't just say, okay, we're going to talk about smoking today and go from there." (JV) The discussions occurred "naturally" but were deliberate and "purposeful" nonetheless. As one father put it, "When we encounter it, it's dealt with .... It's just, you see it, you do it". (XJ) Their approach was predicated on forethought, that is, they had conscious intent to address the topic of smoking with their children. The properties that further define this approach are as follows.

When the interaction occurred. The parents discussed smoking with their children when opportunities occurred either from noticing something themselves or from their children making comments or asking questions about smoking. For the parents opportunities generally involved encountering smoking or seeing an antismoking promotion, such as a television commercial or a poster, while with their children.

> My mother-in-law and my mother still smoke. So, they hide it from my children but my children know that they smoke.... they'll go outside and go around the garage, try to make it not so evident. But, it allows us at

> least to talk about it because it does come up.... Seeing others, like even the grandparents, somewhat makes it okay if they see other people that they know and respect and yet they're smoking. So it has to be clarified.... So to me it gives me a discussion point and we take it from there. (LX)

> When teenagers are out and around and smoking, it worries me that that will attract my children to somehow think it is cool or want to be like them.... the more it's visible and available, that's just a worry. So, it makes my job even more important to, you know, take those opportunities. (UG)

> We just look for the opportunities, if there's an ad on TV, we'll pick up on that or if we're driving in the car, if there is an ad on the radio about not smoking then we'll, I'll pick up on that and just chat about it a bit. (EQ)

As with the parents, often the trigger for the children was seeing someone smoking, but it could have been more subtle such as seeing a cigarette butt on the ground. "It seems to come up a lot cause ... my children will point out when they see someone smoking. So, you always see somebody smoking." (IX) In families where a parent smoked the topic came up often mainly because the child noticed and asked questions as to why the parent smoked, made negative comments about it, or told the parent that he or she should not smoke. A mother whose husband smoked commented,

> I think the issue comes up a lot with us because [husband] is a smoker. So every time he smokes the boys will say, 'Daddy why are you smoking again? Daddy, no smoking'. When [son] was just small he'd say, 'No smoking in this house'.... the exposure is there.... They notice it so a discussion always evolves. (CO)

A mother, who smoked and whose husband also smoked, talked about their children's reaction, which gave her no choice but to discuss it. Her children would say such things as, " 'You don't need to be smoking anyway. That stuff will kill

you'.... And then they're talking about, '[I] can smell it off you, Mom. Go brush your teeth' ". (YK)

> ... the kids, they don't like it at all. They hate the fact that we smoke and they really get down on us.... where I smoke I feel like I have to let the kids know what is going on with me. It is part of my life and it's part of their life so we have no other choice but to discuss it. (YK)

Some parents talked about having very "curious" children or as one mother put it, "intuitive [children who] ask a lot of questions about a lot of things including smoking". (CO) They felt that they actually did not have to raise the topic much themselves because their children did a good job of that. To illustrate the point, one mother said, "I find it fascinating that they, you know, walk past a smoker and it doesn't even register in my consciousness but my kids are like, 'Oh, wow, look at that' ". (FR) Where the children tended to raise the subject often, the parents took advantage of opportunities mostly in response to such provocation. They felt that it was especially important to respond when the children raised the issue because it indicated that the children were interested in discussing it. As one mother said, "If it comes up from them, you got to take it and run with it". (UG) Where the children were less inclined to raise the subject, the parents took the lead in bringing it up.

Purpose of the interaction. The chance encounters and triggering situations were "golden" opportunities "that open up the door for discussion" (EQ), and the parents took advantage of those "teachable moments" to clarify or validate their children's understanding of smoking, give information about

smoking, or reinforce the antismoking message. “They don’t know it [the harmfulness of smoking] until we tell them.” (MY)

Intensity of the interaction. These parents believed that it is important to start providing smoking education when children are young. “As soon as your child understands what you’re saying, I think then that’s the opportunity to plant the seed there that it’s not a good thing.” (IU) They believed that when children are old enough to grasp messages about health and “start asking questions about [smoking] then they’re old enough to probably understand a little bit about it”. (JV) They believed that young children “are particularly mindful of what [parents] think”. (RD) Hence, they deliberately started talking with their children about smoking before school-age. One mother said, “I started my antismoking campaign with [daughter] really young ... when she was probably around 2½ or 3 years old”. (AM)

Although the parents took advantage of presenting opportunities, some were more earnest than were others. Those parents were sure to “take advantage of every opportunity” (IU) to convey an antismoking message and as one mother said, to ensure that it became “innate knowledge”. “…. if it comes up. I mean, you know, if we pass someone who’s smoking, you know, the first thing I say is … they don’t realize how harmful that can be, right.” (WI) Other parents raised the topic more periodically, “not all the time but enough that it stays in their [children’s] mind”. (AM)

> ... not saying that I’m consciously doing this all the time... if we walk in some place and there’s a lot of smoke, or if they run into one of my many

> relatives who smoke, or whatever, then they'll say something, say, 'Mommy, does she smoke?' and I'll say, 'Yes' and we'll talk about it then ... if an opportunity comes up, provoked by them or something that I see that I want them to, I wanna sort of bring the point home about smoking then I'll seize that moment. (VH)

Regardless of their intensity, parents acknowledged that they needed to be careful to not "force" the issue or "harp" on it. They felt that it is important to not make the topic so common that it loses its effect, to have the "right balance" between raising it enough but not too much. "You got to be careful with kids because there's a fine line between sharing the information and it just at some point becomes information." (EQ)

Character of the message. The parents' emphasis in discussing smoking with their children was on the health effects. In addition to general health, parents also discussed any of several specific health and other issues such as effect on asthma and sports activity, ETS, unacceptability of mimicking smoking, and factors that influence people to smoke including for current and some former smokers, their own addiction.

The strength and nature of the health message conveyed varied among the parents. Although they gave an "honest" message about smoking based on facts, some, involving formerly smoking and never smoking parents, stressed the importance of using an "age-appropriate", "progressive" approach. That is, they took into account developmental level and tried to give a message that they thought the child would understand at his or her age. Referring to her five year old, one mother said, "I've tried to be honest but without painting too horrible of a

picture.... We tell him the truth but obviously in a more kid-friendly version". (LX). For preschool and young school-age children, these parents tried to keep the "explanations simple" and used general messages about health. They said things about smoking that "make children understand that it's not a good thing" (LX) such as "[cigarettes] really smell gross and they can make you sick … it keeps you from being able to run and play", (AM) "it's not healthy for your body", (DP) and "people have yucky coughs". (RD) For older school-age children, these parents talked about smoking being "dangerous" to health and causing diseases, but they avoided talking specifically about cancer and death and giving graphic messages about the health consequences.

> I wouldn't introduce pictures or anything like you see sometimes on the back of cigarette packages.... Sometimes you'll see a picture of someone's mouth. It's been eaten away by cancer, or a set of lungs from a smoker or something.... I wouldn't want to shock them with horrible pictures.... (JY)

Parents who were cautious in their messaging thought that detailed and explicit messages about health consequences were more appropriate for children who were nearing or at adolescence, that is, once they are better able to understand disease, risk, probability, and long-term outcomes. "... as they get older, grade 6, grade 7, I mean, they can definitely handle the real statistics around the numbers of cancers that are caused and the number of people that die." (DP)

> The older children, more the graphic images, I think that that has an effect with them. They can kind of see sort of the end result, Wow, okay that's what that's going to look like. I don't want that for my body.... I certainly think probably by the time they're in grade 6 getting ready to enter junior high. (BN)

> I think later on as they get older … I think that the heavy guns should be brought out. I think once they get older and they really understand about their body and what smoking does to their body, I think that they should be blasted because unless they see the effects, the side effects and, you know, I think it is a possibility they might think about [smoking]. (RD)

These parents were particularly mindful of what they said to their children if the other parent or a close relative such as a grandparent smoked, as they did not want to cause the children to become scared or worried. As the mother of young school-age children said,

> I'm not going to talk to my children about that, especially with their father smoking. You don't really want to let them know that he might die from this, type of thing.... They'd still get the message of the, it smells bad and it doesn't look very nice and it'll make you sick, even though their father is a smoker, being exposed to seeing him smoke. I still think they need that negative message ... so I still give them everything negative that they can understand at their age about smoking. (IX)

Referring to her 10 year old daughter whose grandmother smoked, a mother said,

> She's hearing so much in school and at home, the negatives of smoking so she says to me, 'Mommy I'm really worried. Is nanny going to die?'.... This is a really hard situation because I can't say to her, yes, if she's going to keep smoking because I mean that would terrify her. So I don't want to say that to her. Yet, I want her to know how harmful smoking is. So it is really a bit of a difficult situation there.... I just say, 'Well [daughter], you know, smoking is really not good for you. It's really bad. But nanny's doing really good. She's trying to cut back.... she's really trying her best'.... They're at the age where it's a fine line. I don't want to scare them into thinking that something's going to happen to their grandmother because she smokes, right.... Then I try to, not really downplay it, but like just try to reassure her, you know. 'Nanny will be alright'.... (ET)

Another mother of young school-age children, whose husband smoked, related a story about her son's reaction to overhearing someone talking about how people who smoke can go blind.

> I could see [son] … just kind of looking like this, very, like scared look on his face and … his eyes filled up in tears and he said, 'Mommy', he said, 'does that mean daddy is not going to be able to see when he gets old because he smokes?' Right. And he was upset about it because he raised it then several times through the [evening] and again like when I tucked him in and stuff, right. So you kind of have to reinforce, you know, right. It's difficult. (CO)

> It's hard especially when they are so young to know what to tell them and what not to tell them right, because you don't want to tell them something to the point that it's going to frighten them and scare them and like I said before especially when they have a dad that smokes. (CO)

Other parents, including some who never smoked and some who formerly smoked along with the two who currently smoked, were less cautious in their approach. They always gave a strong, frank message to their children, even pre-school children. They thought that children need the blatant facts about smoking and that young children can understand about serious consequences. "I mean even my six-year old can understand lung disease or heart disease or that you can die from smoking or you can get cancer." (UG)

> ... when you're trying to share a message with children, there's often a need to be protectionist of how you send that message ... and want to soften the impact as much as possible but send the message. I don't think there should be any softening of the message at all. (EQ)

Where possible, these parents used real-life situations to show the serious health effects of smoking, for example, the illness or death of a grandparent. They wanted to be sure that the children received the message that smoking is "serious stuff". As one mother said, "When it becomes real that is, to me, what makes an impact....". (EQ) The mother of young school-age children said that she purposely

pointed out to her children their grandmother's "struggle" with COPD because the reality probably makes it "stick with them and mean something". (UG)

> 'See how Grandma's coughing and that's from all the years that she's been smoking.' And, so, there's this link in their minds like, OOOH, I don't want to cough like that.... because [grandmother] really coughs and coughs and coughs in the morning quite a bit and has been hospitalized with COPD. (UG)

Another mother conveyed that her father had died of lung cancer when her son was five years old and that she told him at the time why her father had died.

> We have been very up front in having discussions with him to let him know that poppy smoked for a long period of time.... and what smoking does and that smoking causes lung cancer and that the result of lung cancer is that in all likelihood you will die. And we have not kept that from him.... I want him to know that smoking does a lot of damage to your body, that ultimately it could kill you and I think that's the important message because I think that's the truth of it, and it's important for him and kids generally to know the truth about smoking. (EQ)

This mother had a similar sentiment.

> We were very honest about it, that [their grandfather] died because he smoked.... I'm big on being really upfront with all kids. I think even really young kids.... I don't try and color things for the younger kids and ... certainly since my dad got sick, we've been talking about smoking. So I'd say when they were 3 and 5.... (PB)

Parents who had relatives who smoked and the two parents who smoked themselves recognized that such messages can cause children to worry. However, they thought that, regardless of any emotional impact, it still was important for their children to know about the serious health effects. As one mother who smoked said, "We discussed that smoking is not good for you and this [serious effects] is what happens. I've showed him the pictures on the cigarette packages

and the nasty teeth and explained stuff to him....” (TI) Another mother, who had never smoked, said, “I don’t think shying away from that is really helpful because it is reality and the children will find their ways to deal with it”. (UG). However, for children who indicated that they may be troubled by the facts, parents tried to reassure them by explaining that while smoking is always harmful not every person who smokes ends up with serious disease or dies because of it and serious effects happen later in life, “that it’s not going to happen right away”. (UG)

> The issue is sometimes when you have family ... and she’s saying, ‘Mommy, are they going to get sick?’ And my answer is, ‘Yea, there’s a good chance, down the road and maybe they’ll be old, that cigarette smoking will make them sick and then their quality of life or the way that they’re living, they won’t be as healthy and they won’t be able to do as many things as they would have, had they not smoked’. (IU)

The parents who smoked tried to further comfort their children by indicating that they were fine and wanted to quit and would continue trying. A mother explained how she dealt with the situation when her son saw an antismoking television commercial of a smoker who had a tracheotomy and asked her, “.... ‘Like mommy, could that happen to you?’ ” (TI)

> I couldn’t say, no. When they ask you questions like that, what do you say cause you can’t say no and I just said to him, ‘No, please God, mommy won’t be smoking by then. Please God that won’t happen to mommy’. Cause what can you say to them.... I just said, ‘No, hopefully mommy will never have to go through that’. (TI)

Some parents directed the health message to their children’s personal situation, in particular the fact that they had asthma or were interested in sports. Those parents thought that that kind of message might be more meaningful and therefore better capture their children’s attention than would general health

messages. For children with asthma, parents had talked with them about how smoking can make asthma worse. For children who were interested in sports, parents had talked with them about how smoking affects physical activity and how people who smoke may not be able to play sports or may not be as good at it as people who do not smoke.

> My kids are very into sports so I have used it there too, to say, if you're going to play hockey you need the best lungs that you can have and that it's going to prevent you from running and skating and those types of things. (JV)

Some parents also addressed health in terms of the effect of ETS. As one mother, who had never smoked, said, "I also bring it up in terms of rights of other people not to be exposed to second-hand smoke". (VH) The parents explained that smoking restrictions were in place to protect people because even second-hand smoke is dangerous to health. A mother, who currently smoked, said, ".... what second-hand smoke does to your loved ones and stuff like that. We talked about all that". (YK) One mother recalled having a conversation with her daughter when a ban on smoking in public places was introduced.

> The older daughter is particularly sensitive to smells and smokes and she says, 'Well, that's good because whenever I smell it I can't breathe'. I said, 'Yea, a lot of people felt that way and so that's why those laws are here to help protect everybody else's health too'. (UG)

A few parents had witnessed their children mimicking smoking and were compelled then and there to reinforce the health message. Generally, the children had used an object, such as a candy stick or crayon, to imitate the behaviour. The

parents, who included a smoking parent and non-smoking parents, had talked to their children about the inappropriateness of the pretending.

> I think it was after Halloween, so the [children] were going around with their candy cigarettes and playing the little cool, look at us game ... and I said, 'Girls, what are you doing ?' ... And, they are like, 'Oh, we're just smoking'. 'Don't you ever let me see you do that. Mommy would be really upset if I ever saw you smoking a real cigarette and it's not even fun to pretend you're smoking.' So, I keep the negative there whenever I get the opportunity to throw negative into smoking. (IX)

Another mother's response to her child was that she should not "... do that even in fun. 'Smoking is dangerous and you don't make jokes about things that are serious and things that could hurt you.' And, you know, she very quickly, 'I'm sorry mommy. I won't do that again.' " (BN) Most of the parents had noticed their children ever do it only once. Where a child had repeated the behaviour, the parents reinforced the message that they did not like seeing it because smoking is harmful to health.

As a result of the conversations about health, many children had wondered about why people smoke or asked a question such as " 'Why would people smoke if it's so bad?' " (FR) Parents responded by talking about factors that influence people to smoke including addiction. A mother described her response to her child, who had noticed young people smoking, " '.... I'm sure that they know that it's bad for them but maybe they felt pressured by their friends to try it or maybe they don't really believe that it's going to hurt them even though they've been told that....' " (BN) Another mother commented that,

> I talk about addiction and I explained to them that a lot of people start smoking because they think it's cool. Or, girls do it to keep weight off,

> those kinds of things, and then before they know it they're hooked and being addicted to anything is not cool. (VH)

The two parents who currently smoked felt that it was important to let their children know about their addiction and that they were not smoking because they wanted to but because they had to.

> I couldn't sit down and dispute and say to her, it's okay for me to do it cause I'm a grown-up. I couldn't very well do that ... I tried to explain to her ... 'it's very hard for mommy to quit smoking. It's very hard and I know it is unhealthy....' I think it's important for them to know that people who are smoking.... don't like that they are smokers either.... We're not like standing up going, 'Oh, this cigarette is fantastic, don't ever smoke', you know what I mean. I think it's important they know that that's not how we feel. That's not how it works, right. (TI)

Parents recognized that children may have difficulty understanding the concept of addiction and so kept their explanations about addiction simple for young children.

> I know they don't quite understand addiction. I tried to explain that people want to stop smoking but they can't. 'Well, why?' 'Because you know their bodies feel like they need it. They feel like they need it.' I said, 'You know how you get hungry and you want to eat. It's the same thing as people who are smoking. They want to stop smoking but they have a feeling like they need to smoke'. I've tried to explain it to them in those terms ... 'That's why', I say, 'you never want to ever start because you could get that feeling and then you'll want to stop and you won't be able to'. (FR)

A few formerly smoking parents had told their children or planned to tell them that they themselves had smoked. They believed that telling their children about why they had begun to smoke, their personal experience with addiction, and why ultimately they quit was a good teaching strategy. "Being a former smoker, it

may be easier for me to talk about smoking to my kids ... cause, you know, I've been there and I've been smoking. I know how hard it is to stop." (ET)

> I think that would be beneficial because they would know from experience then, like I wouldn't be just telling them something that I didn't believe. I experienced it and I know that it's a tough, tough decision to give up. It's not easy.... (XJ)

> I guess you might as well be honest about it because if you're not smoking now you can turn around and say well it was a bad choice. It was a bad decision and I'm sorry that I made it because I definitely feel much better for not smoking. But I would also tell them about the fact that it hasn't left me. You know, that when I'm around somebody who smokes that I feel like I want to have a cigarette. (RD)

Other parents had not told their children that they had smoked and were unsure as to whether they would tell them in the future as they were concerned that it could be a negative influence.

> They don't know that I am [a former smoker] and I would really like to keep it that way. I mean there may come a point where I will tell them that, yes, I did try this and realized that it was a bad decision and that for my health I needed to stop. And, hopefully that'll be successful but right now they don't know anything about that. (BN)

> They don't know that I smoked. Like, I definitely don't want them to know that I started when I was young and stuff like that, well just for the simple fact, I don't want them to smoke.... When they get a little bit older it may be a little bit easier in that way to say to them ... like mom used to smoke and it's really addictive and once you start it's really hard to stop and it's really gross. It makes your clothes smell, your teeth yellow.... (ET)

Who interacted. The fathers and some of the mothers in this category of parents indicated that they and their children's other parent were about equally involved in addressing smoking with their children. A majority of the mothers who were living with a spouse or partner indicated that it was they mainly who addressed smoking with their children but that the fathers were supportive of their

messages. Their greater role in addressing smoking with their children was due to the fact that they spent more time with the children because they were more available than were the fathers.

> I have most interactions with the children because [husband] works a lot but he's discussed it as well. We were always on the same page.... He would echo the same things that I'm saying. If the children spoke to him or had questions about it, he would say the same things.... It's probably really more up to me just because of time. I'm a full-time parent and he's working a lot. (FR)

For some, it also was because they had a stronger negative reaction to the behaviour than did the fathers and were more compelled to deal with the issue. The mothers who were single parents either did not know or believed that the fathers did not engage in discussion with their children about smoking. These parents felt that the responsibility lay with them to discourage their children from the behavior. A mother whose former husband smoked said,

> ... I don't think he speaks to them about it. So, he's just going along with his cigarette and everything is wonderful. Definitely, as a smoker, he should be talking to them more, like daddy wishes he had never done this and this type of thing. But, he's not doing that. He doesn't use it as an opportunity to sit down and talk to them.... (IX)

Conditions that influenced the approach. The two conditions that influenced parents to interact with their children through discussing smoking with them by intentionally taking advantage of opportunities are detailed as follows (see Table 2, p. 123).

Belief concerning communicating with children about smoking: Use open dialogue to impart the facts when opportunities arise. Parents believed that taking

advantage of ordinary opportunities is a good strategy for initiating discussion with children about smoking and allows smoking education to be carried out in an ongoing manner throughout childhood. They believed that discussions need not be "planned out or scheduled" (EQ) and that "giving information that's appropriate at the time is more effective than just pummelling them [children] with information, if they are not ready for it" or the timing is not right. (FR)

Further, verbal communication with children about smoking should be an "open dialogue". Parents should be "honest ... objective, non-punitive, and non-judgmental when discussing smoking" (LX) and children should feel that they can talk to their parents and ask questions without getting a negative reaction. "It's natural for them to ask questions and I've always encouraged my child to ask questions because I say that's how you learn." (RG)

> .... We talk to our kids everyday cause we want to make them feel that they can come to us if there's a problem with drugs or alcohol, smoking, or boys, or anything. We want them to feel that they can talk to us. And, I gotta say they open up and talk to us. (CR)

Parents need to be careful not to be "heavy handed" because that can "backfire" and "become an obvious outlet for rebellion" (RG). Talking to children about smoking is about "equipping [them] to deal with things rather" (RG) than simply telling them "don't smoke". It should not be "the Ten Commandments". (RG)

Parents thought that a mutual exchange not only allows parents to convey the facts but indicates to the children that their input and ideas are important. It provides them with the basis to "formulate their values and opinions" (UG) regarding the matter and "think for themselves" (RG) so that they do "not get

easily led". (IU) "They really need to be able to make the right choice when they find themselves in the situation." (BN) As one mother said, "knowledge is power". (TI) Open dialogue is the foundation for a positive relationship between the parent and child, increasing the chances that he or she will accept the message in the long-run. "I think the big part of prevention is having the relationship established with them and talking about it beforehand." (VH)

Saliency of the issue: Smoking was foremost in parents' minds. The parents who participated in the study had knowledge of the health consequences of smoking including that it causes serious addiction and illnesses. However, for some parents, their knowledge caused them strong emotions, such as deep concern or worry, sadness, and guilt, which kept smoking foremost in their minds or as one father said, "top of mind" (JY). Because smoking was so present in their consciousness, when opportunities arose they intentionally took advantage and discussed the behaviour with their children to ensure that they were well informed in an effort to avert it. The parents knew that if their children started to smoke "it could become a lifelong addiction for them". (BN) "It's a fear I have." (FR)

The parents' emotions were evoked because of any of several personal experiences. These included being a smoker or former smoker, having close family members who smoked or had been affected by smoking, having a child who had asthma, and being a negative role model or having negative parental role modeling in the family.

The two parents who smoked had concern about their own health. "Sometimes, too, like when I get sick [a cold] I'll have this lingering cough for about three weeks after ... I'll hack and hack and I'll say, 'God I got to quit smoking'." (TI) That mother further commented that she knew "... what it does to a person ... we know the facts because we're living them". (TI) Similarly, the other mother's thoughts were, "... I'm a smoker myself and I know where I'm coming from when I do talk to them about it". (YK)

The formerly smoking parents regretted having smoked. Some had concern about the potential health impact that although not evident at the time could surface in the future.

> It's probably the biggest regret I ever had. Even after you've quit for years you still really don't know the long-term health impacts you've made. And now I have young children. So, now it's even more ... I realize more now what I did in the past. Like, what did I do for the sake of a cigarette? I don't know the impact I've had on my health long-term ... (IX)
>
> … personal choices that you make can affect ultimately your life at the end of the day and whether or not you get to enjoy your life, whole life with your child.... looking back on it now, yes it's frightening to think that both [husband] and I smoked. (EQ)

As a formerly smoking mother said, because of her personal experience, "I'm even more determined to ensure my children don't smoke". (IX)

Many of the parents had close family members who smoked, some of whom had serious illness because of it. Some parents had close family members, including their own parents, who had died prematurely as a consequence of smoking-acquired disease. Having a family member who smoked, regardless of whether or not the family member had illness, heightened their awareness of the

health risks and gave them cause for concern. For instance, a non-smoking mother whose husband smoked but was not yet exhibiting any ill effects said,

> … I'd like [the children] to be able to grow up with a father. He's got a history of heart disease in his family. He's got hereditary high cholesterol and he's a smoker. Plus he leads a pretty sedentary lifestyle.... it's really frustrating, it really is. (CO)

Those who had a close family member who had illness were saddened by it, and those who had lost someone because of smoking had lived that emotionally difficult experience and it had left a lasting impression on them.

