

## Smoking Among Disadvantaged Women: Causes and Cessation

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La présente étude avait pour objectif d'établir les facteurs sociaux et psychologiques liés au fait de fumer ou de cesser de fumer chez les femmes défavorisées. On a fait des entrevues individuelles et en groupe auprès de femmes défavorisées vivant dans les Provinces atlantiques. Les participantes étaient surtout pauvres, sans emploi, isolées géographiquement et composaient des familles monoparentales. Les facteurs liés au fait de fumer comprenaient la réaction face aux tensions, la solitude, l'incapacité à gérer les difficultés, une efficacité personnelle moindre, les pressions sociales et l'accoutumance. Les participantes estimaient important le soutien apporté par les pairs (c'est-à-dire les femmes vivant les mêmes situations) et les partenaires. Elles considéraient que les professionnels de la santé et les programmes classiques pour cesser de fumer ne les aidaient pas. Elles jugeaient que les centres pour femmes et les organismes pour femmes étaient les lieux adéquats pour les programmes visant à cesser de fumer. Les questions méthodologiques sont à l'étude.

This study aimed to identify social-psychological factors associated with smoking and smoking cessation among disadvantaged women. Individual and group interviews were conducted with disadvantaged women in Atlantic Canada. Participants were predominantly poor, unemployed, geographically isolated, and single parents. The factors asso-

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ciated with smoking included coping with stresses, loneliness, powerlessness, low self-efficacy, social pressures, and addiction. Support from peers (i.e., women in similar circumstances) and partners was considered important. Health professionals and traditional cessation programs were not perceived as supportive. Participants viewed women's centres and women's agencies as appropriate deliverers of cessation programs. Methodological issues are discussed.

Women have been excluded from health research, which has resulted in a view of health predicated on a male model (Clancy & Massion, 1992; Dresser, 1992). Although in more recent years increasing attention has been given to gender as a framework for understanding women's health (Phillips, 1995), the emphasis has been placed on biological sex differences. There are, however, powerful social and political factors that influence the quality of women's health and well-being. When women are asked about their health concerns, they consistently identify violence, stress, and poverty as significant factors in well-being (Phillips; Walters, 1992). Indeed, gender is intricately connected with social, cultural, and economic factors, which may determine health and well-being. In Canada, poverty rates are higher for women than for men in every age group (National Council of Welfare, 1994). Women on average have lower incomes than men, are concentrated in lower-status occupations, and are underemployed (Health Canada, 1994). Further inequalities arise from the traditional division of labour; work in the labour force is paid, whereas work in the home is not. The "feminization of poverty" is reflected in the earning differentials that presuppose the economic dependence of women on men, and the disproportionate impact of cutbacks to public benefits on women due to their greater poverty and their responsibility for children (McLanahan, Sorensen, & Watson, 1989).

There is evidence that gender and class intersect in determining women's health behaviours such as smoking. Given that 25% of Canadian women smoke (Health Canada, 1995a), and that women start smoking younger and consume more cigarettes than their predecessors did (Davies, 1990), it is not surprising that there has been a substantial increase in the death rate of women from cancers related to smoking (National Cancer Institute of Canada, 1995, p. 20) and in other health effects such as earlier menopause, reduced fertility, and increased risk of stroke (USDHHS, 1989). Despite these health concerns, there are lower smoking cessation rates among women than among men (Coambs, Li, & Kuzlowski, 1992). Women in disadvantaged groups have higher smoking rates than other women smokers in Canada (Health Canada, 1995b); low-income women are more likely to be smokers (Health Canada, 1993a, b). Smoking has also been associated with the stress of caregiving in situations of financial hardship; young

women smoke to manage the pressures of child care (Romans, Herbison, Walton, & Mullen, 1993) and smoking among older women is linked to caring for relatives (Kirkland, 1994; Penning & Chappel, 1993). Social and geographic isolation is also associated with high levels of cigarette smoking among women (Health Canada, 1995b; Romano, Bloom, & Syme, 1991). Moreover, the difference in smoking rates between higher- and lower-educated women has increased (Millar & Stephens, 1993).

Cultural affiliation is related in more complex ways to smoking status. Preliminary data reveal that smoking prevalence is high among aboriginal women in Canada, particularly the Inuit, which may reflect the cultural significance of tobacco (Millar, 1992; Stephens, 1994); aboriginal women also receive the lowest average income in Canada. More women, in particular francophones, smoke in Quebec than in other provinces. There are lower rates of smoking, however, among many immigrant women than among Canadian-born residents (Millar & Hunter, 1990). The lowest levels of smoking were found among immigrant women of Asian origin and the highest levels among French, German, Polish, and Ukrainian immigrant women (Statistics Canada, 1994). Furthermore, immigrants are more likely than other Canadians to have quit smoking and to smoke fewer cigarettes.