> I have strong feelings against smoking because of my personal experience with my parents. I grew up in a household where both parents smoked and smoked heavily.... I watched them several times try to quit smoking and they never were successful.... ultimately my father died a very sudden death ... He had a massive heart attack and I attribute that to his smoking a couple of packs a day.... And, since then my mother has again tried to quit smoking and she hasn't been able to and she's dearly wanted to. (FR)

> .... [seeing] my parents try to quit and not being able to was distressing to me.... But, anyway, that really spoke to me, the struggle that he [her father] went through was really, really, that upset me. (FR)

> .... It's very personal to me. (FR)

A mother amply summed up how it was that personal experience with past smoking and family illness motivated her and her husband to look for opportunities to talk about smoking with their child.

> I can't say that had we not experienced Dad's death and why that was, that we would have been as forceful on the issue because it is very different to read about it and know about it and to live it firsthand.... the life experiences that we've had ourselves in terms of, you know, being past smokers, knowing what smoking can do, having a death in the family that resulted from smoking. I think all of those things sort of formulate the basis for where we start and from there then we just look for the opportunities to ... chat about it a bit. (EQ)

Parents whose children had asthma were concerned that it would get worse if the children were to take up smoking. Their knowledge of the deleterious effects of smoking on asthma added impetus to their need to prevent their children from smoking.

> .... I mean you hear people talking about ... my grandfather was 90 before he died and he smoked all his life. Well that's the exception to the rule. We know that the majority of smokers have issues and I do not want my child to go down that road especially where she's asthmatic. (IU)

For a few parents, their knowledge that parental smoking is a risk factor for smoking by children, which ultimately can harm them, contributed to their emotional response. The two smoking parents recognized their negative influence. A mother who smoked and whose own parents had smoked commented,

> I remember my brother. He didn't smoke when he was a teenager because he was so into sports and then when he hit his late teens he picked up smoking. And it was almost like do we not escape it. Like, is it inescapable because our parents did it. Like is it still there. Like, because he was so against it because he was an athlete... (TI)

Although trying their best to minimize the effect of their smoking on their children, they worried about it and openly expressed feeling guilty or discomfort about it.

> Actually, I feel guilty even asking them [older children] to watch their sister for me to go outdoors and have a cigarette. But sometimes I just crave it so bad and if [husband] is not here then I seem like I have no other choice but to ask them.... Sometimes he'll [son] ... watch her for me. But he'll bring her out in the porch and two of them will be stood in the window and just seeing their little faces in that window I can't even smoke my cigarette. I just got to put it out and come in out of it.... it makes me feel really bad but it still does not stop that craving. (YK)

> I was using the washer when my mom yelled out, she said, 'Where's your mom?' And she's (daughter) like, 'I think she's outside having a cigarette'. And, I was just thinking, you know, if she doesn't see me she assumes I'm outside having a cigarette, you know. She doesn't think, oh well, maybe she's doing laundry or maybe she's doing this. She assumes I'm having a cigarette, right. And, or I'll run outside for a minute. I could be putting garbage out and she'll say, 'Oh, what you gotta have a smoke?' you know. And, it's God, you know, like they got me figured out. So, that kind of, that kind of bothers me. (TI)

Their additional burden and sense of responsibility made these parents feel an urgent need to talk with their children about smoking and desperation to prevent it.

> Yea, I think it makes me more desperate ... to try to get that message across than it would if I wasn't a smoker cause I'd probably just tell them stuff. And it'd be like, you know, that's nasty, blah, blah, blah. I think as a smoker, it's almost like I know if they grow up and they smoke I'm going to feel like I failed and I'm going to have guilt. So, I think like that's a big thing, is trying to avoid that whole thing by making sure they don't smoke. (TI)

> I look at her, the two of them. I mean, they're so, they're so beautiful, you know. And to think like they'll grow up and if they smoke and then ... Just what it does to you. (TI)

> I just love my children so much that I don't want to see anything happen to them due to smoking.... they're like my gifts from God and like I just want them to have the best in life and smoking is no way to go ... (YK)

Non-smoking parents of children whose other parent smoked also were concerned about the negative role modeling. As one mother said, "I think definitely parents smoking.... I certainly think that is a factor on whether or not they choose to smoke and I think it's kind of common knowledge that usually you see smoking children have smoking parents". (CO) That mother illustrated her concern through relating this story,

> The way our household is different is that we have a strong non-smoker and a strong smoker. So I'm telling them one thing but yet they're seeing daddy smoking. And, you know, it's always been a source of discontent between myself and [husband] because I am very anti-smoke and he loves to smoke, so that's frustrating. Whereas, he doesn't push the benefits of smoking or anything positive about smoking on the [children], I find lots of time it's to no avail.... (CO)
>
> [Son] was sitting here on the floor the other day and he had one of those little twistable crayons and the next thing he was going [mimicking smoking].... And, I said, '[husband], prime example there'. [Husband] was sitting there having a cigarette blowing smoke out the door.... When I saw [son] doing that the other day, oh, I was just so mad ... whereas he probably wouldn't have done that had daddy not been sitting there puffing on a cigarette. (CO)

These parents felt that it was all the more important that they address smoking with their children.

Telling their children about the health effects of smoking and their opposition to it: Responding on the spur-of-the-moment if their attention was drawn to the issue by external cues. Some parents interacted verbally with their children about smoking by telling them about the health effects and their opposition to it. The parents did not engage their children in conversation about smoking as such. Rather, they used a directive style of verbal interaction to let their children know their thoughts. Their method was to comment about smoking if their "attention" was drawn to it by some smoking-specific external cue. For instance, a father said, ".... If a commercial comes on TV about smoking and if they're [the children] doing something, I get their attention, 'Look at that, look at that, pay attention', right". (AP) Their comments tended to be random and in the moment. "We don't have one specific time, one specific moment. It's just at that particular time and moment when it pops up." (TH) Although their comments

were goal-driven, that is, meant to deter smoking, their overall approach to the matter was not premeditated in the sense of being deliberately planned or executed electively, rather, it was more spur-of-moment and may be likened to a hit-or-miss approach. As one mother said, "It is not something that we purposely sit down and discuss". (GV) The properties that further define this approach are as follows.

When the interaction occurred. The parents remarked about smoking when their attention was drawn to it by such cues as questions or comments about smoking from their children, exposure to smoking, and smoking-attributable illness in the family. As one father indicated, he had not said anything about smoking to his children before their grandfather had become ill with lung cancer and died because of it. "The death of a grandparent [was] very helpful for bringing up the topic." (OA)

Purpose of the interaction. The parents' aim was to inform their children of the health effects of smoking and ensure they knew that the parents were against it, in an effort to persuade them not to smoke. Their reaction to the issue was "... to make sure they [children] don't get involved with it". (NC)

Intensity of the interaction. The topic had first come up with their children before the children were school-age. Most parents had commented about smoking only occasionally over time, or "every now and then", (TH) and those parents tended to be moderate in their approach. Others varied in the frequency with which they "reiterated" their message about smoking, from occasionally to often,

but they tended to be hard-line in their approach. As one father said, “I’m not going to sit there every day and tell them don’t you smoke today.... But if the topic does come up, well I give [them] more than a mouthful”. (AP) Another father commented, “Since they were old enough to talk, it’s basically been burned into their skull like, ‘smoking is bad’....” (DS)

Character of the message. The parents who had a moderate approach kept information about the health effects simple, telling their children things such as “it’s not healthy”, (DS) “it can make you sick”, (GV) and “it is bad for [breathing]”. (TH) Similar to some of the parents whose approach was to *discuss smoking with their children by intentionally taking advantage of opportunities*, these parents felt that their children, who ranged from early to middle school-age, were too young to understand the serious health consequences. “I don’t like to go as far as saying it’ll kill you cause I don’t know if she’s actually prepared for that.” (GV) Parents indicated that they would give a stronger message about the health effects when their children were older and “... make sure they know all the negative things and what can happen....” (BQ) and that “there are no benefits [to smoking] ... only sad side effects and risks”. (BQ)

The parents who were hard-line in their approach told their children about the serious health consequences of smoking. Similar to some of the parents whose approach was to *discuss smoking with their children by intentionally taking advantage of opportunities*, these parents did not differentiate their message based on the child’s age but believed that children should receive the strongest message regardless of age. They used examples of family members, where possible.

> With my children I say, it's heart disease and I tell them lung disease. I had an aunt that died with lung cancer and I told them it had to do with smoking and I had an uncle that had to have his throat sliced on both sides and opened because of throat cancer and I told them that it all had to do with smoking.... And like your arteries are blocking and like that's what I explain to my 9 year old and she understands it. (NC)

To send a strong message, parents made firm, unequivocal statements such as "smoking kills". A father who smoked said, ".... I tell them straight up too. I ain't going to beat around the bush and say well smoking can [kill]...." (AP) Similarly, a formerly smoking father said that he wanted his children to have the "message" that,

> It'll kill them.... Not it'll make you sick, not it'll make you unpopular ... just it'll kill you. You will die from this soon. I don't like the idea that you can say that someday this'll probably make you sick.... It [cancer] will kill you if you get it. This will give it to you. No sense of correlation. An absolute sense of causation.... (OA)

They wanted their children to know the "real reality of it" (AP) and believed that fear was good for them. "Anything that will keep them from smoking is a good thing." (OA) "I tell them right up, 'Man, it tears your lungs apart. It's going to tear your body apart'. Like I'll tell them in a way that they'll listen and they'll remember, right." (AP)

> .... give them all the information and yes scare the crap out of them at the same time because they will be making a decision that affects the rest of their lives while they are incapable of making decisions that affect the rest of their lives wisely.... (OA)

Parents who had smoked or who were currently smoking also had commented on their own smoking in an effort to reinforce the health message.

Formerly smoking parents had told their children that they had smoked but quit because of the health risks.

> I told [daughter] that I smoked and I have no problem in telling them [his children]. Maybe some parents won't want to tell them because [their children may think], mom tried it or dad tried it so I can try it too.... I got no problem telling my children, listen I smoked and if I had it all back again I would never ever have done it and I would tell them exactly why because I know.... (FU)

Smoking parents had told their children that they knew that smoking was harmful and wished that they could quit. "I'll have a cigarette in my hand and I'll say 'That's not good.... It's bad for you'...." (TH)

Regardless of the strength of their health message, parents voiced their opposition to smoking by making sure that their children knew that they were against the behaviour or that they expected them not to smoke. The smoking parents realized that they were not being good role models and wanted their children to get the message "don't do as I do, do as I say". (GV) "I'll have a cigarette in my hand and I'll say.... 'I don't want to see you guys smoking'...." (TH) As a father said,

> Well, basically, like he knows it's wrong. I know it's wrong.... Just because daddy does it, doesn't make it right. Just because daddy does it all the time, everyday whatever, you know, it's not right.... It's just the way I guess that they were raised. Since day one, it was put in their head that smoking is wrong even though I do it. Just because I do it doesn't make it right. It's wrong. (DS)

Similarly, a mother said, "That's kinda the way that I go about it. Like, just because I do it don't mean it's okay that I do. I know I shouldn't do it". (GV) Some parents implied or told their children that smoking is an adult behaviour and

not appropriate for children. A mother whose daughter had commented on seeing a teenager smoking had said to her, " 'I know, it's bad for you. They shouldn't be doing it. They're too young for it' ". (TH) Hard-line parents gave their children warnings that it would not be tolerated. "I'll suggest to them that 'I hope I do not catch you [smoking]'." (NC) Or, they told them about the punitive consequences they could expect if ever caught smoking. "If he smoked and I caught him... I told him this a few times... [I would] make him smoke every one of them and turn his stomach to give them up." (MB)

> I tell them, 'You better not go smoking anyway cause I'll come get you. I'll find you'. So, if they goes having a smoke they're looking around the corner to see if I'm there cause I got that put in their head, right. And, I just put it there and keep it there in a good way, you know, there's no harm, right. I tell them they'll get everything out of their room, all of their toys, the TVs, everything, gone.... And we always check their clothes and everything to make sure, right, smell clothes.... (AP)

Who interacted. Some of the parents in this category, while indicating that both they and their children's other parent made comments about smoking to their children, did not indicate whether they or the other parent were more involved in addressing the topic. One mother and one father suggested that because they felt so strongly about smoking, it was they, not their children's other parent, who commented mostly on the issue. The single mothers did not talk about their children's father.

Conditions that influenced the approach. The two conditions that influenced parents to interact with their children through telling them about the health effects of smoking and their opposition to it by responding on the spur-of-

the-moment if their attention was drawn to the issue by external cues are as follows (see Table 2, p. 123).

Belief concerning communicating with children about smoking: Hit home the message when the issue arises. Parents believed that smoking is an issue to which parents need to pay attention and address from time to time as well as on an as needed basis, that is, when the risk increases, such as with adolescence, or smoking actually materializes.

> ... when it's brought to our attention or if there's a feeling that we got to talk about smoking with them or [if] we smell smoke off of them, yes we would. Or, if they sat down and told me that one of their friends was smoking well then I'd go into the disadvantages of smoking and tell them there's no benefit in it. (AP)

They believed that when the matter arises parents need to "hit home" the message that smoking is "harmful" and "unacceptable".

Saliency of the issue: Smoking was in the back of parents' minds. Similar to the parents whose approach was to *discuss smoking with their children by intentionally taking advantage of opportunities*, these parents knew about the health effects of smoking. Rather than an emotional response, however, their response was more matter-of-fact, a gut reaction that smoking is "horrible", "disgusting", and "atrocious by far" (DS) so just "don't do it" (DS). For these parents, the issue was in the back of their minds.

Acknowledging to their children the negative effects of smoking: Responding only when their children brought it up. For a small group of parents, their verbal interaction with their children about smoking entailed acknowledging

the negative effects of the behaviour. These parents had a non-assertive style of interacting with their children about smoking in that they did not raise the topic or enter into a conversation with them. As one mother, who was referring to her 11 year old daughter, said, "... I just haven't really had a conversation about that yet". (HW) The parents simply acknowledged the negative attributes of the behaviour by confirming the children's understanding when the children raised it. Their method was to comment only when their children brought it to their attention. These parents had not taken on smoking as an issue. For instance, one mother said that the topic had come up with her daughter only since grade six and it was the daughter who raised it. Another commented that she did not know how she would approach the topic with her child because "I never really sat down and actually thought about what I would need or what I would need to say". (HW) Although these parents believed that in order to prevent smoking it is important for children to be informed, they did not take on an active role themselves. The properties that further define this approach are as follows.

When the interaction occurred. The parents' interaction with their children about smoking was dependent on the children bringing it up and was in the form of a response to questions or comments that the children made. As one mother, who was referring to her five year old, said, "I've never approached it.... He's had a few questions about what it is and so I've responded to his questions. I've never actually said anything just outright about it". (LA) Similarly, a father commented,

> I guess, I kind of will only enforce that smoking is bad or that smoking is not good for you if they bring it up.... Like usually you need like a lead into it, you know what I mean, and we never just, just sit down and talk about smoking. (KZ)

The children brought up the topic by making comments or asking questions when they were provoked by such things as having done something in school about smoking or having seen antismoking signage or someone smoking.

> ... most of the time it even comes up, it's probably because of something she's heard or learned in school and she's kind of bringing it to me.... she's talking about how it can turn your lungs black and what's in the cigarette. Stuff like that. (HW)

> ... my oldest son, he points out the non-smoking signs and he tells me you can't smoke here, it's not good to smoke and you shouldn't smoke here.... He kind of picked that up himself. I told him what it [the signs] was but he understands that smoking is not good and you shouldn't do it or you shouldn't do it in certain places. (KZ)

> .... They've approached me with it because they've seen their dad smoke.... If his dad gets his jacket on or whatever, he'll [son] ask him, 'Are you going for a smoke?' So, it's become normal to see his father smoking. So that's where his questions and thoughts about it have come from. He has seen cigarette butts on the ground and asked me from those kind of things why it's there and whatever. (LA)

Purpose of the interaction. Up to that point in their children's development, the parents had not given much consideration to smoking as an issue that needed their attention. However, they did not want their children to smoke, so their responses to them were to convey the message that smoking is not good for you or that it is harmful to health and that "no one should smoke". (KZ)

Intensity of the interaction. The parents had not initiated discussion with their children about smoking. They merely responded when their children raised it. Some of the children had noticed and asked about smoking before they were

school-age, others had not commented until they were older. Similarly, some of the children had raised the topic only occasionally, others had raised it often. A father said, "Yea, you can bank on it [coming up] probably once a week", (WI) mainly because the children noticed him smoking and commented.

Character of the message. The parents responded to their children's questions and comments by letting them know that they were correct about smoking and that smoking is not a good thing to do. As one father said,

> Well, I assure him that's he's right, like, 'hey you're right, you're not allowed smoking around here'. He'll say, most of the times, after he points out that there's a no smoking sign, he'll say, 'Smoking is bad for you' and I'm like, 'You're right, smoking is very bad for you'.... (KZ)

Similarly, a mother commented that she did not say anything to her daughter when the daughter talked about smoking except to let her know "... that she's right.... She'll come home [from school] and say, 'We saw pictures and their lungs are black, like black'. And, I say, 'Yea, I know' ". (HW) Their responses were routine rather than considered, and they did not offer extra detail or explanation about the behaviour or explicit information about the health effects. A father remarked,

> I'll tell my kids that smoking is bad and whatnot but it's not that I go in-depth really with it. I suppose where I've just said it lots of times it's just, you know what I mean, it's just running on type thing. (KZ)

A mother said that in response to questions that her five year had asked, she had

> ... told him, it's yucky and it's dirty. It's something that adults do and not all adults. I pointed out that I don't smoke. I pointed out who doesn't smoke and that most people don't. And, I think that is all that I've really

> said.... I haven't gotten to the health aspects of it yet cause I'm not sure how ready he is for those kinds of [things]. So it's more like his level, what he's asking and I respond to those. (LA)

The parents who smoked invariably had been confronted by their children about it. They had responded to their children by indicating that they knew that smoking was not good for them. The children had reacted in any of a number of ways such as questioning their parents as to why they smoked, pointing out the discrepancy between what the parents were saying and doing, and urging them to quit. A father said, "I try to tell them, when it comes up, that it's not good. It will make you sick. Of course they shoot back and say, 'Well why do you smoke?'.... and give me grief for smoking". (WI) Another father commented that sometimes when he replied to his son that " 'Smoking is very bad for you' ", the son retorted, " 'Hey, you smoke' ". (KZ) A mother said that her son had told her "that I should quit and he doesn't want me to smoke and it's bad for me and he wants me to be around to take care of him". (QF) The parents responded that "Yes, I know I shouldn't smoke" (KZ) or tried to appease the children by suggesting that they would like to quit or intended to do so. A father said, "I put them off and say 'Daddy's going to quit soon. One of these days daddy's going to throw them down'.... my famous escape is *soon*.... It's easy to brush it off and carry on to the next conversation". (WI) A mother said, "I do respond. Like, I tell him, 'I tried. I do try but it's really hard' ". (QF)

Who interacted. The parents in this category either did not comment on the involvement of their children's other parent in addressing the topic of smoking or indicated that the other parent also did not address smoking with the children to

any extent. One of the fathers, who currently smoked, was the spouse of a mother who also participated in the study. Although he thought that their children's knowledge about smoking and antismoking attitude had resulted from being taught in school about smoking, the mother had reported that she had intentionally discussed smoking with their children often and from an early age by taking advantage of opportunities.

Conditions that influenced the approach. The two conditions that influenced parents to interact with their children through acknowledging to them the negative effects of smoking by responding only when their children brought it up are as follows (see Table 2, p. 123).

Belief concerning communicating with children about smoking: Be supportive of the message when it comes up. Parents believed that there was no need for them to do anything more at the time except be supportive of the antismoking message by confirming it when it came up because their children already had received information about smoking through social sources. They thought that young children, in general, are exposed to antismoking messages in society through such sources as television and especially school. As a consequence, children know about the negative effects from an early age. A father's thoughts were, "I think it is well covered off in schools.... From kindergarten they're taught that it is not good and I think it's a good start". (WI) Similarly, a mother said, "They do talk about it in school every year and like a lot.... They're doing a really good job in school". (HW)

In particular, parents thought that their own children were adequately informed. Those whose children were young school-age thought that young children need only simple messages about smoking such as “it makes you sick”, (KZ) “it [is] yucky and gross”, (LA) and “smoking is not good for you”, (WI) and their children had received those messages. Similar to some of the parents who had interacted with their children either by *discussing smoking with them by intentionally taking advantage of opportunities* or *telling them about the health effects of smoking and their opposition to it by responding on the spur-of-the-moment if their attention was drawn to the issue by external cues,* these parents thought that detail about the serious effects and explicit messaging are more appropriate for older children as they can better understand and handle that type of messaging. Referring to her young children, a mother said,

> At 5, they can’t rationalize what lung cancer is or, you know, they don’t really understand sickness or anything that can come from it so a lot of those things they just wouldn’t understand. There’s not really much of a point to me in telling them that because it’s just going to confuse them and give them too much information.... At 5 years old, it’s not a good time for them to be thinking about death. As they get older, definitely they can start to rationalize a little better that, yes, everybody is going to die and that this might, you know, be the contributing factor, right.... Definitely not, not as young children should, should they be told those kinds of things.... Preadolescents, they can start to understand more of the health risks. (LA)

Similarly, referring to his young school-age children, a father’s thoughts were,

> I don’t think you really want to give them shock treatment either, go at it too hard.... Adolescents, you can bring on the pictures that you see on cigarette packages, the teeth, the cancerous lungs, the brain tumours. I think they’re old enough to swallow that. But a young age like where [children] are now I think that would be totally inappropriate. I think you’re going to scare them.... I think that’s the kind of shock treatment

> that adolescents need, you know, to bring it home. This can happen to you. (WI)

The parents of older school-age children thought that their children were very well informed about smoking. Referring to her daughter, one mother said, "She's after telling me stuff about smoking, I mean, I smoked and she'll come to me and tell me stuff I didn't really [know]". (HW) Another mother talked about being impressed with an essay her daughter had written about smoking as a part of her school work. She felt that her daughter "is well up-to-date on" the health effects and the reasons people smoke. (OD) The parents' perspective on talking with their children about smoking was reflected well in the statement of one mother, "It's already being talked about. What more do you do if it's after being talked about". (HW)

Saliency of the issue: Smoking was not on parents' minds. Similar to the parents whose approach was either to *discuss smoking with their children by intentionally taking advantage of opportunities* or *tell their children about the health effects of smoking and their opposition to it by responding on the spur-of-the-moment if their attention was drawn to the issue by external cues*, the parents whose approach was to *acknowledge the negative effects of smoking by responding only when their children brought it up* also had good knowledge of the health consequences. Although these parents did not condone smoking, they also did not respond emotionally to it. Their response was more neutral as reflected in the view that "I think everybody knows the cons of it, the health...." (WI) For these parents, smoking was not on their mind.

Outcomes of the Parents' Action and Verbal Interaction. The three main outcomes for parents that reflect how they felt and what they thought as a result of their action toward smoking and verbal interaction with their children about the behaviour are (a) feeling that they were doing their best to deter smoking, (b) feeling comforted by their children's knowledge and acceptance of the antismoking message, and (c) recognizing the need for continued effort by parents and society (see Table 3, p. 126). For two outcomes *feeling that they were doing their best to deter smoking* and *recognizing the need for continued effort by parents and society* there was variation according to the verbal interaction approach that the parents had taken with their children. For two outcomes *feeling that they were doing their best to deter smoking* and *feeling comforted by their children's knowledge and acceptance of the antismoking message* there was variation in what was experienced by the parents.

Feeling That They Were Doing Their Best to Deter Smoking. Regardless of the overall approach that they had taken, parents felt that they were doing their "best" to deter smoking. Those whose approach was to have a no-smoking rule and discuss smoking with their children by intentionally taking advantage of opportunities felt that they *had given their children a good foundation to make the right choice if confronted with the behaviour in the future*.

> …. I guess it's just if it's an ongoing educational thing in a family, maybe. I'm just hoping that it works out for us, that when she's a teenager she won't be any more inclined to smoke than what she is now. (AM)

> ... I would hope that it'll be something that they'll be able to actually make a choice on and hopefully choose not to but not something that they kind of drift into because everyone does. (PB)

> …. you're really making the decision for them when they're younger. And once they get to a certain age and they have money, they have their own mind, and you know, hopefully what you've given them for years and years and years will be a deterrent later on. (RD)

Those whose approach was to have a no-smoking rule and tell their children about the health effects of smoking and their opposition to it by responding on the spur-of-the-moment if their attention was drawn to the issue by external cues felt that they *had given their children a strong message to discourage smoking*. ".... We got them convinced... not to smoke.... they're to the point now they don't want to smoke. Smoking just turns them off now." (AP) Those whose approach was to have a no-smoking rule and acknowledge to their children the negative effects of smoking by responding only when their children brought it up felt that they *had reinforced the antismoking message*. "I'll get my point across for sure every time they ask about smoking. I'll make them understand that smoking is not good. No one should do it." (KZ)

The parents had not sought or used any particular smoking prevention resources in their efforts to deter their children from smoking. Rather, they were guided by personal knowledge about smoking, which they had acquired through their own experience, and general knowledge about smoking, which they had acquired over time, along with their belief concerning communicating with children about the behaviour. For instance, one father said that he was going by the advice that most people give which is "… 'talk to your kids'. Like sometimes you see it on television. Talk to your kids about drugs and stuff. I guess it's similar for smoking, you know". (XJ) Some parents thought that perhaps few if

any smoking prevention resources were available for parents because they had not come across any. “I don’t know if it’s out there from public health but if you’re not looking for that information sometimes you don’t see it. Maybe it’s there and I just haven’t seen it.” (ZL)

Questioning what they were doing. Although parents felt that they were doing their best, a few, spanning the three verbal interaction approaches and including parents who currently smoked, formerly smoked, and never smoked, wondered whether what they were doing was the most appropriate. They questioned in their own minds things such as whether their antismoking message was too strong or not strong enough, they talked about smoking too much or not enough, or they gave enough detail or not enough detail for the child’s age. “I’m wondering where you draw the line and like how much information you give them at what age and you kind of wonder okay if that was a little bit too much to say....” (AM)

> So they are well versed in what I have chosen to give them to work with. But whether it’s the right thing, I don’t know. What is the appropriate thing to tell any child about smoking... I’m a parent, I’m doing the best I can and I have no idea if it’s right or wrong. (OA)

> I don’t know like exactly what I should be saying, what I shouldn’t be saying in regards to like how strong do you get. If you’re not stern enough, well, maybe then they’ll think that it’s not a big issue. So, I don’t know where the border or guideline [is]... if you should bring it up on your own or if you should wait till the child brings it up on their own, or what, right. So, it’s kind of iffy like, you know.... (BQ)

Although they had not looked for resources, they acknowledged that they could benefit from having more information on youth smoking, prevention strategies,

and communicating with children about smoking and thought that a resource that they could use with their children would be helpful. "…. I feel you're doing it on your own type of thing, for the most part…." (IX) A mother commented that she would like to have an age appropriate book with simple language and pictures that she could use with her young children that

> …. stresses the dangers of smoking and what it does to you…. to explain what happens…. And, maybe it is something that is available. It's not something I ever went looking for…. I'd certainly like to have something else outside of me saying, you know, it makes you sick or it does this to you or it does that to you. I'd like to have something that I could actually show them and you know take them through, like, this is what a healthy heart looks like. This is what a heart that smokes looks like.... (CO)

Other parents had similar thoughts.

> .... I want to do my best obviously that I inform her so that she does not get easily led.... Sometimes I wonder that I am overly concerned and that may make her... unnecessarily worried more so than the average child would be.... So, you wonder whether or not it's overkill.... There is nothing carved into stone as to what you should or shouldn't do.... I would like to see something developed to help parents.... (IU)

> ... it's difficult for me to speak to my [children] about it as a smoker, telling them how it's not good for them. Once again, it's hypocritical. But, it would certainly be interesting to have some sort of a strategy that you could read up on, on how to approach it. I'd certainly have a look at it. Some sort of a guideline for a smoking parent to, how to speak to your children about it. (WI)

> If there is a way that we could almost know what they were going to ask then we would be prepared for their questions. I know that, that would be something difficult because once he [son] gets older he can form more sophisticated questions. I don't know that I'm necessarily going to be able to answer him or that I'll be ready for them because sometimes they just surprise you with a question out of the blue. So, I don't know, some kind of reading materials, [to] maybe know what they're going to ask, when they're going to ask, when is the right time to broach things with them. I know there's not, never really a right time but, you know, what age can they handle what or, you know. (LA)

Despite their misgivings, however, these parents seemed to have reconciled their uncertainty by accepting that they were handling the issue the best they knew how. “I mean, I don’t know, I guess you just have to do your best.” (AM)

Feeling Comforted by Their Children’s Knowledge and Acceptance of the Antismoking Message. Parents were feeling comforted and somewhat encouraged by the fact that their children understood and accepted the antismoking message. As one mother said, her child’s response led her to feel that “… we did something right or I like to think we did. At this point anyway, I like to think we did....” (EQ) At the very least, the children knew that smoking is unhealthy and can make people sick. Depending on the extent of the information conveyed to them by their parents and what they had gathered from other sources, such as school and public antismoking measures, some knew about specific health consequences including that smoking can cause serious illnesses such as cancer and even can cause death. “If we are driving in the car and they see someone smoking, I’ve heard them say, ‘That guy’s gonna die. He’s gonna die from smoking. Look at him [brother], he’s gonna die’.” (OA)

Children varied in the intensity of their acceptance of the antismoking message from being “receptive” to “internalizing” it. Those who were receptive demonstrated it through any of a number of actions; for example, they engaged in conversation with their parents about smoking or showed interest in the subject by asking questions and making comments about it. “When they ask me questions themselves I find it helpful because it makes me feel like they’re interested in my opinion and they’re interested in how I feel about smoking, and they do bring it

up…." (CR) Many displayed an "antismoking" attitude, or as one mother said a "non-smoking attitude", by making negative comments such as "smoking stinks" and "smoking's yucky". Children who had relatives who smoked expressed concern about them. A mother talked about her sons' reactions when they became aware that their uncle smoked. "[They] asked me about it and they said, 'He might get sick. Doesn't he know?'.... So, they're really aware of that connection…." (PB) Children accepted what their parents said about smoking without making counter arguments.

> They generally are very receptive to it. Yea, then they'll give other examples of things that they've seen and they have never presented a counterpoint. They'll make comments and it will be in support of one or more of the comments that I've said. For example, 'Yes, mommy because I've seen this', or whatever, you know, 'I agree' or 'That was horrible', you know…. (VH)

Children also indicated that they would not smoke. "I said, 'What do you think about smoking?'…. and he said, 'I'll never smoke. It'll make me sick'." (PB)

The children who had internalized the antismoking message displayed an even stronger acceptance of what they had learned. They were quite knowledgeable about smoking and could "make a very strong case for not smoking" based on the health facts. (ZL)

> My 9 year old is dead-set against smoking. I bet you, if you do a questionnaire on her… she'll tell you all of it, the risks, and she'll tell you what it's like and what she don't like about it and all this.... (NC)

The children were ardently opposed to smoking as demonstrated by their antismoking attitude, or as one mother said "surprisingly strong opinions", (RG)

and behaviour. “He has noticed kids smoking and he says to me, ‘Mommy, why do they do it?’ and I say, ‘Well, what do you mean [son]?’ and he goes, ‘Why would you pay money for somebody to kill you?’ ” (RG) The children made negative comments about smoking, such as it is “disgusting” and “gross”, went out of their way to avoid tobacco smoke, and demonstrated antismoking assertiveness with family members who smoked.

> …. She has a real aversion to smoke. She puts her hand over her face. She’ll hold her nose. She’ll hold her breath. She’ll avoid people. Like, if we are going into an entrance, she’ll make a wide loop around anyone that she sees smoking or if she catches the whiff of smoke she’ll say ‘ooohhhh’…. she gives people a wide berth if she knows that they’re smoking. (AM)

> .... He tells all of us. He just says stuff like, ‘You’ll get cancer. You’re going to get cancer’. Cause, of course, that’s everywhere you look and he’s old enough. I mean he’s been reading since like when he started kindergarten.... So, you couldn’t really keep anything from him cause he’d read the cigarette packages and he’d read the labelling on it and he’d say ... ‘Cigarettes cause lung cancer. Why are you smoking if it causes lung cancer? Why would you do that?’ And he knew stuff. He’ll say that to us, you know. ‘This is what’s going to happen to your teeth. This is what’s going to happen to your lungs.’ So, I’m hoping that he remembers that when he gets a teenager and someone passes him a cigarette. (TI)

> My stepfather smokes and even when she’s around him ... He’ll smoke outside and come back in and just the smell off him. You can see the face on her. Like, she’s really [assertive] and gets up in his face and says, she’ll get up on his lap and say, ‘How come you smoke? Do you know that’s bad? Do you know ... what they put in that? Rat poison ... we learned in school that’s in tobacco too.... You shouldn’t do that. You should quit’. (HW)

The children expressed concern about relatives who smoked and wanted to encourage them to quit or actually tried by telling them about the dangers of smoking.

> They [children] actually have one uncle who smokes ... and they saw him recently ... and they were shocked. And, they started asking me about it and why he smokes.... 'Does he know how bad this is?'.... They're really concerned about their uncle and 'Does he know this [about the diseases it causes]...?' They hope he is going to give it up.... (JV)

A mother talked about how it was her daughter's influence that had been the impetus for her and her husband to quit smoking.

> A big thing for my daughter is I find they do a lot of stuff in school which is why … we quit. She'd always come home and be really talking about what's in the tobacco and how it can hurt you and then she'd be really in your face all the time saying 'please'. We actually quit on the day of her birthday. That's how much she really got on our backs.... She's really like antismoking. She thinks it's really bad and it's really disgusting.... As soon as she was old enough to realize, I guess, what we were doing and that she didn't want us doing it, it didn't take her long to try to get us to quit.... She was so anti, like wanting us to quit, hopefully she won't want to do it herself.... She really, really, really doesn't want us to smoke. So that's why I'm hoping that if she's like this now, she's going to stay like that and then not want to pick it up herself. (HW)

The children were acutely aware of the "issue" and tended to comment when they saw someone smoking. "Right now I'm just glad that she does have the message. That's the biggest thing. She does have the message and she does talk about it. Anytime that she sees someone she will definitely comment on it." (IU)

> I remember one time we were leaving the [mall] and there was a woman standing with two kids and as we were walking out … [daughter] … looked up at me, 'MOM that woman was smoking around two little kids. Do you think they're her kids?' And, I figured I was going to get a shoe in the back of the head or something like this, right. 'Do you think they are her kids? She is smoking.' (AM)

They were tuned in to the issue perhaps even more so than were their parents. "…. They notice it even more than I do…. " and their "… views on smoking are even stronger…." (ZL)

Concerned about their children's response. Some of the parents whose children had internalized the message, although pleased that their children were antismoking, had concern about their children's response. All were parents whose approach was to discuss smoking with their children by intentionally taking advantage of opportunities. These parents felt that they had to be careful about the message they conveyed for one or two reasons. They did not want their children to inappropriately tell others that they should not smoke and they did not want them to think negatively of people who smoked. "My seven year old daughter, if she sees someone smoking she wants me to go up and talk to them or she wants to, herself, to tell them that they shouldn't do it…." (JV)

> My little boy will get so worked up that I have to stop him from marching up to other people and telling them not to smoke…. That's one of the reasons why I don't want to come on as strong as I do because I don't want him to get up on a soap box and start. (RG)

Some children already had demonstrated such behaviour, which the parents had to try to temper.

> And, you know, you just have to guide them in that direction, that even though other people do make bad choices, it's up to her the choices she makes, but she cannot tell other people what they can and can't do…. there was a lady smoking and she went straight up to her … and said, 'You know that smoking can make you sick'….. Most people do not get upset when a child, but still you have to make them know that they can't just go up to strangers. (IU)

> Friday, I took the two of them [children] to [a restaurant] and there was a guy out there smoking and I knew what he [son] was going to say. And as soon as we came out [son] said, 'Mom, look he's smoking'. And I [said], 'Ssshh [son], don't say anything'. So when we came out he said, 'Hey, you put that cigarette down'. And I said, '[Son], this is a young man you are talking [to]. You can't tell other people not to smoke. That's none of

> our business'. 'Yea, but mom it's gross.' I said, 'Yea, it is really gross but still we can't tell strangers not to smoke'. (ET)

As well, some children already had acquired the view that people who smoke are "bad" people and the parents felt that they now had to correct that inadvertent misperception. They wanted their children to have the understanding that the behaviour is not good for health but people are not bad because they smoke.

> I find that because of what I've said to my kids, now when they see someone that's smoking they think they're a bad person and that's the kind of thing that I'm trying to now work around…. So, then I've got to try to backtrack and work around that to say, no. I mean they can't just stigmatize people because they smoke, or think of them as less of a person, or look at them negatively. Like, I try to separate the person from the act. So, I've tried to use that approach. But I don't know if it's working. I still kind of think that they are looking at people in a bad way because they smoke and I don't want them to do that. You know, you just kind of want to distinguish that the smoking is bad. It's not that they're a bad person. Like they ask me if the smokers are robbers? They ask me that. So, they are connecting that and I don't want them to do that. I really don't want to go too heavy on the smoking then because I don't want them to be looking at people that negatively…. That's the hardest thing I'm finding now. Yea, how to educate them without them, you know, looking down on people. (JV)

Recognizing the Need for Continued Effort by Parents and Society.

Although parents felt that they were doing their best to deter smoking and they were feeling comforted by their children's knowledge and acceptance of the antismoking message, they recognized the need for continued effort, both on the part of parents and society.

Parents have a continuing responsibility to do what they can to deter smoking. Parents knew that smoking was possible and at some level wondered whether their children would stay smoke-free when they were older. Some

thought that smoking was more of a remote possibility because their children were so against it. Others thought that the possibility was more likely, despite their children's current negative reaction to it. "And generally I'm wondering if they just tow the line. 'Yes, mommy I'll never smoke' and they might." (PB) ".... It's just one of those things where, you know, I'm sure in one way, shape or form, they all probably try it, even if they try it just to see what it's about." (GV) Hence, they thought that because of the continuing threat that may become more pronounced at adolescence, parents have an important continuing "responsibility" to do what they can to deter smoking.

> Well it is still the parent's responsibility, if one of the children is smoking or not smoking. I mean you can't leave it up to everybody else, even though it is in school ... and on TV sometimes and advertised, [that's] not the point. It's still your responsibility to teach them the difference. (TH)
>
> ... say from 10 years old to say 18, 19 years old, if you can save them [in] that period of time like when the peer pressure is there all that, [if] you can save them from that, I think you're pretty well in the clear then. I do, right. And that's your responsibility because from the age of 10 to 18 they're your responsibility anyway. So do what you can, I guess.... (AP)

To that end, parents whose approach involved discussing smoking with their children by intentionally taking advantage of opportunities recognized the need to *maintain open communication about smoking*.

> I've always talked to my kids, hopefully at a level they could understand. I got in early on this stuff, you know, around drugs and alcohol and smoking and even sex. I mean as much as they can understand…. I have really had just open communication at the child's level is where I've been with it and that's what I hope I'm going to be able to continue on…. (VH)
>
> I really think that you shouldn't give up letting them know that it's not a good thing.... If you don't approach it early and with consistency, you

> know, just like any other thing that you want your child to learn and grow with, then don't be surprised [if they start smoking]. (RD)

Parents whose approach involved telling their children about the health effects and their opposition to it by responding on the spur-of-the-moment if their attention was drawn to the issue by external cues thought that they would need to *continue to be vigilant as their children get older in order to curb any tendency to smoke.* "... stay on top of it ... inquire about it and always check what they're into...." (AP) Parents whose approach involved acknowledging to their children the negative effects of smoking by responding only when their children brought it up thought that they would need to *step up their effort as their children become adolescents*.

> …. When they get adolescents that's when you come on hard…. I think children will be children and they are going to experiment at some point. So, you know, when that point [adolescence] does come, well I mean, that's when you have a talk to them. (WI)

Regardless of the degree of their "doubt", it was their awareness of any of several characteristics of youth smoking and, for some, their understanding of adolescent development that provoked it. Parents knew that social influences, in particular peer pressure and negative role modeling, play a part, especially as children get older. Many were in the situation of having smoking in their families. They either smoked themselves or their children's other parent, grandparents, aunts, uncles, or cousins smoked; in some cases multiple family members smoked. As one mother said, along with her son's father who smoked, "…. he [son] is surrounded by men in this family who smoke, my brothers, [husband's]

brothers, both grandfathers". (CO) Some parents recognized that children, especially adolescents, may begin to smoke despite knowing the health facts and having had a negative attitude toward it.

> Well, really it's a real concern for me because … children in grade 1, grade 2, and grade 3 ... know that smoking is harmful. They know that it's dangerous. They know that it causes cancer and then when I ... drive past the high school ... I see all these kids outside smoking. And, it just, it really bothers me that somewhere along the way they forget the message or the message just doesn't seem as important to them anymore. And, I just, I find that really disconcerting as a parent.... But, it just seems to be that there is still an idea out there that despite knowing that it is not good for you, it's still an okay thing to do. (BN)

Some recognized that children begin to smoke despite having parents who do not approve of the behaviour.

> …. I think I was, we were pretty heavily influenced not to smoke. I mean my dad smoked and my mom didn't but my mom ... was pretty rabid. Like my dad was never allowed to smoke in the house. We never had smokers in the house. She was, you know, it was constant. It was bang, bang all the time.... So, I do think that, being a former smoker, you can [smoke] even though you're educated about it at a very young age and certainly it was a big deal in our family ... you can still succumb ... and smoke.... (PB)

> My mother [smoked]. My father never smoked. My father despised cigarettes from day one and always told me never to smoke and he was adamant that we would never smoke as children, seeing the effects that it was having on our mother.... I didn't smoke in front of my father for years.... I hid smoking from him because I knew how much he despised it. I mean obviously he knew I smoked and sometimes he'd bring it up to me and I'd deny it. (FU)

Some non-smoking parents were mindful of the fact that children may begin to smoke despite growing up with non-smoking parents and in a non-smoking home. "Because my children grew up in a non-smoking house, I don't think I can be confident that, you know, they're not going to do it because they didn't grow up

with it....” (DP) The realization that they may not be protected from the possibility of their children smoking was strengthened for some parents by the fact that their children had, on at least one occasion, pretended to be smoking.

> ... they’ll pretend that they’re smoking. They’ll say, ‘Look, I’m smoking’ and then they’ll mimic the blowing out which obviously they must have seen that somehow, you know. Like, I guess, they see it in the media. They see other people smoking. So, they’ve never witnessed it in their home but they already know how to role-play. (DP)

In general, the parents, regardless of their smoking status, who had observed their children pretending to smoke were disturbed by the behaviour. Although seemingly innocent, they wondered whether it was a precursor of things to come.

> And then she’ll say, ‘Look mom, I’ve got a cigarette’ and I’m like ‘Yea, that’s yucky honey, that’s gross’. And she’ll say, ‘Oh, it’s just pretend’. So I’m hoping that that’s not like a sign of what’s to come. (TI)

Some parents thought that adolescents are particularly vulnerable to smoking because of their need to fit in or, simply, their developmental perspective, which reduces inhibitions about harm. “I guess time will tell, cause I know there are so many pressures on them when they get older.” (JV)

> …. they’re [adolescents] affected by so many other factors outside of your control. They’re affected by their friends, what their friends are doing. It’s not necessarily they pick up smoking because they want to smoke.... if you had a child who was one who needed to be part of the group and everybody in his group smoked then, you know. So that’s what’s difficult about it. It’s not something that’s under your control really. I mean, at this stage, yes it is because they don’t have friends at 6 and 7 who are smoking. So, I mean, all you can do is tell them the bad and what happens to people who smoke but as they get older, you know, there are other things that come into play. (CO)

> …. I think they must think in terms of, you know how you have a sense of immortality when you're young; that it won't really hurt me, that I can smoke and I can quit when I want to or whatever. (FR)

Some believed that despite their best intentions, they may not command as much influence once their children become adolescents because of adolescents' need for independence and tendency to rebel against parental authority. Talking to them about smoking may be challenging. "…. Adolescence, now that's going to be, maybe take a different turn, you know, smoking is not that bad but parents are always getting on about it." (VH) "…. I think sometimes teenagers do it to rebel against their parents because they know their parents don't want them to do it." (ZL)

> I would say at 6 and 7 they'll be more concerned with my opinion of them as well as their friends' opinion of them than when they're 12 and 13…. I suspect that at 12 and 13 if they're in the midst of rebellion, my opinion is the last and least concern. It's their friends, their associates, how they look, the right shoes, the right clothes. (OA).

Society needs to take more responsibility for preventing smoking among children. Parents thought that because they can do only so much *society needs to take more responsibility for preventing smoking among children*. "…. I think we need to be more… and not just parents, all of society needs to be more vigilant about not letting them smoke and I think like.... All society should be concerned about youth smoking. Very concerned." (TI) Children may be more inclined to accept a message that is received through different sources. As one mother said, "…. They'd know that it's [the message] everywhere. It is not just the parents that might bring those values". (UG)

Parents generally were pleased with societal efforts in recent years to curb smoking.

> I think that the public is making so much awareness now with smoking…. I mean when I was their [her children] age I didn't even think about smoking like as a bad thing. I just thought of it well everybody is doing it. But now it is like everybody is being taught against it. (YK)

> ... remember like years ago there used to be ads on TV with smoking. You'd see buddy really enjoying himself out having a cigarette up in the mountains and stuff like that. None of that's permitted anymore. Or, on the radio, it's not permitted. In magazines, there's no more cigarette ads ... and I think that's actually helping parents. It's all the awareness that's around us right now about smoking. And, not only that, on cigarette packages, did you see the pictures and stuff [graphic warnings] that they print on cigarette packages? Like, that's really good advertising [against smoking]. (YK)

However, they identified areas where further work needs to be done, which essentially were in terms of regulations and smoking prevention education. Some thought that regulations should be strengthened to reduce access of children to tobacco. Some thought that the same was needed to reduce exposure of children to the behaviour. These parents knew that even though youths were not legally permitted to purchase cigarettes, children still were accessing them because they continued to see youths smoking. "I still think they're too easy to get. I really think cigarettes are still just too easy to get." (TI)

> .... you pass by the school and they're smoking and you go over by work and they're smoking, so somebody is giving them the cigarettes.... Same as it was when I was [growing up]. It was complicated back then but you still got around it. You found ways to get them.... (FU)

> I think it [buying cigarettes] should be like a liquor store. I think you shouldn't be allowed to walk in there unless you're 19. They shouldn't sell cigarettes in convenience stores. That's what I would think. That would save on some kids getting hold [of cigarettes]…. (MB)

Because they believed that exposure of children to smoking is a risk factor for the behaviour, some wanted to see tighter regulations to restrict public visibility of the behaviour such as a ban on smoking in the vicinity of entrances to public buildings or even a total ban on smoking in public areas.

> …. I think of smoking and how we banned it from public buildings…. Anyhow, it's also extremely visible to children then because there's these collections of people outside buildings now smoking which of course you have to walk through. And, so I think, yes, it was a good idea to ban smoking and in public work places but, on the other hand, I certainly didn't want to create these other things that have happened, that do have an impact on our children and on other people. (RG)

However, the area that parents thought would produce the greatest impact is smoking prevention education. When they were growing up there was little emphasis on smoking prevention in society generally. For many, aside from perhaps being told or warned not to smoke, their own parents had not raised the subject or talked with them about it. "That's like my parents, they never ever talked to me about smoking when I was growing up. Never." (MB) Parents believed that a lack of education about the health consequences was a main cause of the high rate of smoking in the past.

> My parents smoked. Everybody did in my family and not enough information I guess about it to deter me and my parents never, ever told me that... They'd tell me not to do it but they didn't tell me why I shouldn't do it and I think that was the big thing because to tell me not to do something is, okay, well, why shouldn't I do it, you know. And, I didn't know why I shouldn't. (TI)

They thought that "education is the best tool" (ET) for prevention. They recognized that there had been more smoking prevention education in recent years, but many thought that it was not enough, especially at the school level.

Some wanted more done at the community level and identified children and parents as key targets.

The parents' position about school was based on their impression that little smoking prevention education currently was being carried out in the early grades. They thought that school is a good avenue for getting the message to children and that smoking should be covered early and often in the school curriculum. "I would certainly like to see some kind of program done in the schools, in their primary level, kindergarten to grade 3, because I think that's when the children are most impressionable...." (IU)

> I think that school is really important. They need to hear the message in school as well, and they need to hear it not just once a year. It needs to come up on a fairly regular basis as part of the health program or whatever and I think it needs to start in kindergarten and repeat the message regularly and loudly every year until they reach that vulnerable you know grade 6, grade 7, grade 8, grade 9, whenever it is that they are most likely to be taken in by it.... (BN)

> … I think getting the schools to do more in-depth programs whether it be, like say, have a week where they have stuff going on to teach kids. And, then, like I said, sending stuff home so we can then continue it at home after they come home from school. And, kind of have the school backing us up while we back the school up ... Like, actually have stronger information out there rather than me sitting on the couch just trying to come up with something off the top of my head. So, I think the school should definitely have something out there that's strong and substantial. (GV)

Likewise, parents who thought that the topic had been covered well in their children's particular schools acknowledged the important role of schools in smoking prevention.

The parents who thought that there should be more initiatives at the community level that are directed to children suggested things such as prominent billboard messages or advertisements in movie theatres and the media. They thought that television advertisements against smoking were a particularly good way to get the message across to children. “I find that TV ads, it’s a very powerful medium.” (OA) Their perception, however, was that there were very few such advertisements and they were unable to recall any specific ones. “You don’t see a lot of advertisements against smoking. You really don’t. You sit down and watch television. There’s very little about smoking. Very little.” (CO) They were of the impression that advertisements that had been aired were directed to adolescents and adults, but antismoking messages also should be produced for young children and conveyed through children’s television programming.

> I think there’s like one commercial out now, like an antismoking commercial. You don’t see a lot. It’s not in your face all the time and especially on younger children’s programming, younger children’s stations. If there was more TV coverage, TV commercials of antismoking, giving antismoking messages, the kids would be seeing it at a younger age. But, you don’t [see it].... They don’t put out the antismoking messages as much now. But, [having it] in children’s programming time slots would be a definite positive. (IX)
>
> .... Children spend an awful lot of time in front of the TV so if the message is there as well and they’re seeing it and it’s in a media that they’re going to, you know, respond to or sort of take the message in, that’s really important. (BN)

Some parents were of the view that there needs to be an ongoing prevention initiative at the community level to increase parent awareness of the problem of and facts about youth smoking, inform them about the important role that they can play in smoking prevention, and guide their approach.

> There should be some kind of program or resource centre or something to help the parents who probably don't have the right, I guess, angle to take to go towards that topic or right route to take to discuss certain topics, especially smoking. (DS)

Although they were comfortable with what they were doing themselves, they thought that there may be parents who do not address smoking with their children. They suggested that smoking prevention education materials be readily available to parents through such venues as schools and health clinics.

> … health information in written form that's easily accessible to parents on tips on how to talk to children about smoking and tips to increase your child's chances of being a non-smoker. Like, you know, in doctors' offices and in the schools and things like that, that people can easily access…. (LX)

> ... another good idea would be like a video, you know, like a video for parents to sit down with their children to watch, you know, talking about the dangers and stuff of smoking. That'd be a good idea. (ET)

Some suggested that to increase the chances that parents are actually informed, smoking prevention materials should be distributed to them by health or education authorities as a routine measure and on a regular basis.

The Context for Parental Continuing Action and Verbal Interaction.

The parents' feelings and thoughts as a consequence of their action and verbal interaction are not endpoints but represent dynamic internal processes. Although some parents were uncertain about the appropriateness of the verbal interaction approach that they had taken with their children and some were concerned about their children's strong response to the antismoking message, in general, parents felt that they were doing their best to deter smoking and felt comforted by their children's knowledge and acceptance of the message. However, they recognized

the need for continued effort and thought that parents have an ongoing responsibility to deter the behaviour. These feelings and thoughts gave them reason to continue their effort and as such contributed to the ongoing context for their continuing action and interaction to deal with the latent danger (see Figure 2, p. 120).

A Possible Negative Case

The parent whose approach did not completely fit the theory was the father of a late preadolescent child. He was a former smoker who had quit smoking before becoming a parent. Because it is unclear as to whether his approach represents a true negative case, it has been labelled a possible negative case.

Like other parents in the study, this parent had a no-smoking rule to avoid ETS. However, it is not certain as to whether his rule also was in place to limit exposure of his child to smoking such as was the case with other parents in the study. In identifying factors that influence children to smoke, his emphasis was on access to tobacco and peer pressure. He did not raise exposure to smoking as a possible influencing factor. More information would be necessary to clarify whether his reason for having a no-smoking rule also included avoiding exposing his child to the behaviour.

What was most obviously different about this father compared with other parents in this study is that he did not verbally interact with his daughter about smoking and did not perceive smoking as a latent danger for her. Although,

similar to other parents in this study, he had knowledge of the serious health effects of smoking and factors that contribute to youth smoking and did not want his child to smoke, he had never raised the topic or discussed smoking with her or said anything at all about it to her. He thought that his wife also had not discussed smoking to any extent with their child. Consistent with his impression that she had not played an active role, the wife, who also was a participant in the study, had conveyed that she acknowledged the negative effects of smoking when the daughter had brought it up but had not done anything more.

This father had not addressed smoking with his child as he thought there was no need because she had good knowledge of the health effects of smoking and had demonstrated an antismoking attitude. His daughter had learned about smoking through school. “I feel she knows pretty much about them [dangers of smoking] now anyway.” “I think she knows the messages. Smoking kills, diseases, heart disease, and cancer.” He remarked that she did not ask questions about smoking but if she did, he and his wife would “talk about it. But, other than that we don’t. We don’t make it an issue”. The daughter made negative comments about smoking when she noticed or was exposed to it and promoted an antismoking message with her grandparent who smoked. “ ‘Pop, if you never smoked, you’d live much longer’, she said.” “… she says smoking stinks … when I take her down to Dad’s, as soon as she comes [home], ‘Pop’s house stinks of smoke’.... she made out a list of what smoking does and showed her grandfather....” Because of her good understanding of smoking and antismoking attitude, he believed that she would never smoke, hence, not a latent danger. “I

don't talk to her about it. She knows the dangers and that, right. I don't think she'll ever smoke." "Not the way she acts now like [about] people smoking and that…." "… I can't imagine her smoking."

What makes it difficult to determine whether this case is a true negative case is that although it is different in some respects from other approaches in this study, it also shares similarities. What makes it seem like a negative case is that the father did not interact at all with his child about smoking and did not perceive smoking to be a latent danger for her. Although they varied in the style and method they used, all the other parents in this study had verbally interacted in some manner with their children about smoking in an effort to deter the latent danger. However, some of those parents, the ones whose approach was to acknowledge to their children the negative effects of smoking by responding only when their children brought it up, had interacted minimally. Like the father here, they too had not raised the topic with their children and they did not think there was need to do more at the time because their children already were adequately informed about smoking. Those parents were dependent on their children to bring up the topic. Similarly, the father here indicated that he would talk about smoking with his daughter if she asked questions, but she did not. This parent may have perceived smoking as a latent danger for his daughter had she not been so well informed. It may be possible, then, to conceptualize this case, not as a negative case, but as a variation within the verbal interaction approach *acknowledging to their children the negative effects of smoking by responding only when their*

children brought it up and represented by the category *not addressing the topic of smoking at all*.

Summary

Although there was one case that did not completely fit, the predominant findings from the parents represent a substantive theory that explains how they communicated with their children about smoking. The meaning that parents applied to youth smoking is that it is a latent danger. The meaning was shaped by their knowledge of the health effects of smoking and their knowledge of the nature of youth smoking. Parents knew that although their children were not smoking at that point in time, the possibility was there for them to start in the future. They did not want their children to smoke and to deter the behaviour they communicated with them by taking action in the form of a no-smoking rule to decrease exposure to the behaviour and by verbally interacting with them on the subject. Their verbal interaction consisted of discussing smoking with their children by intentionally taking advantage of opportunities, telling their children about the health effects of smoking and their opposition to it by responding on the spur-of-the-moment if their attention was drawn to the issue by external cues, or acknowledging to their children the negative effects of smoking by responding only when their children brought it up. Their action and verbal interaction produced outcomes for them in the form of feelings and thoughts that contributed to the context for their continuing intervention. The findings of this study have implications for further theory development and research and for health promotion practice, which are discussed in Chapter 6.

Similarities and Differences Between Professionals' Perspectives and Parents' Perspectives and Practices Concerning Youth Smoking Prevention

There were some similarities between professionals' perspectives on smoking prevention for children and parents' perspectives and practices with their children. There also were differences between professionals and parents. However, in general, both professionals and parents thought that parents, school, and society at large have important roles to play in youth smoking prevention.

The Role of Parents

The nursing and NGO professionals' perspective was that for an effective approach, parents need to both talk with their children about smoking and take action to reduce their children's exposure to the behaviour. Although there was variation among the parents in what they had done, and except for one parent, they had interacted verbally, in some manner, with their children about smoking and had a no-smoking rule. The lack of verbal interaction of the parent who was the exception represents a possible negative case.

Verbal interaction. The professionals' view was that parents have the main responsibility for educating their children about smoking. That perspective was demonstrated in two of the verbal interaction approaches taken by the parents, namely talking with their children about smoking by intentionally taking advantage of opportunities and telling their children about the health effects of smoking and their opposition to it by responding on the spur-of-the-moment if their attention was drawn to the issue by external cues. Although different in style

and method used, those parents had taken it upon themselves to address smoking with their children. The parents whose approach was to acknowledge to their children the negative effects of smoking by responding only when their children brought it up had not initiated interaction with their children to address the topic of smoking. However, regardless of the extent of their involvement with their children, parents across the three different approaches accepted responsibility for educating their children about smoking. They thought that they had a continuing responsibility to do what they could to deter smoking as their children get older.

While the nurses and NGO professionals thought that smoking prevention education should come from parents first and foremost, they also thought that many parents may not address smoking, to any extent, with their young children. Some parents had a similar view. Although they were comfortable with what they were doing themselves, they thought that there may be parents who do not address smoking with their children. In fact, the parents in this study whose approach was to acknowledge the negative effects of smoking by responding only when their children brought it up had not addressed smoking to any extent with their children and one parent had not addressed it at all. The other parents had addressed smoking at least periodically through either discussing it with their children by intentionally taking advantage of opportunities or telling their children about the health effects of smoking and their opposition to it by responding on the spur-of-the-moment if their attention was drawn to the issue by external cues. Some of those parents had addressed it often. The parents whose approach was to acknowledge the negative effects of smoking by responding only when their

children brought it up conveyed that the reason they had not done more was that their children already had an adequate understanding of smoking, which they had received through social sources including school. That explanation is consistent with the professionals' view that parents may not address smoking with young children because they think it is being dealt with in school.

Other reasons that professionals thought could explain parents' failure to adequately address smoking were that parents do not know the facts about youth smoking and do not view it as a relevant issue for young children. Contrary to those views, parents in this study actually had good knowledge of youth smoking, including about risk factors and children's vulnerability to the behaviour, and had acknowledged the relevance of the issue for young children. They recognized that smoking is a greater risk for adolescents than for younger children but thought that it also is possible for younger children to start smoking. Indeed, some had personal knowledge based on having tried or actually started to smoke before they were adolescents or having relatives or friends who had done so. Some, even recently, had seen preadolescents who were smoking. The parents had not looked for resources to assist them in intervening with their children about smoking, which was consistent with the professionals' observation that parents rarely sought help to proactively deal with the issue. However, they all had interacted in some way with their children about smoking, based on what they thought was best. Their interaction, regardless of extent of involvement, further indicates that they viewed smoking as a relevant issue even for young children.

Despite their misgivings about parental involvement in smoking prevention education, the nurses and NGO professionals thought that parents can have an effect through addressing the behaviour with their children. They suggested that parents talk with their children from an early age and often but not too much, use open communication, use a casual approach by taking advantage of opportunities or teachable moments, and not be authoritarian. That perspective mirrored what the parents whose approach was to discuss smoking with their children by intentionally taking advantage of opportunities believed and did in relation to verbal interaction with their children. It differed, however, from the approaches taken by the other two groups of parents. The parents whose approach was to tell their children about the health effects of smoking and their opposition to it by responding on the spur-of-the-moment if their attention was drawn to the issue by external cues differed most notably from the professionals' perspective by their directive style of interaction. Rather than engaging their children in conversation about smoking, those parents simply told their children what they thought of the behaviour and what they expected of them. The parents whose approach was to acknowledge to their children the negative effects of smoking by responding only when their children brought it up differed most notably from the professionals' perspective by their tendency not to actively pursue the topic with their children or have explicit discussion with them about it.

***Character of the message*.** Nurses and NGO professionals thought that antismoking messaging should be age-appropriate with simple messages about health and healthy living being the focus for young children to avoid causing

them undue concern and messages about serious health effects being reserved for older children, those nearing or at adolescence. The teachers held a similar view. Interestingly, although the approach of the parents who discussed smoking with their children by intentionally taking advantage of opportunities was consistent in many respects with the perspective of the professionals, there was inconsistency with regard to age-appropriate messaging. Some of those parents stressed the importance of age appropriateness, and to avoid alarming their children, they were cautious about what they told them. Other parents in that category always gave a strong message to their children, even young children, which included information on serious health effects. There was similar variation among the parents whose approach was to tell their children about the health effects of smoking and their opposition to it by responding on the spur-of-the-moment if their attention was drawn to the issue by external cues. Some of those parents kept their messages about the health effects simple for their young children; whereas, others talked about the serious health effects of smoking regardless of their children's age. As well, although the parents whose approach was to acknowledge to their children the negative effects of smoking by responding only when their children brought it up did not engage in discussion with their children about smoking, at least some were of the view that young children need only a simple message about smoking and that messages about the serious effects are more appropriate for older children.

There also was similarity between professionals and parents in terms of the content of the message. In addition to knowing about the health effects,

nursing and NGO professionals thought that older children need to know about the factors that influence children to smoke, in particular peer pressure and addiction. Further, they need guidance on how to resist peer pressure, and parents who smoke should discuss with their children their experience with smoking and addiction in an effort to help the children understand why they are continuing to smoke. The approach of the parents who discussed smoking with their children by intentionally taking advantage of opportunities most resembled the professionals' point of view as they tended to discuss various aspects of smoking including influencing factors. Indeed, the parents who smoked, across the three verbal interaction approaches, at least acknowledged to their children that they knew that smoking was not good for them and they should not smoke, and most indicated to them that they would like to quit or intended to do so.

Action. Both professionals and parents thought that it is important to have smoking restrictions to limit exposure of children to the behaviour. Nursing and NGO professionals were of the view that parents should have non-smoking homes and vehicles to send the message that smoking is unhealthy and unacceptable and that such a rule is especially important in homes where there is a parent who smokes. Although parents had a no-smoking rule, some, including smoking parents, had a stricter rule than did others. Those parents totally prohibited smoking in their homes and vehicles and endeavoured to avoid exposing their children to smoke and smoking in general. Other parents were less inclined to try to avoid all exposure. Some of those parents, including smoking and non-

smoking, smoked themselves or permitted smoking in their homes when their children were not present.

The Role of Schools

Both professionals and parents considered schools to be a good avenue for getting a smoking prevention message to children. However, the professionals' impression was that smoking prevention education may not receive as much attention in schools as is necessary. In particular, the teachers noted that smoking prevention education was not a required component of the curriculum for the primary grades and thought that even in the elementary grades coverage may be limited. Some parents held an opposing view. They thought that schools were doing a good job in teaching children about smoking and that their children, including young children, had received good education about smoking from their schools. Other parents held a view similar to that of the professionals. Specifically, they thought that little education was carried out in the early grades and wanted to see more done at the primary level. Indeed, similar to the perspective of the professionals, parents in this study were of the opinion that smoking should be covered early and often in school and integrated throughout the grades.

The Role of Society

Both professionals and parents were of the view that for greatest effect, the larger society has to share responsibility for youth smoking prevention. The NGO professionals and some parents wanted to see stronger social policies. They identified youth access to tobacco products and exposure to pro-smoking

messaging as requiring more attention. The professionals highlighted exposure from sources such as movies and marketing as problematic; whereas, the parents highlighted exposure in public places.

The professionals did not comment on the need for smoking prevention efforts at the community level, aside from the need for resources to assist parents in addressing smoking with their children, but some parents wanted to see more education initiatives. Some wanted more in the form of advertisements for children and thought that antismoking messages should be produced for young children's television programming. Some were of the opinion that there needs to be ongoing prevention initiatives directed to parents to inform them about youth smoking and their role in prevention and to guide their approach. Similar to the nurses and NGO professionals' impression that there were few, if any, resources specifically for parents about youth smoking, some parents also thought that perhaps there were few because they had not come across any. Interestingly, although most of the parents in this study were comfortable with what they were doing to deter their children from smoking, a few wondered whether their approach was the most appropriate. They thought that they could benefit from a resource to guide them. Other parents, even though they did not identify the need for themselves, thought that smoking prevention resources should be readily available to parents. Parents and professionals had similar ideas about how to reach parents. They thought that venues such as schools and health clinics and direct distribution to parents by health or education authorities are good ways to make resources available and accessible to parents.

Conclusion

The principle finding from this study was a substantive theory, derived from data gathered from parents, that explained how parents communicated with their children about smoking and is represented by the category *Dealing with a latent danger: Parents communicating with their school-age preadolescent children about smoking*. There was one parent whose approach deviated from the theory. Because it is not clear as to whether that approach represents a negative case or represents a variation within the approach *acknowledging to their children the negative effects of smoking by responding only when their children brought it up*, it has been labelled a possible negative case.

Another important finding in this study was derived from the professionals' perspectives. The professionals thought that *smoking prevention requires a multipronged approach involving parents, school, and society*. Most of the professionals had occupations that involved some aspect of smoking prevention or tobacco control and had expertise in the field. It is not surprising then that they held such a view.

What perhaps has more significance is that, although there were some differences, there was close congruence between professionals' and parents' perspectives. Parents also thought that parents, school, and society have important roles to play in smoking prevention. The similarity may reflect the context for smoking in which both the professionals and parents were situated. Much attention has been paid in recent years to smoking prevention. Public policies and education have increased public awareness of the health risks and the importance

of youth smoking prevention (Health Canada, 2002; Health Canada, 2006a; USDHHS, 2004a) and may have increased awareness generally of the importance of intervention at the three levels, namely, parents, school, and society. The professionals thought that parents are a young child's most important influence and have the main responsibility for educating their children about smoking. Although they differed in the extent and quality of their interaction with their children about the topic of smoking, parents' acceptance that they have a responsibility to deter their children from smoking is congruent with the view of the professionals. Of the three verbal interaction approaches that parents in this study used, discussing smoking with their children by intentionally taking advantage of opportunities closely matches the suggestions offered by the nursing and NGO professionals about talking with children concerning smoking; whereas, the other two approaches differ from their suggestions. The parents in this study also had a no-smoking rule to limit exposure of their children to smoke and smoking, albeit, some parents had a less stringent rule than that suggested by the professionals.

CHAPTER 5

DISCUSSION OF THE FINDINGS

Although parental communication with children about smoking was examined in some previous studies, generally the focus was narrow and a comprehensive examination to gain an in-depth understanding was not carried out. By and large, the studies were about communicating with adolescent or late pre-adolescent children and many were from the children's perspectives. No studies were found in the literature about parental communication with young school-age children concerning smoking. Further, no theories were found that explain the phenomenon of parental smoking-specific communication. Although parental communication, in general, is considered to be foundational for various child outcomes, including behavioural and psychosocial outcomes, there also does not appear to be a theory in the literature that is specific to that concept (Miller-Day, 2002; Riesch, et al., 2000). Often, parental communication has been described as an aspect of a broader concept such as parenting style, mindful parenting, parent-child relationship, parental socialization of children, or family functioning (e.g., Baumrind, 1991; Darling & Steinberg, 1993; Dixon, 1995; Duncan, Coatsworth, & Greenberg, 2009; Jackson, Bijstra, Oostra, & Bosma, 1998; Russell, Mize, & Bissaker, 2002; Wen, et al., 2009). This study addresses the knowledge deficit concerning smoking-specific communication with school-age preadolescent children.

The findings represent a substantive theory that explains how parents communicated with their children (see Figure 2, p. 120). Parents perceived

smoking to be a latent danger for their children. That meaning was influenced by their knowledge of the serious health effects of smoking, the result of which was that they wanted their children not to smoke. It also was shaped by their knowledge of the nature of youth smoking, which heightened their awareness of the vulnerability of children to the behaviour. They recognized that smoking was more prevalent in adolescents but knew that it also could occur in younger children. So, although it had not emerged, the possibility was there. To deter the behaviour from becoming manifest, parents communicated with their children by way of taking action and verbally interacting with them on the topic.

Their action was to have a no-smoking rule to protect their children from ETS and to limit their children's exposure to smoking. Their verbal interaction consisted of discussing smoking with their children by intentionally taking advantage of opportunities, telling their children about the health effects of smoking and their opposition to it by responding on the spur-of-the-moment if their attention was drawn to the issue by external cues, or acknowledging to their children the negative effects of smoking by responding only when their children brought it up. The parents' action and interaction produced outcomes for them in the form of feelings and thoughts that contributed to the context for their continuing action and interaction to deal with the latent danger. Although they felt that they were doing their best to deter smoking and were comforted by their children's knowledge and acceptance of the antismoking message, they recognized the need for continued effort, both on their part and by society more generally.

In essence, to deal with the threat, parents took action and verbally interacted with their children. They thought that society, including school, also has a responsibility for preventing smoking among youths. Likewise, the professionals in this study thought that parents, school, and society in general all have a responsibility toward smoking prevention for children. To correspond with these themes, the following discussion of the findings is divided into four main sections, which are parental action, parental verbal interaction, role of school, and role of society.

Parental Action

Parents in this study had a no-smoking rule to limit exposure of their children to ETS and smoking. However, the strictness of the rule varied, with some parents having a stringent rule and other parents being less stringent. Parents who had a stringent rule, including current, former, and never smokers, held strong views against exposure to ETS and smoking, were opposed to any exposure of their children to smoking, had a total ban on smoking in their homes and vehicles, and made a point of not exposing their children to ETS and smoking in places outside their homes. This is similar to the findings in other studies that the more negative parents' attitudes were toward smoking (Proescholdbell, et al., 2000) or ETS exposure (Yousey, 2006), the more likely they were to have greater restrictions on smoking.

Parents in this study who had a less stringent rule tended not to require total avoidance of tobacco smoke and smoking. For instance, some had partial restrictions in that they prohibited smoking in their homes and vehicles when their

children were present but otherwise allowed it. Parents who smoked did not take precautions to conceal from their children what they were doing. Former and never smokers in that group, although opposed to exposure to ETS and smoking, had a less stringent rule to accommodate a spouse or other relatives who smoked. There is evidence in the literature of smoking being more permissive in homes where there was a smoker than in homes without a smoker (e.g., Hill, et al., 2003; Kegler, et al., 2007).

Conditions that influenced parental action. Parents knew that ETS is harmful to health and that smoking in the presence of children had become socially unacceptable. That knowledge was the main reason for their no-smoking rule. It has been demonstrated in other studies that parents had knowledge of the harmfulness of ETS and it influenced them to have restrictive household smoking rules (e.g., Binns, et al., 2009; Herbert & Schiaffino, 2007; Hill, et al., 2003; Kegler, et al., 2007). Parents in this study also had knowledge of factors that put children at risk for smoking including modeling of the behaviour. Parents who smoked acknowledged that they were a negative example.

It is well accepted that ETS is harmful to health (Health Canada, 2006b; USDHHS, 2006) and that exposure to smoking is a risk factor for youth smoking because of modeling and perceived social acceptability of the behaviour (Alesci, Forster, & Blaine, 2003; Corbett, 2001; Turner, et al., 2004). The greatest potential exposure of children to ETS is in the home and the most effective measure against it is a complete ban within the home (Akhtar, et al., 2009; Biener, et al., 1997; Health Canada, 2005b, 2006b, 2007d, 2008e; Spencer, Blackburn,

Bonas, Coe, & Dolan, 2005; Yousey, 2006). Consequently, and consonant with the position of nursing and NGO professionals in this study, it is recommended that homes and vehicles should be completely smoke-free and parents who smoke should not do so in the presence of their children (e.g., American Academy of Pediatrics, 2009; Ferguson, 2009; Health Canada, 2005b, 2006b, 2008e; Ontario Ministry of Health Promotion, 2009).

There is some research evidence to support the importance of avoiding exposure of children to smoking. Although there is inconsistency in findings, with some studies indicating no effect of household rules on youth smoking (e.g., Berg et al., 2009; Castrucci & Gerlach, 2006; den Exter Blokland, et al., 2006; Engels, et al., 2005), in many studies restrictions on exposure to smoking were found to be protective for youth smoking (e.g., Bernat, et al., 2008; Bricker, et al., 2005; Clark, et al., 2006; Kodl & Mermelstein, 2004; Rainio & Rimpela, 2007). It is difficult to know the meaning of the discrepancy among studies because of differences in study methods. However, where household smoking rules were found to be important, a complete ban on smoking in the home was more effective than a partial ban (Clark, et al., 2006; Farkas, et al., 2000; Powell & Chaloupka, 2005; Szabo, et al., 2006).

That the parents in this study had knowledge of the harmfulness of ETS and, consequently, had a rule to limit exposure of their children to tobacco smoke may reflect the increased attention in recent years, at the societal level, to raising awareness of the health effects of and reducing exposure to ETS. Prominent initiatives which have taken place include legislation, which prohibits smoking in

public places and workplaces, and mass media campaigns about ETS and the effects on children. There is evidence suggesting that these initiatives have made a difference. Whereas in the past it commonly was the case that parents did not have any restrictions on smoking in their homes (e.g., Biener, et al., 1997; Clark, et al., 1999), consistent with the findings in this study, many parents now at least have partial restrictions with the majority having a total ban (e.g., Binns, et al., 2009; Kegler, et al., 2007; Muilenburg & Legge, 2009; Rainio & Rimpela, 2007; Thomson, et al., 2005; Yousey, 2006). For example, in Canada exposure of young children to ETS in the home has declined considerably in recent years, from 33% in the mid 1990s to 5% in 2009 (Health Canada, 2007d, 2010a).

Parental characteristics. There were no apparent patterns in this study of parental smoking status or parental socio-demographic characteristics for a stringent or less stringent no-smoking rule. There is evidence in the literature that parents who smoked were more likely than non-smokers to not have a rule or to have a less strict rule (e.g., Berg, et al., 2009; Binns, et al., 2009; Bricker, et al., 2005; den Exter Blokland, et al., 2006; Engels & Willemsen, 2004; Fearnow, et al., 1998; Harakeh, et al., 2005; Herbert & Schiaffiano, 2007; Kegler, et al., 2007; Kodl & Mermelstein, 2004). However, there were only nine smoking parents in this study and that may have precluded such a relationship from being detected. The evidence in the literature with respect to the relationship of parental socio-demographic factors to parental household smoking rules is not clear. Low family income, non-intact family structure, and less parental education were associated with not having a smoking ban or having less strict rules and were unrelated to

smoking restrictions (e.g., Binns, et al., 2009; Kegler, et al., 2007; Proescholdbell, et al., 2000; Rainio & Rimpela, 2007; Thomson et al., 2005; Yousey, 2006).

Parental Verbal Interaction

In addition to having a no-smoking rule, parents in this study verbally interacted with their children by using particular interaction styles and methods. At the least, parents had acknowledged to their children negative effects of smoking. Some had given more information and many had discussed the behaviour in-depth.

Parental verbal interaction style. Although there does not appear to be a theory that is specific to parental communication with children concerning the topic of smoking or a theory that is specific to more general parental communication, one which may be used to examine parental communication is Parenting Styles theory as proposed by Baumrind (1968, 1991, 1993). Parenting styles refer to sets of general characteristics by which parents differ from one another in their behaviours toward their children. The four styles, which represent varying levels of demandingness (i.e., limit-setting and behavioural control) and responsiveness (i.e., nuturance), are authoritative, authoritarian, permissive, and rejecting-neglecting parenting. Inherent in parenting style is communication style, which is defined by effectiveness and directionality (e.g., Baumrind, 1991; Darling & Steinberg, 1993; Holmbeck, Paikoff, & Brooks-Gunn, 1995).

Authoritative parents have a balanced approach of demandingness and responsiveness. They encourage verbal give-and-take with their children and

expression of opinions and provide explanations for their assertions and decisions, rather than just give orders. They are assertive while at the same time being supportive and not intrusive or punitive (Baumrind, 1968, 1991, 1993). It may be said, then, that authoritative parents engage in good quality communication. Good quality communication has such attributes as attentive, responsive, acceptant, open (two-way exchange of ideas), meaningful, honest, nonjudgmental, non-punitive, and relaxed. It is considered to be more effective for positive child outcomes than communication that is characterized by such attributes as one-sidedness (lacking verbal give and take), superficial, strained, conflictual, controlling, judgmental, or punitive (Dixon, 1995; Jackson, et al., 1998; Riesch, et al., 2000; Robin, 1992; Russell, et al., 2002).

Authoritarian parents have higher levels of demandingness than responsiveness. They exercise their power and expect their rules and orders to be obeyed without having to give an explanation. They maintain tight control over their children's behaviour and are likely to provide punishment for failure to conform to their expectations and rules. Permissive parents are more responsive than demanding. They tend to provide little guidance, are nondirective, and place few demands or controls on their children. They are warm and affirmative toward them, avoid confrontation, and use little punishment (Baumrind, 1968, 1991, 1993). The communication approaches of authoritarian and permissive parents would be considered to be of a quality that is not most conducive to favourable child outcomes. Rejecting-neglecting parents are neither demanding nor responsive. They put forth minimal effort in their parenting role and essentially

are uninvolved with their children. This pattern of parenting would be considered to be devoid of good communication and is associated with detrimental child outcomes (Baumrind, 1968, 1991, 1993).

The interaction styles that the parents in this study used with their children concerning the topic of smoking share a resemblance with parenting styles. It is important to note that parenting styles were not examined in this study, so it is not possible to know whether the interaction styles exhibited by the parents in relation to the topic of smoking are direct reflections of parenting styles that they may have had in interacting with their children more generally. However, how they verbally interacted with their children about smoking, in other words their styles, is coherent with the inherent communication characteristics of authoritative, authoritarian, and permissive parenting styles.

The majority of parents interacted with their children by discussing smoking with them, which reflected an open style. Parents believed that communication with children should be an open dialogue to engage children in discussion that is objective and not, as they described it, “heavy-handed”. They viewed open dialogue as the basis for an informed choice about smoking and a positive parent-child relationship. Their style fits with communication characteristics of authoritative parenting.

Other parents used a directive style in their verbal interaction with their children about smoking. Parents believed that the message that smoking is harmful and unacceptable needs to be “hit home”. They did not engage in

conversation with their children about smoking, as such, but let them know their thoughts. These parents communicated about smoking by simply telling their children about the health effects and their opposition to it. They made their children aware that they were against smoking or told them, in no uncertain terms, that they expected them to not smoke. The style of those parents matches communication characteristics of authoritarian parenting.

The remaining parents, who comprised the smallest group, had a non-assertive style of verbal interaction with their children about smoking. Parents believed that all they needed to do at the time was be supportive of the antismoking message that their children already had received through other sources. Consequently, they did not raise the topic or enter into a conversation but simply acknowledged to their children the negative effects of smoking by confirming the children's understanding of the behaviour. The style of those parents resembles communication characteristics of permissive parenting.

Clearly the parents in this study whose interaction style was to discuss smoking were demonstrating communication that is considered to be good quality. Indeed, the manner in which they verbally interacted with their children about smoking is consistent with recommendations by authorities in the field and the suggestions offered by the nurses and NGO professionals who also participated in this study. The consensus is that parents should engage their children in open, honest, and nonthreatening conversation about smoking while listening to and respecting child input. Parents should not lecture or nag children about smoking but let them know that they believe in their ability to make the best

choice about the behaviour. Conversation with children about important issues such as smoking is facilitated by a warm and supportive parent-child relationship (e.g., Health Canada, 2008e; Ontario Ministry of Health and Long-Term Care, 2003; USDHHS, 2009). Only one study was found in the literature that is relevant to parental interaction style in discussing smoking with children. The study involved adolescents and the findings revealed that when the quality of the discussion was high, in terms of being constructive, equal, and respectful, the adolescents were less likely to engage in smoking (den Exter Blokland, et al., 2009; Harakeh, et al., 2005).

Parental verbal interaction method. While parental interaction style may be examined in relation to Parenting Styles theory, parental verbal interaction method may be examined in relation to another general parenting model, that of Mindful Parenting. Mindful parenting is a relatively new concept in the parenting literature with little empirical investigation to date. Although there does not appear to be a fully developed theory about the role of mindfulness in parenting, the model proposed by Duncan, Coatsworth, and Greenberg (2009) is useful to understanding how mindful parenting may be beneficial to the parent-child relationship that in turn affects child outcomes. Mindfulness is viewed as "a quality of consciousness.... a receptive attention to and awareness of present events and experience.... involves being fully aware of what is occurring in the moment...." (Brown, Ryan, & Creswell, 2007, p. 211-214). Theoretical and empirical literature provides support for a beneficial effect of mindfulness on health, well-being, and functioning in physical, psychological, and interpersonal

domains, respectively (Brown & Ryan, 2003; Brown, et al., 2007). Mindful parenting encompasses five dimensions: "(a) listening with full attention, (b) nonjudgmental acceptance of self and child, (c) emotional awareness of self and child, (d) self-regulation in the parenting relationship, and (e) compassion for self and child" (Duncan, et al., 2009, p. 258). The listening component of mindful parenting entails a focused attention and awareness to accurately perceive the child's behavioural cues and verbal communication. Mindful attention and awareness permit parents to respond with deliberation to what is occurring in the present moment rather than responding with automaticity, in other words, with automatic or habitual thoughts, feelings, or actions. It is believed that acting with automaticity, or mindlessness, leads to a less than optimal parent-child relationship (Dumas, 2005; Duncan, et al., 2009).

It is not possible to know whether the interaction methods that the parents in this study used with their children concerning the topic of smoking reflect differences in mindfulness, as mindful parenting was not examined. However, their methods, or what they did to interact with their children about smoking, share similarity with characteristics of mindful parenting or the converse, automaticity.

The parents' interaction methods corresponded with particular interaction styles. Those whose style was to discuss smoking with their children did so by intentionally taking advantage of everyday ordinary opportunities. Smoking was foremost in their minds and they had conscious intent to address the topic with

their children. Their considered method, along with their open style of verbal interaction, fits with characteristics of mindful parenting.

Parents whose style was to tell their children about the health effects of smoking and their opposition to it did so by responding on the spur-of-the-moment if their attention was drawn to the issue by smoking-specific external cues. Smoking was in the back of their minds and whether it was raised was random rather than being deliberately planned. Their more hit-or-miss method, along with their directive style of verbal interaction, is inconsistent with mindful parenting and fits with characteristics of automaticity.

Parents whose style was to acknowledge to their children the negative effects of smoking did so by responding only when their children brought up the topic. Smoking was not on the minds of those parents in that they did not have a strong emotional reaction to cause them to take on an active role, at that point in time, in addressing the topic with their children. The lack of forethought in their method, along with their interaction style, which reflected limited engagement with their children and tendency towards routine responses, fits with automaticity.

As was the case with their style, the method of the parents who discussed smoking with their children by intentionally taking advantage of opportunities is consistent with advice by smoking prevention authorities including the nursing and NGO professionals who participated in this study. It is recommended that to address smoking, parents should proactively take advantage of opportunities that

arise in everyday situations. Conversations do not have to be formal but can occur at any time that parents and children are together (Health Canada, 2008e).

Other characteristics of the verbal interaction approaches. In conjunction with interaction style and method, there were particular characteristics which further defined the interaction approaches taken by the parents in this study. Although those mainly differentiated the approaches, there were some commonalities between approaches.

Parents whose approach was to discuss smoking with their children by intentionally taking advantage of opportunities started talking with their children at an early age and talked about it at least periodically to ensure that it stayed in their children's minds. Their emphasis was on health effects including effects that were directly relevant to their children's personal situation such as effect on asthma and sports activity. To show the health effects, some parents talked about real-life situations such as the illness or death of a family member. Parents also tended to discuss other aspects of smoking including influencing factors such as peer pressure and addiction. The two parents who smoked talked about their personal addiction. Some formerly smoking parents had told their children or planned to tell them about their own smoking experience because they thought it was a good teaching strategy. Others were unsure as to whether they would share their experience in case it would be a negative influence. The parents had given an honest message based on the facts about smoking. Taken as a whole, it may be said that parents who discussed smoking with their children by intentionally

taking advantage of opportunities were inclined toward a comprehensive approach.

Parents whose approach was to tell their children about the health effects of smoking and their opposition to it by responding on the spur-of-the-moment if their attention was drawn to the issue by external cues had commented about smoking before their children were school-age. Although some had commented only occasionally over time, others had commented often. Their emphasis was on informing their children about the health effects of smoking and ensuring their children knew that they were against the behaviour. Parents who were more hard-line in their approach made unqualified, rather than more exact, statements about the serious health consequences of smoking. Both formerly and currently smoking parents had commented on their own smoking in an effort to reinforce the health message.

Parents whose approach was to acknowledge to their children the negative effects of smoking only when their children brought it up had not raised the topic themselves. They had responded to their children's comments or questions by confirming the children's understanding of the behaviour. However, they had not offered extra detail about the behaviour or explicit information about the health effects. Those who smoked indicated to their children that they knew smoking was not good for them and they should not smoke or they would like to quit or intended to do so.

Although no studies were found concerning younger children, there is evidence in some studies that many parents at least raised the topic of smoking with their late preadolescent and adolescent children (e.g., Baxter, et al., 2009; Bush et al., 2005; Butler, et al., 2009; Chassin, Presson, Rose, Sherman, & Todd, 1998; de Leeuw, et al., 2008; Ennett, et al., 2001; Miller-Day, 2002; Muilenburg & Legge, 2009; Riesch, et al., 2000; Tang, et al., 1999; von Bothmer & Fridlund, 2001; Wyman, et al., 2006). It is difficult to tell from most studies how much parents talked with their children and the type and range of content. However, similar to some of the parents in this study, it was noted in other studies that parents did not talk often about smoking with their adolescent children (de Leeuw, et al., 2008; Riesch, et al., 2000). Only 8.4% of parents of 10 to 16 year olds reported that they talked a lot with their children about smoking (Chassin, Presson, Rose, Sherman, & Todd, 1998). While 91% of parents of 10 to 11 year olds reported that they had spoken to their children about smoking, some described the level of child engagement and variety of topics as not high (Beatty, et al., 2008). Like many of the parents in this study, it seems that the main focus of any parental communication with children about smoking was on health consequences, although parental expectations against smoking or warnings not to smoke, financial cost, and peer pressure were addressed in some cases (Ennett, et al., 2001; Miller-Day, 2002; Throckmorton-Belzer et al., 2009; von Bothmer & Fridlung, 2001).

As with style and method, it is characteristics of the approach whereby the parents discussed smoking with their children by intentionally taking advantage of

opportunities that most closely match smoking prevention recommendations including what the nurses and NGO professionals in this study suggested. It is recommended that parents begin to discuss smoking with their children at an early age, ideally before age 5, to start shaping their attitudes and beliefs, and talk about smoking in many conversations (American Academy of Pediatrics, 2009; Ferguson, 2009; Health Canada, 2008e; Ontario Ministry of Health and Long-term Care, 2003). Although there does not appear to be a specific recommendation about whether parents who formerly smoked should raise and discuss with their children their past experience with smoking, it is argued that it is important for parents who smoke to talk with their children about smoking, as parents who smoke still can have influence against the behaviour. Parents should talk about how and why they started smoking, how they wish that they did not smoke, the power of addiction, and the difficulty of quitting. They should let their children know that they know it is bad for their health and they should ask their children not to make the same mistake that they had made (Health Canada, 2008e; Ontario Ministry of Health and Long-term Care, 2003). Of note is that all of the parents in this study who smoked, across the three verbal interaction approaches, at least acknowledged to their children that they knew that smoking was bad for them and they should not smoke.

Some of the parents in this study took into account their children's developmental level and tried to give age-appropriate messages. These included parents whose approach was to discuss smoking with their children by intentionally taking advantage of opportunities and parents whose approach was

to tell their children about the health effects of smoking and their opposition to it by responding on the spur-of-the-moment if their attention was drawn to the issue by external cues. Similarly, some of the parents whose approach was to acknowledge to their children the negative effects of smoking by responding only when their children brought it up were of the view that young children need only a simple message and messages about serious health effects should be reserved for older children. Other parents did not regard age-appropriateness. Those parents gave a strong message about serious health effects irrespective of their children's age. This was the case both for some parents whose approach was to discuss smoking with their children by intentionally taking advantage of opportunities and some whose approach was to tell their children about the health effects of smoking and their opposition to it by responding on the spur-of-the-moment if their attention was drawn to the issue by external cues. The recommendation by authorities, which is what nursing and NGO professionals in this study also suggested, is that parents should take a developmental approach to discussing smoking with their children (Health Canada, 2008e; USDHHS, 2009). However, there does not appear to be any hard-and-fast rule about what to discuss with children at particular ages. It is suggested that since children mature at different rates and since parents know their children best, they may have a better sense of what is appropriate at different ages for their own children (Health Canada, 2008e). General advice is that parents should (a) provide facts about the health effects of smoking, starting with simple messages at an early age such as smoking smells bad and it can make people sick; (b) bring children's particular

interests into conversations in a meaningful way to show how smoking can be harmful such as how it can affect their physical activities; (c) share real personal and family stories with children such as a family member's smoking-related illness; (d) talk about peer and other social influences such as smoking in the media; (e) help pre-adolescent children learn how to deal with peer pressure that may become prominent during adolescence; and (f) let children know how they feel about the behaviour and why and that they disapprove of it (American Academy of Pediatrics, 2009; Health Canada, 2008e; Ontario Ministry of Health and Long-term Care, 2003).

Two characteristics of parental smoking-specific discussion that have been examined for effect on youth smoking are content, or what was discussed, and extent, which refers to how much or how often smoking was talked about. In a study whereby adolescents reported about their parents' discussion with them, what was discussed made a difference. Adolescents were less likely to have ever smoked when their parents had talked about health risks of smoking and breathing in smoke and the addictive qualities of smoking. They were more likely to have ever smoked when their parents had talked about not being allowed to smoke, the price of cigarettes, and friends smoking (Huver, et al., 2006). When parents were asked directly about their smoking communication with their adolescent children, findings revealed that talking about family smoking rules did not have an effect on their children's smoking status. Their children were more likely to be current smokers when the parents talked about the consequences of breaking family rules or expectations against smoking (Komro, 2003). It is not clear from those two

studies why some content was not effective or was counter-productive, but a possible explanation is that adolescents may be more receptive to factual information about health effects that are commonly accepted than to other discussion that they may perceive as judgmental, rule-laden, or impinging on their freedom.

Studies of the extent to which parents talked with their children about smoking have not yielded consistent findings for children's smoking outcomes. Based on children's reports, less communication with their parents about smoking was associated with greater smoking onset for elementary school-age children (Jackson, 1997; Jackson & Henriksen, 1997) and greater lifetime and current smoking for adolescents (Otten, Engels, & van den Eijnden, 2007). In a number of studies, an effect for frequency of discussion on youth smoking was not evident among pre-adolescent or adolescent children, either when the variables were reported by children or by parents (e.g., den Exter Blokland, et al., 2006; Engels, et al., 2005; Ennett, et al., 2001; Huver, et al., 2007a; Kodl & Mermelstein, 2004; Miller, et al., 2006; Thompson & Gunther, 2007). Surprisingly, in some studies, the more frequently that parents communicated with their adolescent children about smoking, the more likely the adolescents were to smoke, regardless of whether it was examined from the children's or parents' perspectives (e.g., Harakeh, et al., 2005; Huver, et al., 2006). It is difficult to determine the meaning of these mixed findings because of differences in study methods including different measures of frequency.

Although it is recommended by authorities on smoking prevention, which include nursing and NGO professionals in this study, that parents talk with their children about smoking often or in many conversations, what is meant by often or many is not defined but appears to be equated with the advice to take advantage of any and all opportunities (Health Canada, 2008e). Likely, effectiveness of communicating with children about smoking is dependent on a balance of optimal style, content, and frequency, with messages matched to the child's developmental level. No studies were found in which those factors were examined to determine the best balance.

Conditions that influenced parental verbal interaction. The impetus for the parents' verbal interaction with their children about smoking was their knowledge of the health effects of smoking and knowledge of youth smoking. It also was their knowledge of youth smoking and, for some, their understanding of adolescent development that provoked parents to think of smoking as a continuing threat that could become more pronounced during adolescence and consequently to think that parents have a continuing responsibility to do what they can to deter the behaviour.

Aside from direct personal experience as a result of being a current or former smoker or knowledge as a result of having relatives or friends who smoked, the generally good knowledge of the parents in this study about the health effects of smoking and about youth smoking may reflect efforts in recent years, at the societal level, to provide public education about smoking and prevent the behaviour among youths. There have been a number of initiatives including

social policies (e.g., legislation prohibiting the sale of tobacco products to minors, restricting promotion of tobacco products, and requiring graphic warnings on tobacco products) and mass media campaigns (e.g., advertisements about the health effects of smoking and youth smoking).

Whether the knowledge base of the parents in this study is reflective of the knowledge that other parents have about smoking is difficult to know. No recent studies were found in which parental knowledge about smoking, and more specifically youth smoking, was examined. There were a few studies in which parental beliefs about the health effects of smoking or about youth smoking were assessed (e.g., Chassin, Presson, Rose, & Sherman, 1998; Clark, et al., 1999; Fearnow, et al., 1998; Kegler & Malcoe, 2005; Kodl & Mermelstein, 2004; Robinson & Kirkcaldy, 2007a). Although it was noted that some parents held weak or misinformed beliefs about health effects or the nature of youth smoking (Clark, et al., 1999; Kegler & Malcoe, 2005; Kodl & Mermelstein, 2004; Robinson & Kirkcaldy, 2007a), it is difficult to determine the extent to which their beliefs reflect accepted knowledge because of insufficient detail about the beliefs.

The parents in this study knew that social factors can influence children to smoke. Peers and parents were identified as especially important. Although what they thought varied among them, other factors parents considered important included that adolescents are particularly vulnerable to smoking because of needs and challenges associated with that developmental period, which also may reduce parental influence; children, especially adolescents, may begin to smoke despite

knowing the health facts and having had a negative attitude toward it; children may begin to smoke despite growing up with non-smoking parents and in non-smoking homes; and children may begin to smoke despite having parents who do not approve of the behaviour.

Numerous studies have been carried out on youth smoking and a large number of correlates have been identified including social, developmental, psychological, personality, and genetic factors (Avenevoli & Merikangas, 2003; Lindsay & Rainey, 1997; Moolchan, et al., 2000; Turner, et al., 2004; Tyas & Pederson, 1998; White, et al., 2003). It is well established that smoking by peers is a risk factor for youth smoking, and although there is inconsistency in research findings, it generally is accepted that smoking by parents also is a risk factor (Avenevoli & Merikangas, 2003; Turner, et al., 2004). Similar to the view of parents in this study, parents and youths in other studies, including tobacco users and nonusers, have reported that they considered parental smoking to be a negative influence for children (Binns, et al., 2009; Denham, et al., 2004; Gittelsohn, et al., 2001; Kegler & Malcoe, 2005; Nilsson, et al., 2009; Plano Clark, et al., 2002).

Consistent with the thinking of parents in this study, it is recognized in child development theory that adolescence is a time when peers become especially important and influential and youths may be more inclined to test parental authority or advice and conform to peer behaviour (Holmbeck, et al., 1995; Steinberg, 2001). Adolescents spend more unsupervised time with friends than do younger children, which heightens possibilities for risk or problem

behaviours (Holmbeck, et al., 1995). Indeed, adolescence is the key period for initiation of smoking. A large majority of people who have ever smoked started by age 19 (Health Canada, 2008a; 2008e). However, it is argued that it is important for parents to stay involved and responsive to their adolescent children because even within the context of greater peer influence parents can retain primary influence (Cox & Harter, 2003; Holmbeck, et al., 1995). Indeed, that parents can make a difference to children's behavioural outcomes is the generally accepted position in the literature on parenting (e.g., Baumrind, 1993; Collins, Maccoby, Steinberg, Hetherington, & Bornstein, 2000; Galambos, Barker, & Almeida, 2003; Holmbeck, et al., 1995; Maccoby, 1992; Okagaki & Luster, 2005).

With respect to smoking, then, the view held by parents whose approach was to discuss smoking with their children by intentionally taking advantage of opportunities that it is important to maintain open communication during adolescence is coherent with the argument in the literature. Further, the parents' view is consistent with the recommendation that parents not only should start talking with their children early about smoking but should continue talking with them throughout childhood and adolescence (Health Canada, 2008e). Similar to what some of the parents thought, the rationale for that position is that as children get older they may change an earlier negative view of smoking to a more positive one, especially at transition times such as when they start junior high or high school. As some of the parents suggested, it is important for parents to be attentive to the issue and not assume that their children are protected because they

themselves do not smoke and they disapprove of the behaviour (Health Canada, 2008e). There is some evidence that parents of adolescents who smoked had not expected it and were unprepared for it because they themselves were non-smokers and their children had been opposed to smoking when they were younger (Small, et al., 2002). Although the tendency is for youths who smoke to come from families where a parent smokes, some who smoke may have non-smoking parents (e.g., Pederson, et al., 1998; Peterson, et al., 2006; Small, et al., 2002). Similarly, although parental disapproval of smoking is regarded as protective, in some studies it did not have an effect on youth smoking (e.g., Dalton et al., 2009; den Exter Blokland, et al., 2006; Ennett, et al., 2001; Tilson, et al., 2004).

Parental characteristics. Little is known about parent characteristics that influence their smoking-specific interaction with their children. In this study, while parental knowledge was found to be important, it is not possible to draw any conclusions about smoking status or socio-demographic characteristics. Of smoking and non-smoking parents, including never and former smokers, there were more parents who smoked for two of the parental approaches, telling their children about the health effects of smoking and their opposition to it by responding on the spur-of-the-moment if their attention was drawn to the issue by external cues (4 of 9) and acknowledging to their children the negative effects of smoking by responding only when their children brought it up (3 of 6), than for the other one (2 of 22). It is not possible to discern any particular significance to that finding as there were no obvious differences between smoking and non-smoking parents within each approach. What made these approaches different

likely was more to do with belief concerning communicating with children about smoking and saliency of the issue than with smoking status. Parental smoking status has been examined in a number of studies about parental smoking-specific discussion with children, but the findings are inconsistent and inconclusive. In some studies parental smoking was not associated with how frequently parents talked with their children about smoking (de Leeuw, et al., 2008; Engels & Willemsen, 2004; Kodl & Mermelstein, 2004). In other studies, compared with non-smoking parents, smoking parents reported having more communication with their children about smoking (den Exter Blokland, et al., 2006; Herbert & Schiaffino, 2007). They also talked more frequently about rules concerning tobacco use and discipline than did non-smoking parents (Ennett, et al., 2001). An opposite effect was evident in some studies where adolescents reported about their parents. Smoking parents were viewed as less likely to talk about smoking (Henriksen & Jackson, 1998; Herbert & Schiaffino, 2007). They also were perceived as being less consistent and credible (Herbert & Schiaffino, 2007) and constructive and supportive in their messaging (de Leeuw, et al., 2008). Because of differences in study methods, it is difficult to interpret the divergent findings among the studies.

Although there were mothers and fathers in all three verbal interaction approaches, there were relatively fewer fathers (2 of 22) in the approach whereby the parents *discussed smoking with their children by intentionally taking advantage of opportunities* than in the other two approaches (5 of 9 and 2 of 6). It may be that mothers and fathers are inclined toward particular approaches, but the

small number of fathers in this study (10 of 38) makes it difficult to determine any specific patterns. No studies were found in which differences between mothers and fathers were examined on the matter of communicating with children about smoking.

Although some parents in this study indicated that there was about equal involvement of both parents in the family in addressing smoking with their children, a number of mothers thought it was they, not the father, who played a greater role. In other studies, parent reports revealed that mothers had higher involvement in antismoking socialization practices than did fathers (Fearnow, et al., 1998; Harakeh, et al., 2005). Children also have reported that their mothers had the greatest involvement in providing information about the health effects of smoking or delivering an antismoking message (Kurtz, Kurtz, Johnson, & Cooper, 2001; Throckmorton-Belzer, et al., 2009). Some of the mothers in this study suggested that their greater involvement in addressing smoking with their children was due to spending more time with them because they were more available than were the fathers. Only one father in this study indicated that he was more involved than was the mother.

As for other socio-demographic characteristics of the parents in this study, there seemed to be a trend of relatively more parents who either were married or had a partner and parents who had any of higher household income, education, and occupational status located in the category *discussing smoking with their children by intentionally taking advantage of opportunities* than in the other two categories. However, the significance of that finding is difficult to know given the

small number of parents in the other two categories (22 vs. 9 and 6). Only one study was found in which an indicator of socioeconomic status was examined for effect on parental smoking-specific discussion. More highly educated parents had less discussion about both rules and discipline concerning smoking; whereas, education did not affect communication about media influence (Ennett, et al., 2001).

The Role of School

Parents in this study acknowledged their role in smoking prevention by taking action and verbally interacting with their children about smoking. However, similar to the view of the professionals in this study, they thought that school also has an important role to play. Many thought that smoking should be covered in all the school grades. Parents in another study expressed similar views about the role of school in smoking prevention. A large majority of the parents of junior high and high school students were supportive of tobacco prevention education in schools and agreed that it should be carried out in kindergarten through grade 12 (Wyman, et al., 2006). Although the parents in this study did not place the main responsibility for smoking prevention on schools, parents in other studies held that view (Clark, et al., 1999; von Bothmer & Fridlund, 2001) and thought that schools can be more effective than parents in teaching children about the dangers of smoking (Clark, et al., 1999).

Of note is that professionals in this study thought that schools should provide smoking prevention education starting with the youngest children. While supportive of early smoking prevention education, the teachers raised concern

about the possibility of such education causing negative emotional reactions, such as fear or anxiety, in young children who have family members, especially parents, who smoke. They thought that teachers need to be careful in their approaches in the early grades to avoid causing such reactions. Teachers in another study voiced a similar concern. They thought that working in a meaningful way with children who came from homes where there were adults who smoked was problematic and sensitivity was required. Most reported treading carefully when presenting information on long-term health effects and being cautious not to say anything that could be construed as criticism of parent behaviour (Spratt & Shucksmith, 2006). The concern raised by teachers parallels the thinking of many of the parents in this study regarding appropriate messaging for young children about health effects. However, professionals in this study thought that the issue could be reconciled by focussing on "health in general" in the early grades, not serious illness. They thought that the best approach to smoking education for young children is to emphasize overall healthy living, which excludes all unhealthy behaviours, smoking being one.

That smoking prevention education should be carried out in schools has been the recommendation of health authorities for many years (American Academy of Pediatrics, 2010; CDC, 1994, 2008). For instance, the CDC (1994, 2008) recommended that developmentally appropriate tobacco-use prevention education should be provided in kindergarten through to grade 12. It should include instruction on the short-term and long-term health and social consequences of smoking, social influences, peer norms, and refusal skills. It

should be reinforced in all school years to ensure that it does not dissipate over time. Further, it can be delivered as a single focus or embedded within broader health curricula as long as it meets the recommended standard. The latter approach is consistent with what professionals in this study suggested for smoking prevention education in the early grades, that is, an integrated health approach.

Despite the recommendation that smoking prevention education should be implemented in schools, and although some parents thought that schools already were doing a good job in teaching children about smoking, even young children, some parents thought that little smoking prevention education was being carried out in the early grades. Professionals in this study had a similar impression; smoking prevention education was not as strong in schools as it could be. In fact, it was not a component of the provincial primary school curricula at the time, and the teachers in this study suggested that even though it was a component of elementary school curricula, it may not be a priority for instruction and therefore may not receive much instructional attention. They thought that pressure to complete objectives in core subjects and teacher preference often determine to what extent smoking is covered in elementary school. Similar to that view, it is recognized in the literature that getting effective programs adopted by schools is not easy because of competing pressures and the high demands on schools for academic achievement (Flay, 2009; Reid, 1999). Although current information is lacking on the extent to which recommended school smoking prevention education is adopted, it is thought that implementation may not be widespread or

may be less than complete in terms of extent and quality (CDC, 2000; Flay, 2009; Stephens, Kaiserman, McCall, & Sutherland-Brown, 2000).

Numerous studies have been conducted to test various school-based interventions, including such approaches as information-giving, affective education, social influence education, and social skills training, and several systematic reviews and meta-analyses have been carried out to examine effect. It is proposed that effective school-based prevention programs could accrue substantial cost-benefit in terms of economic returns and health-related quality of life (Flay, 2009; Stephens, et al., 2000). However, although in some studies, and mainly for social influences intervention, there was support for short-term positive effects of school intervention on children's smoking behaviour, strong evidence for preventing smoking among youths in the long-term is lacking (Bruvold, 1993; Dobbins, et al., 2008; Thomas & Perera, 2006; Wiehe, et al., 2005). This speaks to the need for other interventions that are complementary and effective over the long-term.

The Role of Society

Both parents and professionals in this study thought that in addition to parents and school, society more generally also has an important role to play in youth smoking prevention. Parents thought that children may be more inclined to accept an antismoking message that comes from different sources. In a similar vein, the professionals thought that smoking prevention requires a "community effort" and "coordinated voice" so that the antismoking message is prominent and consistent across sources and is everywhere.

The view held by authorities on smoking prevention and supported by research findings is that a comprehensive, multi-message, multichannel approach is more effective for smoking prevention than single component interventions (e.g., American Academy of Pediatrics, 2009; CDC, 1994, 2000, 2007; National Cancer Policy Board, Institute of Medicine, & National Research Council, 2000; Sowden & Stead, 2003). It is argued that a combination of strategies is synergistic and should include school-based education, community-based activities, interventions that engage parent influence, youth-oriented mass media campaigns, regulations for product sale (restricting access to minors) and promotion, policies for smoke-free environments, and price inflation (CDC, 1994, 2000, 2007; National Cancer Policy Board, Institute of Medicine, & National Research Council, 2000; National Institutes of Health [NIH], 2006; USDHHS, 1994). Even though one strategy may not produce an effect independently, a combination may do so through interaction. The need for a comprehensive and multifaceted approach that is sustained over time (CDC, 2000) may explain, at least in part, why, when examined in studies, single strategies often have yielded disappointing results.

In recent years, the trend in many countries has been to implement such a comprehensive strategy for smoking prevention. In Canada, and more locally in Newfoundland and Labrador, this has been evident through such initiatives as (a) legislation to control the sale of tobacco to minors, restrict promotion of tobacco products, mandate health warnings on tobacco packaging, and prohibit smoking in work and public places; (b) policies to ban smoking on school properties; (c)

smoking prevention curricula for schools; and (d) social marketing and mass media campaigns to promote awareness about the dangers of smoking and ETS. The decline in smoking in Canada in recent years is attributed to the combination of varied initiatives (Health Canada, 2006a).

Parents and professionals in this study generally were pleased with such initiatives. However, many commented that more needed to be done, especially in terms of social policy and education and resources at the community level, because smoking during youth still was common despite being less prevalent than in the past. Some parents and the NGO professionals identified the need for stronger policies to reduce access of children to tobacco products. Even though the legal age for purchase of tobacco products in Newfoundland and Labrador was 19, youths still were obtaining cigarettes. That access is an issue was verified in recent Canadian surveys where it was revealed that about 50% of adolescents in the age bracket 15 to 19 years who were underage in their jurisdictions purchased tobacco products from a retail source, especially grocery and corner stores. The others obtained their cigarettes primarily from social sources, either by taking or buying them from or being given them by friends or relatives. Social sources were more prevalent in younger children with as many as 85% of children in grades 6 to 9 who smoked obtaining their cigarettes that way (Health Canada, 2008a; 2010a; 2010b). Access is a function not only of regulations to prevent sales to minors but also of enforcement of regulations and availability through social sources such as friends and family members (Stead & Lancaster, 2005). Interventions need to address all of those factors.

Some parents and the NGO professionals identified societal exposure of children to smoking as problematic. Although measures had been taken in recent years to prohibit smoking in indoor public places and on school grounds, the parents thought that smoking still was too visible to children and was a continuing negative influence. They wanted to see prohibition of smoking in other public areas to which children are exposed. The NGO professionals identified exposure to smoking from such sources as marketing and movies as requiring attention. They noted that despite social policies that were in place, industry marketing and point of sale promotion still were occurring. That smoking in movies was prevalent is supported by evidence in the literature (Dalton, et al., 2002; Sargent, 2005; Sargent, Dalton, Heatherton, & Beach, 2003). It is well accepted that marketing and pro-smoking messages in media to which children are exposed are important sources of influence for smoking (Dalton, et al., 2009; Distefan, Gilpin, Sargent, & Pierce, 1999; NIH, 2006; Sargent, 2005; Wellman, Sugarman, DiFranze, & Winickoff, 2006). Young people who are exposed to smoking and other promotion of the behaviour receive messages that are contradictory to prevention messages about smoking norms and acceptability of the behaviour that they receive from sources such as parents and school (Alesci, Forster, & Blaine, 2003; CDC, 2000).

Some parents identified the need for more smoking prevention education initiatives, both for children and parents. They wanted more education in the form of antismoking advertisements for children and thought that television was a particularly good medium to get the message across. Their impression was that

there were few such advertisements and what had been produced was directed to adolescents and adults, not younger children. A search and review of television advertisements that had been aired locally in recent years revealed that consistent with the parents' impression, there were few that had been directed to youths and it appeared that none had been directed to children who were younger than adolescence. The parents thought that antismoking messages should be produced for young children and conveyed through children's television programming. Mass media campaigns is a strategy that is recommended for smoking prevention for youths (CDC, 2007; NIH, 2006; USDHHS, 1994) and there is some evidence of effectiveness in adolescents when combined with other interventions (Hopkins, et al., 2001; Sowden, 1998). However, there is a dearth of information in the literature about the appropriateness and effectiveness of mass media campaigns for young children and there does not appear to be a recommendation specifically for children who are younger than adolescence.

Some parents, although comfortable with their own approach, were of the opinion that there needs to be an ongoing smoking prevention initiative for parents to inform them about youth smoking and their role in prevention and to guide their approach. They thought that there may be parents who do not address the topic of smoking with their children. They suggested that smoking prevention resources be readily available to parents. The nurses and NGO professionals held a similar view. They thought that many parents may not address smoking to any extent with their young children and parents would benefit from having resources that informed them about youth smoking and that they could use to educate their

children about the behaviour. In fact, there were some parents in this study who did not raise the topic with their children or address the behaviour to any extent and there was one parent who had not addressed the topic at all. Those were the parents whose approach was to acknowledge to their children the negative effects of smoking only when their children brought it up and the parent whose approach represents the possible negative case.

Consistent with the view expressed by some of the parents and professionals in this study, there were parents in the study who thought that they could benefit from having more information on youth smoking, prevention strategies, and communicating with children about the behaviour. They also thought it would be helpful to have a resource that they could use with their children. Although they felt that they were doing their best, they wondered whether their approach was the most appropriate. Parents in another study also indicated a need to learn how to effectively communicate with their children concerning use of substances, including tobacco, and how to prevent their children from engaging in such behaviour (King, Wagner, & Hedrick, 2002).

Although parents in this study thought that parents in general or they themselves could benefit from having resources about smoking, none had sought out or used resources. Based on their experience, the nurses and NGO professionals in this study noted that rarely had parents requested help to proactively talk with their children about smoking. This suggests that parents may not look for resources on their own initiative. Some parents thought that perhaps there were few if any resources available for parents as they had not come across

any. The nurses and NGO professionals indicated that although their organizations had services and resources concerning smoking more generally, there were few if any resources that were directed specifically to parents. Contact was made with relevant local health and education agencies at the time and only one resource was found that was directed specifically to parents and at only one location, a brochure produced by the Ontario Ministry of Health and Long-Term Care (2003) and titled *Talk it Out: A Parent's Guide to Kids and Smoking*. There also were some internet sites that had brief factsheets and tips for parents about children and smoking (e.g., Health Canada, CDC, Centre for Addiction and Mental Health at the University of Toronto).

Parents and professionals had similar ideas about how to reach parents with resources. They thought that resources could be available through community venues such as schools and health clinics. They also thought that direct distribution to parents by health or education authorities is a good way to make resources accessible and increase the chances that parents are informed and address the topic with their children. Although no studies were found in the literature in which the effect on parents of simple provision of resources was examined, there is some evidence that parents have a preference for resources that can be mailed home or brought home from school (Tilson, et al., 2001) and for parent-directed interventions they are able to complete in their homes (Beatty & Cross, 2006).

My Personal Reflection on the Theory

Strauss and Corbin's (1998) approach to theory development, which involves examining data for relationships among conditions (context), action and interaction (process), and outcomes, was a useful guide to constructing the theory that was generated in this study. The theory explains how parents communicated with their children about smoking, that is, the action and interaction they took, the conditions that influenced their action and interaction, and the outcomes for them as a consequence of their action and interaction. Although not always explicitly stated as such, other substantive theories derived from grounded theory methods also address influencing factors, process, and outcomes. Similar to this theory, some are laid out in a linear fashion that illustrates the relationships among the component parts. Others tend to be more embedded in the narrative story with relationships less overtly delineated (Charmaz, 2006). In this grounded theory, the process is revealed as ongoing action and interaction. In some grounded theories, the process is revealed as stages or phases, which represent change over time (Strauss & Corbin, 1998).

Parents in this study communicated with their children about smoking by having a no-smoking rule and verbally interacting with them through one of three approaches (a) discussing smoking with their children by intentionally taking advantage of opportunities, (b) telling their children about the health effects of smoking and their opposition to it by responding on the-spur-of-the moment if their attention was drawn to the issue by external cues, or (c) acknowledging to their children the negative effects of smoking by responding only when their

children brought it up. Similar to the view of professionals in this study, prior to beginning the study I thought that parents may not view smoking as a relevant issue for their preadolescent children; that they may view it as an adolescent issue and consequently may not see the need to and therefore may not intervene with younger children. I was somewhat surprised when I began data collection and recognized that the first several parents not only were intervening but were intentionally and routinely discussing smoking with their children, the approach that became *discussing smoking with their children by intentionally taking advantage of opportunities*. It was not until the tenth participant that a different approach became apparent. It was, in part, because of my assumption that parents may not be involved with their preadolescent children about smoking that I continued to recruit parents into the study and look for variation in approaches. The one parent who had not interacted with his child at all about smoking was not recruited into the study until near the end of data collection and he was recruited by his wife through the recruitment technique of snowballing. It therefore is possible that there are other parents who also do not verbally interact with their children about smoking.

Because the focus of this study had been on determining *how parents approach the topic of smoking with their children* and the relevance of a no-smoking rule was not immediately recognized in the interviews, there is more data to support the verbal interaction aspect than the action aspect of the theory. Further, because there were more parents (22 of 38) whose approach was to discuss smoking with their children by intentionally taking advantage of

opportunities than there were for the other two approaches (9 and 6), there is more data to support findings about that approach. Regardless of differences in data volume, patterns in the data indicated that parents in this study had a no-smoking rule to protect their children from ETS and exposure to the behaviour and verbally interacted with their children in one way or another to deter the behaviour.

With the exception of Parenting Styles and Mindful Parenting theory, which are about parenting approach more broadly, there is little in the way of theory or research to which the findings in this study can be compared. Parenting styles and mindful parenting were not examined in this study. However, the verbal interaction styles that the parents used with their children concerning the topic of smoking resemble communication characteristics of the authoritative, authoritarian, and permissive parenting styles. Similarly, the verbal interaction methods that the parents used resemble characteristics of mindfulness or the converse, automaticity. The resemblance to the dimensions in those two theoretical models lends support to the variation in verbal interaction styles and methods identified in this study.

Interestingly, during data analysis, while reflecting on each interview as a whole and journal notes taken after each interview regarding how the respective parent communicated during the interview, it occurred to me that there was a similarity between the style of communication parents had exhibited during the interview and the verbal interaction style they had taken with their children about the topic of smoking. Parents whose approach was to discuss smoking with their children seemed to talk freely and they gave detailed information. Parents whose

approach was to tell their children about the health effects of smoking and their opposition to it appeared as being firm and to the point. It was almost as if they were saying *this is what I do and that is all that is to it*. The parents whose approach was to acknowledge to their children the negative effects of smoking and the one parent who had not interacted with his child at all about smoking seemed to have the least to say. Of course, this study was about parental smoking-specific communication and as with parenting styles and mindful parenting, more general communication was not examined. However, as was the case with parenting styles and mindful parenting, the observed variation in how the parents communicated during the interviews lends support to the variation in verbal interaction styles that were identified in relation to their smoking-specific communication with their children.

The significance of the theory generated from this study is that it contributes knowledge about parents' communication with their children concerning smoking. It appears to be a unique contribution as no other theory was found in the literature that addresses parental smoking-specific communication. The study, in general, has implications for further theory development and research. Of particular note is that understanding gained from the theory may be used in health promotion practice.

CHAPTER 6

IMPLICATIONS AND LIMITATIONS OF THE STUDY

Implications for Theory

This study was designed to gain an understanding of how parents approach the topic of smoking with their school-age preadolescent children. Grounded theory methodology, derived from symbolic interactionism, was ideally suited to examining that phenomenon. Symbolic interactionism rests upon the premise that people will behave toward something on the basis of the meaning that it has for them. The meaning, which is socially constructed, is handled and modified through an interpretive process whereby the person selects, examines, sets aside, reorganizes, and transforms it, given the situation and the direction of the action taken or being taken (Blumer, 1969).

The meaning that parents in this study applied to smoking behaviour relative to their children is that it is a latent danger. The meaning was shaped by their knowledge of the serious health effects of smoking, which caused them to want their children not to smoke, and knowledge of the nature of youth smoking, which heightened their awareness of the vulnerability of children to the behaviour. To deter smoking from emerging, the parents communicated with their children by taking action and verbally interacting with them. Their action and interaction produced outcomes for them in the form of feelings and thoughts that contributed to the context for their continuing intervention. Those findings portray a substantive theory that explains how the parents communicated with their children about smoking (see Figure 2, p. 120).

There was one parent whose approach deviated from the substantive theory as he did not perceive smoking as a latent danger for his child and did not verbally interact with her about it. However, the parent was similar in some respects to other parents in the study. He had knowledge of the health effects of smoking and factors that influence children to smoke, did not want his child to smoke, and had a no-smoking rule to avoid ETS. He did not elaborate upon the no-smoking rule, so it is not possible to know whether he also had it to limit exposure of his child to the behaviour. His socio-demographic characteristics were comparable to that of other parents in the study. Similar to the parents whose approach was to acknowledge the negative effects of smoking only when their children brought it up, this parent did not see the need to discuss smoking with his child as she had good knowledge of the health effects of smoking and a negative attitude towards it.

While not invalidating the substantive theory, that possible negative case draws attention to another approach that parents may take with their children about smoking, *not addressing the topic of smoking at all*. All the parents in this study were self-selected for participation in that they responded to a general recruitment effort, which for some involved being selected through snowballing. Hence, it is conceivable that there are other parents whose approach aligns with the possible negative case. It also is conceivable that there are other parental approaches to the topic of smoking that were not identified by this study. For instance, there may be parents who fail to show any disapproval of smoking or whose behaviour indicates approval. There is evidence in the literature that some

parents may engage in prompting behaviours, such as asking their children to bring them cigarettes, which actually could facilitate their children towards smoking (Jackson, 1997; Laniado-Laborin, et al., 2004). In future studies on parental communication with children about smoking it is important to be alert not only for other cases that coincide with the possible negative case found in this study but also for other parental approaches that may exist. Such findings could be used to elaborate this substantive theory.

This theory is about parental communication with children who are younger than adolescence. Because adolescence is a high risk period for initiation of smoking, parents may have a different approach with their adolescent children than with younger children. Indeed, some parents in this study indicated that they would give more detail or a stronger message to older children. Some of the parents in this study, parents whose approach was to acknowledge to their children the negative effects of smoking by responding only when their children brought it up, indicated that they would need to change their approach by *stepping up their effort as their children become adolescents*. Others, including parents whose approach was to discuss smoking with their children by intentionally taking advantage of opportunities and parents whose approach was to tell their children about the health effects of smoking and their opposition to it by responding on the spur-of-the-moment if their attention was drawn to the issue by external cues, indicated that they would need to continue their approach with their adolescent children (i.e., *maintain open communication about smoking,* and *continue to be vigilant as their children get older in order to curb any tendency to*

smoke, respectively). Hence, research needs to be carried out with parents of adolescent children to determine whether and how approaches to the topic of smoking change for adolescent children. That knowledge may then be used to extend the theory derived in this study or generate another substantive theory to explain the phenomenon for that age group.

As well, research needs to be carried out to determine whether this substantive theory is relevant to the experience of parents in rural settings. The parents in this study resided in a city. It is difficult to know whether there is a difference between the rate of youth smoking in rural or remote versus urban locations in Canada because of limited information on the matter. The National Youth Smoking Surveys do not provide information on the basis of geographical location (M. Kaiserman, oral communication, July 9, 2010). However, the rate of smoking for the general population of residents aged 15 years and older is higher in rural (21%) compared with urban (17%) areas (Health Canada, 2009a). Further research could shed light on any contextual or parenting factors that may be different in rural compared with urban locations.

Smoking is one of a number of risk behaviours in which adolescents may engage. Others include drinking alcohol, using illicit drugs, and having unsafe sex (Health Canada, 2010b; Newfoundland and Labrador Department of Health and Community Services, 2007; Rotermann, 2008; The Society of Obstretricians and Gynaecologists of Canada, 2009). There is a need for a formal theory that explains how parents address with their children risk behaviours in general in an effort to prevent them.

Although it is implicit in the literature that parental communication with children about smoking is preventative and there is some research evidence supporting that assumption, there does not appear to be an actual communication theory to explain the phenomenon. There is need for a theory about how parents can communicatively promote smoking prevention and empower their children to make the right choice (Miller-Day, 2002).

Implications for Research

Little is known about the effectiveness of parental communication with children about smoking. Although studies have been carried out on various aspects of parental discussion, including quality, extent, and content, the limited number of studies and discrepancies in findings make it difficult to draw conclusions about the effectiveness for youth smoking outcomes. Parents in this study used one or another of three different approaches in addressing smoking with their children, that is, discussing smoking with their children by intentionally taking advantage of opportunities, telling their children about the health effects of smoking and their opposition to it by responding on the spur-of-the-moment if their attention was drawn to the issue by external cues, or acknowledging to their children the negative effects of smoking by responding only when their children brought it up. Research needs to be carried out to establish the effectiveness of parental approaches to the topic of smoking with children.

General parenting and communication characteristics were not examined in this study. However, the parental verbal interaction approaches that were identified variously resemble the communication characteristics of general

parenting approaches that have been described in the theoretical literature, namely parenting styles and mindful parenting. There is some evidence in the research literature of a relationship between parenting styles and parental smoking-specific discussion (Chassin, et al., 2005; Henriksen & Jackson, 1998). In particular, authoritative parenting was related to more discussion (Chassin, et al., 2005). Further research needs to be carried out in this area, especially to establish whether a relationship exists between general parenting approaches and the verbal interaction approaches that parents take with their children about the topic of smoking.

Some parents and professionals in this study asserted that parents could benefit from resources to assist them in addressing smoking with their children. They suggested that resources should be readily available to parents through such venues as schools and health clinics or be distributed directly to parents through health or education authorities. Research needs to be carried out to determine what resources would be the most useful for parents and the best way to reach parents with any such resources.

This study was about parental approaches to the topic of smoking from the perspective of parents. There is evidence in the literature that children may have different perceptions of their parents' communication and parenting practices than do their parents (e.g. Barnes & Olson, 1985; Baxter, et al., 2009; Chassin, et al., 2005; Chassin, Presson, Rose, Sherman, & Todd, 1998; Darling & Steinberg, 1993; Engels & Willemsen, 2004; Harakeh, et al., 2005; Herbert & Schiaffino, 2007; Kandel & Wu, 1995; Smetana, 1995). What parents do is important but

how children take it also is important (Grusec & Goodnow, 1994). Further, children may respond differently toward mothers versus fathers (Collins & Russell, 1991). For instance, adolescents have reported that they were emotionally closest to their mothers and preferred to talk with their mothers, rather than their fathers, about important topics such as alcohol, tobacco, and other drugs (Miller-Day, 2002) and that their mothers were more influential than their fathers concerning their decisions about whether or not to smoke (Herbert & Schiaffino, 2007). It seems then that it would be important to carry out research to understand children's perspectives about their parents' approaches to the topic of smoking.

As there may be differences between parents in a family with respect to involvement in antismoking messaging with their children or differences between perceptions of each other's involvement, it also would be important to examine the perspectives of both parents. Some of the parents in this study reported that both parents in the family were about equally involved in parenting their children about smoking. A number of mothers indicated that they were more involved than were the fathers. Some parents did not know whether or to what extent their child's other parent was involved in addressing smoking with them. In this study there were five mother and father couples. Although for most of the couples, their perceptions of the other parent's involvement with their children about smoking matched, one parent did not seem to know about his wife's extensive involvement in discussing smoking with their children.

Because perceptions may vary among family members, what parents do may vary between them, and it is important to understand how children perceive

their parents' efforts, research using a family approach needs to be conducted, whereby both parents and the respective child(ren) share their views and experience. Parenting children about smoking occurs within the context of the family with interactions occurring among the parents and children. A family approach may produce an understanding of the complexity involved, including about mother and father roles in the family, family dynamics, and child characteristics, and provide further knowledge to inform prevention interventions.

Mothers and fathers and smoking and non-smoking parents were included in this study in order to compare approaches within those two demographics. There were mothers and fathers in each of the three parental approaches to verbal interaction categories that were identified and although there were no apparent differences between mothers and fathers with respect to the approaches they had used, there were considerably fewer fathers (10 of 38) than mothers (28 of 38) in the study. An effort was made in this study to ensure that fathers were represented and preference was for a more even distribution of fathers and mothers. However, it often is the case in studies of parenting children about smoking that only mothers are represented or fathers are underrepresented. An explanation is not readily apparent but it may be due, at least in part, to mothers being more available than fathers who tend to work more outside the home. In this study there were 10 stay-at-home parents and all were mothers. In future studies on parenting children about smoking it would be important to sample enough fathers to ensure that their perspectives are fully represented and to allow for any differences that may exist between mothers and fathers to be evident.

There also were smoking and non-smoking parents in each of the three parental approaches to verbal interaction categories that were identified in this study. As with fathers and mothers, there were no readily apparent differences between smoking and non-smoking parents with respect to the approaches they had used. In other studies, although there is inconsistency in findings, there is some evidence that parents who smoke may interact differently with their children about smoking than do non-smoking parents (de Leeuw, et al., 2008; den Exter Blokland, et al., 2006; Henriksen & Jackson, 1998; Herbert & Schiaffino, 2007). An effort was made to recruit smoking parents into this study, but there still were somewhat fewer smoking parents (9 of 38) than non-smoking parents (29 of 38 including parents who never smoked or formerly smoked). Although the proportion of smoking parents (about 24%) in the study was higher than the proportion of smokers (about 19%) in the general population at the time (Health Canada, 2008a), in future studies a larger number of smoking parents may allow for any differences in approaches that may exist between smoking and non-smoking parents to be apparent.

There was diversity among the parents in this study in terms of marital status and socioeconomic characteristics. Although it is difficult to tell whether any of those characteristics are associated with a particular verbal interaction approach, certain characteristics seem to predominate in the category *discussing smoking with their children by intentionally taking advantage of opportunities*. These were being married or having a partner and having higher education, household income, and occupational status. In future studies, it would be

important to examine socio-demographic factors further for possible influence on parental approach with children about smoking.

The parents in this study identified personal factors (i.e., knowledge, beliefs, and feelings) that motivated them to act and interact with their children about smoking. Albeit, the social policy and program context for smoking in which they were situated likely played a role in their knowledge of the health effects of second-hand smoke, awareness of the social unacceptability of smoking around children, knowledge of the health effects of smoking, and knowledge of youth smoking. In future studies it would be important to examine the broader social context in which parents are embedded in addressing smoking with their children, which includes factors such as gender, culture (e.g., differences in prevalence and acceptability of smoking), corporate power (e.g., tobacco industry), and politics (e.g., governmental policy and regulations concerning tobacco use). These factors could be examined from a critical social theory perspective.

Implications for Practice

The significance of qualitative research findings is that they increase practitioners' understanding of phenomena and that understanding then may be applied in practice. The richer the information in qualitative findings in terms of complexity (i.e., linking of categories such as context, meaning, action, interaction) and discovery (i.e., new perspectives on or information about the phenomenon), the greater the understanding and potential for application. Five categories of qualitative findings ranging from the least to the most complexity

and discovery are (a) "findings restricted by *a priori* frameworks" (some complexity but no discovery, existing ideas are applied to qualitative data without new insights), (b) "descriptive categories" (some complexity and discovery, clusters of data are labelled into categories), (c) "shared pathway or meaning" (increased complexity and discovery, the essence of an experience is captured through linking of concepts), (d) "depiction of experiential variation" (greater complexity and a high degree of discovery, the essence of an experience is portrayed along with variation related to individuality and context), and (e) "dense explanatory description" (highest level of complexity and discovery, findings portray the full depth and breadth of complex influences) (Kearney, 2001, pp. 147-150). According to Kearney, qualitative findings of varying complexity can be used to guide practice if discovery has occurred; otherwise, there is no new evidence. With higher complexity there is more information that can be judged for relevance and fit with particular situations. Hence, findings restricted by *a priori frameworks* do not provide new evidence for practice; whereas, *dense explanatory description* is the most useful in that it can lead to interventions in the form of anticipatory guidance and coaching.

The substantive theory which was generated in this study may be classified as at the fourth level of complexity and discovery, *depiction of experiential variation*, which means that it may be used by health practitioners for better understanding and in assessment (Kearney, 2001). As illustrated in the following explication of the action and verbal interaction used by parents in this study, when intervening with parents about child smoking prevention,

practitioners may use the *understanding* gained from this theory to *assess* parental communication and to offer guidance that is consistent with recommendations in the literature.

Although parents in this study varied in what they had done and believed concerning communicating with children about smoking, and except for the one possible negative case, they recognized the need for parental intervention with children and acknowledged that they had a role to play in prevention. Parents had acted by having a no-smoking rule, to one degree or another, and had interacted verbally, in some manner, with their children about smoking.

Many parents had a strict no-smoking rule which involved avoidance of smoking outside their homes and a total ban on smoking in their homes and vehicles. Others had a less strict rule. They did not insist on total avoidance of ETS and smoking and some had only partial restrictions in their homes and vehicles. It is recommended that for best effect homes and vehicles should be completely smoke-free and exposure to role modeling of the behaviour should be avoided (American Academy of Pediatrics, 2009; Ferguson, 2009; Health Canada, 2005b, 2006b, 2007d, 2008e; Ontario Ministry of Health Promotion, 2009). Parents in this study had knowledge of the health effects of ETS, knew about the social unacceptability of smoking in the presence of children, and knew about the negative influence of exposure to smoking. It is not clear as to whether the parents who had a less strict rule knew that a total ban is more effective. Health professionals need to determine whether and to what extent parents have a no-smoking rule and inform those who do not have a complete ban on smoking in

their homes and vehicles of the importance of such a ban for best protection of children both in terms of exposure to ETS and to the behaviour. The importance of avoiding, as is possible, other exposure to ETS and role modeling also may need to be reinforced.

Although different in style and method of approach, many parents in this study demonstrated responsibility by taking it upon themselves to address smoking with their children. Those were the parents whose approach was to discuss smoking with their children by intentionally taking advantage of opportunities and those whose approach was to tell their children about the health effects of smoking and their opposition to it by responding on the spur-of-the-moment if their attention was drawn to the issue by external cues. Although the parents in the other approach category had not taken initiative with their children up to that point in their children's development, they had responded to their children by acknowledging the negative effects of smoking when their children brought up the subject. Those parents believed that there was no need for them to do anything more at the time because their children already had an adequate understanding of smoking. However, parents across the three approaches thought that they had a continuing responsibility to do what they could to deter smoking as their children get older, which for some meant maintaining open communication about smoking; for others, continuing to be vigilant in order to curb any tendency to smoke; and for others, stepping up their effort as their children become adolescents (see Table 3, p. 126).

The perspective of professionals who participated in this study also was that parents have a responsibility toward smoking prevention. They thought that parents are a young child's most important influence, have the main responsibility for educating children about smoking, and should engage in prevention efforts, which include talking with their children about smoking and displaying behaviour that is consistent with an antismoking message. That view corresponds with the position of authorities on smoking prevention that parents are a potentially powerful influence on children's decisions to smoke and should take measures to prevent the behaviour (Centers for Disease Control and Prevention, 2010; Ferguson, 2009; Health Canada, 2008e). Indeed, that parents can make a difference to children's behavioural outcomes is the generally accepted position in the literature on parenting (e.g., Baumrind, 1993; Collins, et al., 2000; Duncan, et al., 2009; Galambos, et al., 2003; Holmbeck, et al., 1995; Maccoby, 1992; Okagaki & Luster, 2005).

Of the three verbal interaction approaches that parents in this study used, discussing smoking with their children by intentionally taking advantage of opportunities reflects recommendations for smoking prevention and suggestions offered by the nursing and NGO professionals who also participated in this study. Based on Parenting Styles and Mindful Parenting theory and the characteristics of good quality communication, the other two approaches, telling their children about the health effects of smoking and their opposition to it by responding on the spur-of-the-moment if their attention was drawn to the issue by external cues and acknowledging to their children the negative effects of smoking by responding

only when their children brought it up, would be considered to not be facilitative of favourable smoking outcomes. Health professionals should (a) assess for parents' perspectives on their role in smoking prevention for their children, (b) capitalize on their acceptance of responsibility by reinforcing the importance of intervention with children about smoking and stressing parental potential influence, (c) determine the approach that they are taking with their children, and (d) encourage and support those whose approach is consistent with recommendations and inform others of the recommended approach to addressing smoking with children.

Parents should be encouraged to proactively take advantage of opportunities and discuss smoking with their children using good quality communication. Parents need to know that if they do not take an active role in addressing smoking with their children and do not let them know that they disapprove of the behaviour or if they send few antismoking messages, the children may assume that it is not an important issue or not an important issue for the parents (Crawford, et al., 2001; Kegler, et al., 2002; Plano Clarke, et al., 2002). As a parent in this study commented, "Unless you take a stand and purposely talk about it, kids will assume it's not a big deal or that, you know, it's acceptable in your household". (UG)

Parents whose approach is not consistent with recommendations also may need to be given guidance on how to address the topic with their children. That course of action is supported by the argument in parenting theory that not only is it important what parents do but also how they do it (Steinberg, 2001) and by

research evidence. In one study, parents suggested that interventions for parents about alcohol, tobacco, and other drugs should focus on practical information concerning how to successfully talk with children, how to raise the topic, and what to talk about, rather than on factual information about specific drugs (Beatty & Cross, 2006). In other studies, findings indicated that the most effective family-based programs for preventing smoking by children were those that included a component that involved development of skills in parenting as opposed to those that focussed exclusively on substances and substance use (Petrie, Bunn, & Byrne, 2007). Parents in this study had knowledge about the health effects of smoking, the nature of youth smoking, and factors that influence youth to smoke that is consistent with what is known about smoking. While it is important then for health professionals to acknowledge and validate with parents their relevant knowledge, it may be more important to talk with them about how they intervene with their children, in other words their interaction style and method. Because parents may not seek resources, appropriate resources to guide and assist them in their efforts need to be provided to them. There is evidence in the literature that interventions with parents to promote their participation in smoking prevention efforts result in more discussion with their children (Beatty, et al., 2008; Jackson & Dickinson, 2003; Mahabee-Gittens, Huang, Slap, & Gordon, 2007; Tilson, McBride, & Brouwer, 2005).

Regardless of the verbal interaction approach that parents had taken with their children, they felt that they were doing their best to discourage the behaviour, which meant for some that they had given their children a good

foundation to make the right choice if confronted with the behaviour in the future; for others, that they had given their children a strong message to discourage smoking; and for others, that they had reinforced the antismoking message. There were a few parents, however, from the three approaches who held a concern. They wondered whether what they were doing was the most appropriate way to address the issue, and they thought that they could benefit from having more information on the matter. Similarly, although parents in this study were feeling comforted by their children's knowledge and acceptance of the antismoking message, some of those whose approach was to discuss smoking with their children by intentionally taking advantage of opportunities held a concern. Their children had formed a strong negative view of smoking to the point of wanting to tell others, even strangers, that they should not smoke or thinking that people who smoke are "bad". The parents felt that they had to be careful of the message that they conveyed to their children because they did not want them to react that way. They wanted their children to have the understanding that the behaviour is harmful but people are not bad because they smoke. The parents' concern may reflect a dissonance between their egalitarian approach and their children's more extreme response. Health practitioners need to be aware that parents may hold concerns related to their communication with their children about smoking so that they may provide appropriate guidance and support. In intervening with parents about smoking prevention, it is important to inform them that children may react strongly to messages about smoking so that they may endeavour to provide messages to pre-empt it.

As suggested by parents and professionals in this study and supported by the literature, youth smoking prevention requires a multifaceted approach which involves the efforts of parents, schools, and society at large (e.g., American Academy of Pediatrics, 2009; CDC, 1994, 2000, 2007; National Cancer Policy Board, Institute of Medicine, & National Research Council, 2000; Sowden & Stead, 2003). Parents need to be encouraged to take a proactive role in communicating with their children about smoking regardless of whether or not smoking prevention education and antismoking messages also are available from other sources. Some parents in this study thought that smoking prevention education may not be strong in schools. Parents need to be encouraged to promote strong smoking prevention school curricula and, as suggested by professionals in this study, learn about what is being taught to their children in school so that they may reinforce the message at home. Although there had been a number of initiatives in recent years to curb smoking during youth, including social policy and public education, parents thought that more needed to be done. Parents could be a strong and influential force and should be encouraged to become actively involved in advocacy for further social policy and education campaigns that are directed to preventing smoking among youths.

Limitations of the Study

Although this theory provides for an understanding of parental communication with children about smoking, it is important to recognize that like all theories, it is provisional and open to modification as new knowledge is gained

(Corbin & Strauss, 2008). The implications for practice based on this theory should be considered in light of the limitations of the study.

Many of the parents who participated in this study had a high educational level. Thirty of the 38 had at least some university or college education and 17 were university or college graduates. There were few fathers (10 of 38) relative to mothers and few smoking parents (9 of 38) relative to non-smoking parents. It is possible that the predominant characteristics influenced the findings. As the parents were self-selected for inclusion in this study, it also is possible that they have characteristics that are different from parents who did not participate in the study. For instance, parents in this study viewed smoking as a relevant issue, a latent danger for their children, and may have participated in the study on the basis of those views. Parents who did not participate in the study may hold different views about smoking and consequently may have different approaches with their children about the behaviour. One parent in this study thought that his child would not smoke. He did not consider smoking to be a latent danger for her and did not verbally interact with her about it. That parent was recruited through his wife and otherwise may not have been in the study, precluding the possible negative case from being identified. There may be other parents who hold a similar view and have a similar approach. Although not intended to, in retrospect, it is possible that the recruitment brochures and posters led to a self-selection bias. The invitation on those materials, *Are you Interested in Talking about Children and Smoking? If your answer is "yes", then you also might be interested in this study: Parents' approaches to the topic of smoking with their children*, may have

inadvertently excluded parents for whom the topic of smoking was not important and who did not interact with their children about smoking.

There were a small number of parents in two of the verbal interaction categories. There were 9 parents in one category (telling their children about the health effects of smoking and their opposition to it by responding on the-spur-of-the moment if their attention was drawn to the issue by external cues) and 6 in the other (acknowledging to their children the negative effects of smoking by responding only when their children brought it up), compared with 22 in the remaining category (discussing smoking with their children by intentionally taking advantage of opportunities). A greater number of parents in the smaller categories would have provided more support for the properties and variation within the categories and the variation among the categories. Only one interview was carried out with most parents. A second interview with each parent to add missed detail and validate categories may have provided more supporting evidence for the theory.

The parents in this study identified personal factors that influenced them to act and interact with their children about smoking. There are a range of other factors, from the individual micro to the societal macro such as parenting styles, parent roles, family dynamics, child characteristics, smoking status, socio-demographic factors, gender, culture, power, and politics, which could potentially influence parental approach to the topic of smoking, A focus on the family is of particular relevance to the topic of this research. However, the focus in this study was on individual parent perspectives.

Summary

The product of this study is a substantive theory that explains how parents communicated with their children about smoking. The study has implications for further theory development and research, and the theory has implications for practice. Several implications are of particular note. Parents in this study communicated with their children about smoking by taking action in the form of having a no-smoking rule and verbally interacting with them. The parents' verbal interaction consisted of one or another of three different approaches. However, one parent whose approach represents a possible negative case did not verbally interact with his child about smoking. In future studies on parental communication with children about smoking it is important to be sensitive not only to the potential for other cases like the possible negative case identified in this study but also to the potential for other parental approaches. This study was about parental communication with school-age preadolescent children. Research needs to be carried out with parents of adolescent children in order to understand whether and how parental approaches differ for that age group. Research also needs to be carried out to understand how parents can effectively communicate with their children to promote smoking prevention. In addition to the personal factors that influenced the parents in this study to act and interact with their children about smoking, there may be others, including personal, family, and societal, which were not examined. Although there are limitations inherent in the study, which should be taken into consideration, the understanding gained from

this theory may be used by practitioners to assess parental smoking-specific communication and to offer guidance based on recommendations in the literature.

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Appendix A

Parenting Characteristics in Relation to Youth Smoking:

Examples of Studies

Parenting Characteristics	Relevant Studies
Monitoring (e.g., behavioural control)	Bailey, et al., 1993; Biglan, Duncan, Ary, & Smolkowski, 1995; Bohnert, Rios-Bedoya, & Breslau, 2009; Borawski, Ievers-Landis, Lovegreen, & Trapl, 2003; Chuang, Ennett, Bauman, Foshee, 2005, 2009; Cohen, et al., 1994; den Exter Blokland, Hale, Meeus, & Engels, 2007; Dick, et al., 2007; Engels, et al., 2005; Ennett, et al., 2001; Fors, et al., 1999; Griffin, et al., 2003; Harakeh, et al., 2004; Hill, et al., 2005; Huebner, et al., 2005; Huver, Engels, van Breukelen, & de Vries, 2007; Kandal & Wu, 1995; Kodl & Mermelstein, 2004; Ledoux, Miller, Choquet, & Plant, 2002; Nowlin & Colder, 2007; Otten, Engels, & van den Eijnden, 2007, 2008; Powell & Chaloupka, 2005; Shakib, et al., 2003; Simons-Morton, 2002; Simons-Morton, Chen, Abroms, & Haynie, 2004; Simons-Morton, et al., 1999; Simons-Morton & Haynie, 2003; Simons-Morton, et al., 2001; Svensson, 2000; Wen, et al., 2009
Supervision	Borawski, et al., 2003; Cohen, et al., 1994; Mott, Crowe, Richardson, & Flay, 1999; Richardson, et al., 1993; Zapata, et al., 2004
Support	Chassin, Presson, Rose, & Sherman, 1998; Chassin, Presson, Rose, Sherman & Todd, 1998; den Exter Blokland, et al., 2007; Ennett, et al., 2001; Huver, et al., 2007; Jackson, Henriksen, Dickinson, & Levine, 1997; Kristjansson, et al., 2010; Tucker, et al., 2003; Simons-Morton, et al., 2001

Parenting Characteristics in Relation to Youth Smoking:

Examples of Studies (cont'd)

Quality of parent-child relationship (e.g., attachment, warmth, closeness, psychological autonomy)	Agrawal, et al., 2005; Borawski, et al., 2003; Chuang, et al., 2005, 2009; Cohen, et al., 1994; Engels, et al., 2005; Fleming, et al., 2002; Foster, et al., 2007; Friestad & Klepp, 1997; Harakeh, et al., 2004; Hill, et al., 2005; Huebner, et al., 2005; Kandal & Wu, 1995; Kodl & Mermelstein, 2004; Melby, et al., 1993; Miller, et al., 2006; Miller & Volk, 2002; Nowlin & Colder, 2007; O'Byrne, Haddock, Poston, & Mid America Heart Institute, 2002; Otten, et al., 2008; Reimers, Pomrehn, Becker, & Lauer, 1990; Scragg, Reeder, Wong, Glover, & Nosa, 2008; Simons-Morton, et al., 1999; Simons-Morton, et al., 2001; Svensson, 2000; Tilson, et al., 2004; Wen, et al., 2009; White, Johnson, & Buyske, 2000; Wilson, McClish, Heckman, Obando, & Dahman, 2007
Conflict	Agrawal, et al., 2005; Biglan, et al., 1995; Doherty & Allen, 1994; Hill, et al., 2005; Simons-Morton & Haynie, 2003; Simons-Morton, et al., 1999; Simons-Morton, et al., 2001
Involvement	Bailey, et al., 1993; Fleming, et al., 2002; Hill, et al., 2005; Nowlin & Colder, 2007; Otten, Engels, van den Eijnden, 2007, 2008; Simons-Morton, 2002; Simons-Morton, et al., 2004; Simons-Morton & Haynie, 2003; Simons-Morton, et al., 2001
Communication	Cohen, et al., 1994; Distefan, et al., 1998; Fors, et al., 1999; Huebner, et al., 2005; Miller, et al., 2006; Powell & Chaloupka, 2005; Shakib, et al., 2003; Wen, et al., 2009
Discipline (e.g., negative consequences, psychological control)	Chassin, Presson, Rose, Sherman, & Todd, 1998; Engels, et al., 2005; Fleming, et al., 2002; Foster, et al., 2007; Harakeh, et al., 2004; Hill et al., 2005; Huver, et al., 2007; Kandel & Wu, 1995; Miller & Volk, 2002; Simons-Morton, 2002; Simons-Morton, et al., 2004; Simons-Morton, et al., 1999; Simons-Morton & Haynie, 2003; Simons-Morton, et al., 2001

Appendix B

The Effect of Parental Smoking on Youth Smoking:

Examples of Studies

Effect of parental current smoking on youth smoking	**Examples of Relevant Studies**
Positive relationship	Adalbjarnardottir & Hafsteinsson, 2001; Andersen, et al., 2004; Bernat, et al., 2008; Biglan, et al., 1995; Bricker, Peterson, Sarason, Andersen, Rajan, 2007; Chassin, et al., 2005; Chassin, Presson, Rose, Sherman, & Todd, 1998; Chuang, et al., 2005; Dalton, et al., 2009; Distefan, et al., 1998; Engels, Vitaro, Blokland, de Kemp, & Scholte, 2004; Ennett, et al., 2001; Fleming, et al., 2002; Foster, et al., 2007; Geckova, et al., 2005; Gilman, et al., 2009; Glendinning, et al., 1997; Hill, et al., 2005; Hoving, Reubsaet, & de Vries, 2007; Jackson, 1997; Jackson, et al., 1997; Kalesan, et al., 2006; Keyes, Legrand, Lacono, & McGue, 2008; Kodl & Mermelstein, 2004; Leiner, Medina, Tondapu, & Handal, 2008; Mercken, Candel, Willems, & de Vries, 2007; Otten, Engels, & van den Eijnden, 2005, 2007, 2008; Peterson, et al., 2006; Powell & Chaloupka, 2005; Rainio, Rimpela, Luukkaala, & Rimpela, 2008; Simons-Morton, et al., 2001; Vitaro, Wanner, Brendgen, Gosselin, & Gendreau, 2004; Wang, et al., 1999; White, et al., 2003; Wilson, et al., 2007
No relationship	Boomsma, et al., 1994; Castrucci & Gerlach, 2006; de Leeuw, et al., 2008; Fidler, West, van Jaarsveld, Jarvis, & Wardle, 2008; Harakeh, et al., 2004; Herbert & Schiaffino, 2007; Melby, et al., 1993; Miller, et al., 2006; Pierce, et al., 2002; Reimers, et al., 1990; Sargent & Dalton, 2001; Small, 1994; Tilson, et al., 2004; Wang, et al., 1995; Woodruff, Laniado-Laborin, Candelaria, Villasenor, & Sallis, 2004

Appendix C

Recruitment Brochure

This is an Invitation

This is an invitation for you to take part in a study about smoking in childhood.

Parents' Approaches to the Topic of Smoking with Their Children

Investigators:

Sandra Small
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Dr. Kaysi Eastlick Kushner
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Dr. Anne Neufeld
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What is the purpose of this study?

Ways that parents approach their children about smoking varies. Some mothers and fathers may approach the topic with their young children. Others may wait until their children are older. And, some may not approach the topic themselves. The purpose of this study is to learn about the approaches that mothers and fathers take.

Children and teens continue to smoke at a high rate. Smoking is a major health issue. It is a behavior that often raises concern for parents. But, for the most part, parents have not been included in programs about smoking. It is expected that the findings from this study will be helpful in making mothers' and fathers' ideas and concerns known, and in planning programs.

What is involved in taking part in the study?

In this study, I would like to talk with mothers and fathers who:

- have at least one child in kindergarten to grade 6, and
- either smoke or do not smoke.

Either one or both parents from the same family may choose to be in the study.

During the interview, I will ask questions on:

- your thoughts and feelings about youth smoking,
- how you approach the topic of smoking with your child, and
- your ideas about smoking prevention.

The interviews will be planned for a time and place that is most suitable for you.

Payment is available for expenses you have due to attending an interview. These are:

- reasonable travel costs (public transit, mileage and parking), and
- childcare costs (babysitting).

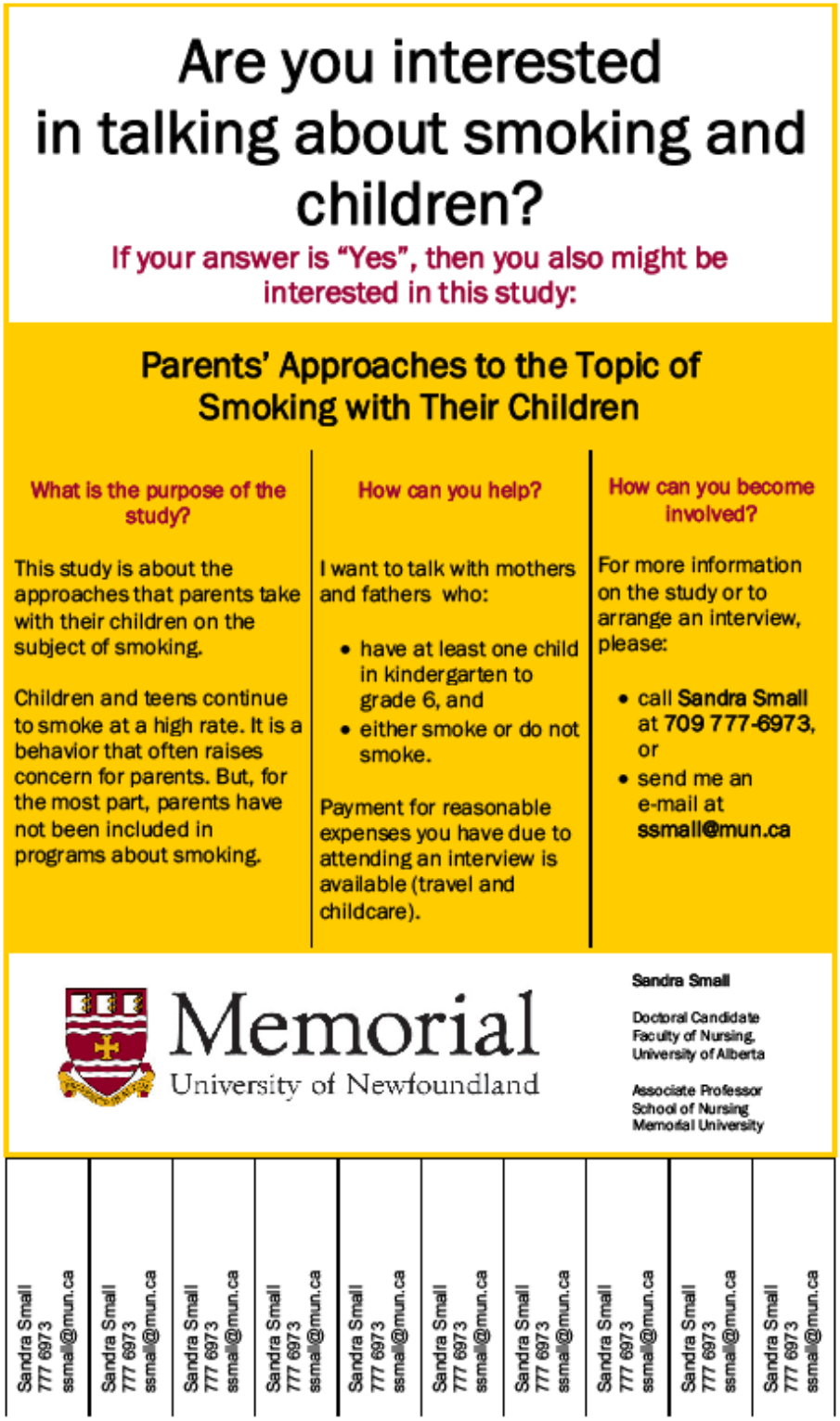
How can you become involved?

For more information on the study or to arrange an interview, please:

- call **Sandra Small** at **709 777-6973**, or
- send me an e-mail at **ssmall@mun.ca**

Appendix D

Recruitment Poster



Appendix E

Interview Guide for Parents

I would like to talk with you about your thoughts on smoking by children. I also want to talk with you about whether or not you talk about smoking with your child/ren, and, if you do talk about it, what things you say and do. There are no right or wrong answers to any questions I ask. I want to learn about your personal views and experience with your children.

First, I would like to ask you a few short questions about your family so that I can become familiar with who the family members are (refer to the first 10 questions on socio-demographic data record):

1. How many children are in your family?
2. Do you have (a) boy(s) or girl(s) (if more than one, from youngest to oldest)?
3. What is(are) the age(s) of your child/ren (if more than one, from youngest to oldest)?
4. What grade is(are) your children in at school (if more than one, from youngest to oldest)?
5. What school(s) do(es) your child/ren attend?
6. Who lives in your household (e.g., mother, father, step-parent, children, step-children, etc.)?
7. Do any of your immediate family members smoke (children, parents)? Do any other members of your household smoke?

Now, I would like to talk with you about smoking by children:

1. Would you please tell me about your thoughts on children smoking? (Specific questions which may be asked: What do you see as factors that influence children to smoke? What do you see as factors that influence children to not smoke?)
2. (If parent has a child who smokes), How do you feel about _____ (name of child) smoking?
3. How would you feel if you found out that _____ (name of preadolescent child who doesn't smoke based on parent's knowledge) has tried a cigarette? How would you respond? What if you found out that he/she actually smokes? How do you think that you would feel about the smoking if _____ was older (an adolescent)?

   (As appropriate), How would you feel if it was _____ (other preadolescent children in the family)?

Some parents may address the topic of smoking with their young children and others may not. Some parents may wait until their children are older before they raise the topic.

4. Is smoking a topic that has been approached in your family with _____ (name of preadolescent child)? (As appropriate), What about with _____ (specify other preadolescent child/ren in the family)? (If no), what are your thoughts on that?

   (If yes), How has the topic come up? How has the topic been approached/by whom/when?

(If parent has a child who smokes), How does having a child who smokes affect how you (or the other parent, or both) address smoking with _____ (preadolescent child/ren)?

How has _____ (preadolescent child/children) responded?

5. Can you think of a specific time when _____ (a preadolescent child) made mention of smoking or asked questions about it? Would you describe the situation for me? What did he/she say? How was it handled (who dealt with it, what was said/done)? How did he/she respond? (Probe here as necessary re possible situations such as the child encountering or observing other children or adults who were smoking, hearing other children talk about smoking, hearing about smoking through the school curriculum or smoking prevention program, hearing about smoking through community smoking prevention campaigns or television advertisements, seeing smoking products in stores, etc.)

6. (As appropriate, depending on parent's previous response as to whether smoking is approached or not), What do you find helpful to you in addressing the topic of smoking with your children? What is not helpful to you? (If parent has not addressed smoking with child/ren), Are there things that have hindered you from addressing the topic of smoking with your child/ren? What things? (Probe as necessary re social contextual factors such as family member smoking status and attitudes, peer influence, school smoking curricula, smoking prevention campaigns, media exposure to smoking, access to tobacco, no-smoking laws and

probe re personal factors such as personal characteristics, e.g., sense of humor, parenting approach, expectations re child behaviour, etc., child personality).

7. What message would you like your child/children to have about smoking? (Specific questions which may be asked: What do you see as the best way to prevent smoking by children? What might make the effort most effective? What do you see as barriers to preventing smoking among children/adolescents? What are your thoughts on how parents can be assisted to promote antismoking messages with their children? What resources would be helpful to parents?)
8. What advice would you give to other parents about approaching the topic of smoking with their children?
9. Is there anything else that you would like to tell me about childhood smoking and about addressing it with young children?
10. How did you learn about this study? (e.g., through brochure sent home from school, poster in a recreation center, another parent, etc.)

Appendix F

Socio-demographic Data Record

Code #: _____

Date: _____

1. **Number of children in the family? _____**

2. **Sex of child (if more than one, from youngest to oldest)?**

   1 male 2 male 3 male 4 male 5 male

   Female female female female female

3. **Age of child (if more than one, from youngest to oldest)?**

   ____ years ____ years ____ years ____ years ____ years

4. **Educational level of child (if more than one, from youngest to oldest)?**

   Grade ____ Grade ____ Grade ____ Grade ____ Grade ____

5. **What school does your child attend (if more than one, from youngest to oldest)?**

   _____

6. **Who lives in your household (e.g., mother, father, children, step-parent, step-children, etc)?**

   _____

7. Smoking status of child (if more than one, from youngest to oldest)?

non-smoker 1 ____ 2 ____ 3 ____ 4 ____ 5 ____

current smoker; how long? ____ ____ ____ ____ ____

past smoker; how long ago? ____ ____ ____ ____ ____

8. Smoking status of mother?

non-smoker _____

current smoker; how long? _____

past smoker; how long ago? _____

9. Smoking status of father?

non-smoker _____

current smoker; how long? _____

past smoker; how long ago? _____

10. Smoking status of any other members of the household?

Who 1_____2_____

non-smoker 1_____ 2_____

current smoker; how long (if known)? 1_____ 2_____

past smoker; how long ago (if known? 1_____ 2_____

11. Sex of parent? _____

12. Age of parent? _____ years

13. Educational level of parent?

less than high school

some high school

high school graduate

some university or college

university or college graduate

some post graduate courses

Masters degree or higher

14. Occupation of mother? _____

15. Occupation of father? _____

16. Household annual income level?

<$10,000

$10,000 - 19,000

$20,000 - 29,000

$30,000 - 39,000

$40,000 - 49,000

$50,000 - 59,000

$60,000 - 69,000

$70,000 - 79,000

$80,000 - 89,000

≥ $90,000

Appendix G

Interview Guide for Professionals

As we discussed, this study is about parents' approaches to the topic of smoking with their children. I would like to talk with you concerning your perceptions of youth smoking, social influences and smoking prevention.

1. From your point of view, what are social factors that influence children to smoke?

2. What do you think are social factors that influence children not to smoke?

3. What do you think can be done to prevent smoking in children? (Specific questions which may be asked: Why do you think that approach/action would work? What do you think are factors which are helpful to an effective approach? What about barriers to an effective approach?)

4. What programs are you aware of that are currently in place to prevent children from smoking? (Use specific questions here to gain detail of each particular program: e.g. Would you describe that program for me?)

5. (If participant has direct contact with parents in his/her role), Would you describe the type of interaction that you have with parents about smoking? (Specific question which may be asked: What concerns and needs do parents raise with you about smoking and their children?)

6. Are you aware of any programs that are available to assist parents to address smoking with their children? (Use specific questions here to gain detail of any program(s): e.g. Would you describe that program for me?)

7. What advice would you give to parents about addressing smoking with their young children?

8. Is there anything else about youth smoking and parents that you would like to discuss with me?

Appendix H

Informed Consent for Parents

Parent Information for Informed Consent to Take Part in a Research Study

Title of the Study: **Parents' Approaches to the Topic of Smoking with Their School-Age Pre-adolescent Children**

Co-Principal Investigators: Sandra Small
Doctoral Candidate
Faculty of Nursing, University of Alberta

Dr. Kaysi Eastlick Kushner and Dr. Anne Neufeld
Faculty of Nursing, University of Alberta

Voluntary Participation

You have been invited to take part in a research study. It is up to you to decide whether to be in the study or not. Before you decide, you need to understand what the study is for, and whether there are any risks or benefits to you. These consent sheets explain the study. If you decide to take part, you are free to leave the study at any time.

The researcher will:

- discuss the study with you
- answer your questions
- keep confidential any information which could identify you personally
- be available during the study to answer questions

Introduction

Children and teens continue to smoke at a high rate. Smoking is a major health issue. It is a behaviour that often raises concern for parents. But, for the most part, parents have not been included in programs about smoking.

Purpose of the Study

Ways that parents approach their children about smoking varies. Some parents may approach the topic with their young children. Other parents may wait until their children are older. And, some may not approach the topic themselves. The purpose of this study is to learn about the approaches that parents use. It is expected that the findings from this study will be helpful in making parents' ideas and concerns known and in planning programs.

Procedure

The study involves two interviews with parents who have children in kindergarten to grade 6.

I would like to talk with parents who smoke and those who do not smoke, and mothers and fathers. Either one or both parents from the same family may choose to be interviewed.

During the first interview, I will ask questions on:

- your thoughts and feelings about youth smoking;
- how you approach the topic of smoking with your child (or children);
- your ideas on smoking prevention;
- the number of children in your family, who lives in your home, your age, your education level, parents' occupations, household income, and household members' smoking status; and
- your child's (or children's) age, school grade, school, and smoking status.

The purpose of the second interview is to have you:

- comment further on any points made during the first interview, if that is needed;
- answer any questions about the topic that may have been missed during the first interview; and
- comment on what I have found in the study up to that point.

Both interviews will be audio recorded, if you agree to that.

Length of Time

The first interview will last about one hour. The second one will last from 30 to 45 minutes. That one will take place within about three months of the first.

Possible Benefits

The only possible benefit to you for being in this study is having a chance to share your thoughts on youth smoking and smoking prevention.

A copy of the final report will be available to you upon request to Sandra Small, School of Nursing, Memorial University, St. John's, Newfoundland, A1B 3V6.

Possible Risks, Discomforts and Inconveniences

There are no expected risks or discomforts for you as a result of being in this study. If you find that there are questions you would rather not answer, you are free to make that choice. The interviews will be planned for a time and place that are most suitable for you.

Privacy and Confidentiality

All information collected about you for this study will be kept confidential, unless the law requires release. The information will not identify you by name. Instead, it will be given a code number. Your name will not be disclosed outside of the research team. Your name or other identifying information will not be used in any presentations, reports or publications about this study. Study information is required to be kept for 7 years. The interviews will be typed out. The audio recordings and printed copies of the interviews will be kept. Your information will be stored at Memorial University.

Payment for Expenses

You will be paid for any travel and childcare costs that you have as a result of attending an interview. Costs are for city public transit, mileage for use of your own car within the city, parking and babysitting. The mileage payment will be based on the usual University rate (cents per km). The childcare payment will be at $7.50 an hour. The payments will be made at the time of the interview.

Liability Statement

Signing the attached form gives us your consent to be in this study. It tells us that you understand the information about the research study. When you sign the form, you do not give up your legal rights. Researchers or agencies involved in this research study still have their legal and professional responsibilities.

Questions about the Study and Contact Information

If you have any questions about taking part in this study, you can meet with the person who is in charge of the study here in Newfoundland. That person is:

- Sandra Small, Tel: 709 777-6973 or email: ***ssmall@mun.ca***

Or, you may contact:

- Dr. Kaysi Eastlick Kushner, Assistant Professor, University of Alberta
  Tel: 780 492-5667 or e-mail: kaysi.kushner@ualberta.ca

- Dr. Anne Neufeld, Professor, Faculty of Nursing, University of Alberta, Tel: 780 492-2699 or e-mail: anne.neufeld@ualberta.ca

Or, you may contact someone from the Faculty of Nursing, University of Alberta, who is not involved with this study. That person is in charge of research there. That person is:

- Dr. Christine Newburn-Cook, Associate Dean of Research Tel: 780 492-6764 or e-mail: christine.newburn-cook@ualberta.ca

Also, you can talk with someone who can advise you on your rights as a participant in a research study. That person is not involved with this research and can be reached at the:

Office of the Human Investigation Committee (HIC), Memorial University, 709-777-6974 or e-mail: hic@mun.ca

Parent Consent Form

Title of the Study: **Parents' Approaches to the Topic of Smoking with Their School-Age Pre-adolescent Children**

Names of co-principal investigators: Sandra Small
Tel: 708 777-6973 or e-mail:
ssmall@mun.ca

Dr. Kaysi Eastlick Kushner
Tel: 780 492-5667 or e-mail:
kaysi.kushner@ualberta.ca

Dr. Anne Neufeld
Tel: 780 492-2699 or e-mail:
anne.neufeld@ualberta.ca

To be filled out and signed by the participant

	Please check as appropriate:	
I have read the consent and information sheets.	Yes { }	No { }
I have had the opportunity to ask questions and discuss this study.	Yes { }	No { }
I have received satisfactory answers to all of my questions.	Yes { }	No { }
I have received enough information about the study.	Yes { }	No { }
I have spoken to _____ and she has answered my questions.	Yes { }	No { }
I understand that I am free to withdraw from the study • at any time, and • without having to give a reason.	Yes { }	No { }
I understand that it is my choice to be in the study.	Yes { }	No { }
I understand that I may not benefit from this study.	Yes { }	No { }
The issue of confidentiality has been explained to me.	Yes { }	No { }
I agree to take part in this study.	Yes { }	No { }
I agree to being contacted in the future by the investigators to be given information on any suitable new study.	Yes { }	No { }

_____ _____
Signature of participant Date

To be signed by the investigator:
I have explained this study to the best of my ability. I invited questions and gave answers. I believe that the participant fully understands what is involved in being in the study, any potential risks of the study and that he or she has freely chosen to be in the study.

_____ _____
Signature of investigator Date

Appendix I

Informed Consent for Professionals

Information for Professionals (Secondary Informants) about Informed Consent to Take Part in a Research Study

Title of the Study: **Parents' Approaches to the Topic of Smoking with Their School-Age Pre-adolescent Children**

Co-Principal Investigators: Sandra Small
Doctoral Candidate
Faculty of Nursing, University of Alberta

Dr. Kaysi Eastlick Kushner and Dr. Anne Neufeld
Faculty of Nursing, University of Alberta

Voluntary Participation

You have been invited to take part in a research study. It is up to you to decide whether to be in the study or not. Before you decide, you need to understand what the study is for, and whether there are any risks or benefits to you. These consent sheets explain the study. If you decide to take part, you are free to leave the study at any time.

The researcher will:

- discuss the study with you
- answer your questions
- keep confidential any information which could identify you personally
- be available during the study to answer questions

Introduction

Children and teens continue to smoke at a high rate. Smoking is a major health issue. It is a behaviour that often raises concern for parents. But, for the most part, parents have not been included in programs about smoking.

The broader social environment may affect how parents approach the topic of smoking with their children. You are being asked to be involved in this study because of your work in smoking prevention and / or tobacco control. Your expertise in this area will add to an understanding of the social setting in which parents address smoking with their children.

Purpose of the Study

The purpose of the study is to learn about parents' approaches to the topic of smoking with their school-age children. It is expected that the findings from this study will be helpful in making parents' ideas and concerns known and in planning programs.

Procedure

Participating in this study will involve an interview with you. I will ask you questions about:

- youth smoking,
- general social issues around smoking, and
- smoking prevention.

The interview will be audio recorded, if you agree to that.

Length of Time

The interview will last about one hour.

Possible Benefits

The only possible benefit to you for being in this study is having a chance to share your thoughts on youth smoking and smoking prevention.

A copy of the final report will be available to you upon request to Sandra Small, School of Nursing, Memorial University, St. John's, Newfoundland, A1B 3V6.

Possible Risks, Discomforts and Inconveniences

There are no expected risks or discomforts for you as a result of being in this study. If you find that there are questions you would rather not answer, you are free to make that choice. The interviews will be planned for a time and place that are most suitable for you.

Privacy and Confidentiality

All information collected about you for this study will be kept confidential, unless the law requires release. The information will not identify you by name. Instead, it will be given a code number. Your name will not be disclosed outside of the research team. Your name or other identifying information will not be used in any presentations, reports or publications about this study.

Study information is required to be kept for 7 years. Typed out copies of the interviews and the audio recordings will be kept. Your information will be stored at Memorial University.

Liability Statement

Signing the attached form gives us your consent to be in this study. It tells us that you understand the information about the research study. When you sign the form, you do not give up your legal rights. Researchers or agencies involved in this research study still have their legal and professional responsibilities.

Questions about the Study and Contact Information

If you have any questions about taking part in this study, you can meet with the person who is in charge of the study here in Newfoundland. That person is:

- Sandra Small
  Tel: 709 777-6973 or email: ssmall@mun.ca

Or, you may contact:

- Dr. Kaysi Eastlick Kushner, Assistant Professor, University of Alberta
  Tel: 780 492-5667 or e-mail: kaysi.kushner@ualberta.ca
- Dr. Anne Neufeld, Professor, Faculty of Nursing, University of Alberta,
  Tel: 780 492-2699 or e-mail: anne.neufeld@ualberta.ca

Or, you may contact someone from the Faculty of Nursing, University of Alberta, who is not involved with this study. That person is in charge of research there. That person is:

- Dr. Christine Newburn-Cook, Associate Dean of Research
  Tel: 780 492-6764 or e-mail: christine.newburn-cook@ualberta.ca

Also, you can talk with someone who can advise you on your rights as a participant in a research study. That person is not involved with this research and can be reached at the:

- Office of the Human Investigation Committee (HIC), Memorial University, 709-777-6974 or e-mail: hic@mun.ca

Secondary Informant Consent Form

Title of the Study: **Parents' Approaches to the Topic of Smoking with Their School-Age Pre-adolescent Children**

Names of co-principal investigators: Sandra Small
Tel: 708 777-6973 or e-mail:
ssmall@mun.ca

Dr. Kaysi Eastlick Kushner
Tel: 780 492-5667 or e-mail:
kaysi.kushner@ualberta.ca

Dr. Anne Neufeld
Tel: 780 492-2699 or e-mail:
anne.neufeld@ualberta.ca

To be filled out and signed by the participant

	Please check as appropriate:	
I have read the consent and information sheets.	Yes { }	No { }
I have had the opportunity to ask questions and discuss this study	Yes { }	No { }
I have received satisfactory answers to all of my questions.	Yes { }	No { }
I have received enough information about the study.	Yes { }	No { }
I have spoken to _____ and she has answered my questions	Yes { }	No { }
I understand that I am free to withdraw from the study • at any time and, • without having to give a reason.	Yes { }	No { }
I understand that it is my choice to be in the study.	Yes { }	No { }
I understand that I may not benefit from this study.	Yes { }	No { }
The issue of confidentiality has been explained to me.	Yes { }	No { }
I agree to take part in this study.	Yes { }	No { }

_____ _____
Signature of participant Date

To be signed by the investigator:
I have explained this study to the best of my ability. I invited questions and gave answers. I believe that the participant fully understands what is involved in being in the study, any potential risks of the study and that he or she has freely chosen to be in the study.

_____ _____
Signature of investigator Date

Appendix J

Parental Verbal Interaction by Socio-Demographic Characteristics

Verbal interaction approach[a]	Socio-demographic characteristics											
	Parent (n)		Marital status (n)		Household income (n)[b]			Education (n)				
	Mother	Father	Single	Spouse or partner	Low	Middle	High	Less than high school	High school graduate	Some university or college	University or college graduate	Masters degree or higher
Discussing smoking with their children: Intentionally taking advantage of opportunities (n = 22)	20	2	4	18	4	7	10	2		5	11	4
Telling their children about the health effects of smoking and their opposition to it: Responding on the spur-of-the-moment if their attention was drawn to the issue by external cues (n = 9)	4	5	3	6	4	4	1	1	1	6	1	
Acknowledging to their children the negative effects of smoking: Responding only when their children brought it up (n = 6)	4	2	3	3	4	1	1	1	2	2	1	

Parental Verbal Interaction by Socio-Demographic Characteristics (cont'd)

Verbal interaction approach[a]	Socio-demographic characteristics								
	Occupation (n)[c]								
	Business, finance, administrative	Applied sciences, technology	Health	Education, law	Art, culture	Services, sales	Trades	Stay-at-home parent	Unemployed, disabled, student
Discussing smoking with their children: Intentionally taking advantage of opportunities (n = 22)	3	1	2	5	2	2		5	2
Telling their children about the health effects of smoking and their opposition to it: Responding impulsively if their attention was drawn to the issue by external cues (n = 9)			1		2	1	1	3	1