Clearly, smoking is linked to poverty, unemployment, and other disadvantaged circumstances. Regrettably, however, research on the smoking behaviours of disadvantaged women and on the barriers and supports to their cessation is meagre. Accordingly, the objectives of this Canadian study were: (1) to identify the social and psychological factors that influence the smoking behaviour of disadvantaged women, and (2) to identify strategies, interventions, and agencies that foster reduced smoking levels among disadvantaged women.

## **Methods**

Research teams at two Canadian health-promotion research centres engaged in several sequential data-collection activities during the six phases of the project. These included: (Phase 1) a comprehensive literature review; (Phase 2) a secondary data analysis of the Ontario Health Survey and the Atlantic provinces' Heart Health Surveys; (Phase 3) telephone interviews with representatives of 13 women-centred cessation programs in Manitoba, Ontario, Quebec, Nova Scotia, and Prince Edward Island; (Phase 4) focus-group interviews with 254 disadvantaged women and individual interviews with 134 disadvantaged women in 10 provinces; (Phase 5) telephone interviews with represen-

tatives of 29 non-traditional support agencies in 10 provinces; and (Phase 6) telephone interviews with 22 disadvantaged women using these non-traditional support services.

This paper will focus on the Atlantic component of the fourth and sixth phases, which involved interviews with disadvantaged women. Smoking rates are higher in the Atlantic region than elsewhere in Canada (Statistics Canada, 1991) and 74% of women smokers are moderate to heavy smokers (Nova Scotia Department of Health, 1993). Furthermore, there are higher unemployment rates, lower income levels, and lower levels of educational attainment in the Atlantic region than in the rest of Canada (Statistics Canada, 1991, 1994). The Atlantic region also differs from the rest of Canada in terms of the rural nature of all four provinces (Statistics Canada, 1993), which could contribute to social isolation. No research focuses on tobacco use among rural women (Health Canada, 1995b).

#### *Phase 4*

The three specific *objectives* of the consultations with disadvantaged women were: to record their recollections and reflections about their experiences with smoking; to elicit their opinions and beliefs about smoking cessation; and to explore the psychosocial factors associated with smoking and smoking cessation. A total of 126 women participated in the Atlantic region interviews: 84 in the nine focus groups and 42 in individual interviews. Disadvantaged women smokers over 20 years of age who were poor, unemployed and/or single parents, had low levels of formal education, and lived in rural and isolated communities were included as participants. Consistent with qualitative methodologies, the sampling was purposive.

The interviews were conducted in sites accessible to these women, including women's centres, family-resource centres, a public school, a library, a food-processing plant, and an apartment residence for low-income single women. Refreshments were provided and child-care costs were reimbursed. Group interviews were completed in approximately two hours, individual interviews in one hour. At each focus group, the facilitator was assisted by an observer/recorder. During the introductory portion of both the group interviews and the individual interviews, the facilitator/interviewer clarified the objectives of the study, provided a brief overview of the procedure, and assured participants that all comments were confidential and that their names would not be used in the report.

The same interview guide was used for individual and group interviews. The guide included eight questions focusing on the reasons why these women began to smoke and continued to smoke; two questions about the perceived impact of non-smoking messages in the media, in public places, etc.; eight questions on their opinions and experiences with smoking cessation or curtailment; and six questions regarding strategies, services, and support that would help them stop or reduce smoking. The questions were exploratory, open-ended, and accompanied by probes. Three examples follow.

Now, I'd like to ask you to think back further...to the first time you smoked. What was it that got you to take those first cigarettes? What were your immediate impressions about smoking? What were the reasons you became a regular smoker? (Probes: Family? Friends? Work group? Advertising? Image? Adventure?)

What do you like about smoking? What keeps you smoking? What does smoking do for you? (Probes: Weight control? Comfort? Relaxation? Enjoyment? Companionship? Boredom? Coping? Addiction/being hooked? Stress reduction?)

Let's create the ideal service or support to help you become a non-smoker. Think about the things that you would find most helpful. (Probes: Where would this service or support take place? What group or organization would be most capable of doing this?)

At the conclusion of each individual and group consultation, a socio-demographic questionnaire was administered. One of the 11 items elicited the participant's current level of motivation with regard to smoking cessation. The woman was asked to choose which of four statements most closely described her cessation intentions, based on four stages of behavioural change involved in smoking cessation (Prochaska & DiClemente, 1983). All the group and individual consultations were tape-recorded and transcribed. Content analysis of themes and sub-themes in the qualitative data was conducted by the research team. The researchers identified themes and categories and attempted to achieve consensus.

### *Phase 6*

The two *objectives* of the consultations with the women who used "non-traditional" support services (outside traditional tobacco-control organizations), such as women's centres and other organizations devoted to women in disadvantaged circumstances, were to identify interventions and strategies for smoking reduction or cessation, and to determine the role and credibility of these support services as deliverers of cessation



programs. The 12 telephone interviews in Atlantic Canada were conducted using an eight-item interview guide, encompassing open-ended and closed-ended questions. These participants (who had not been interviewed in Phase 4) were asked to talk about (1) their experiences and needs with regard to smoking cessation, (2) the appropriateness of community-based support agencies as providers of smoking-cessation programs or services, and (3) the desirability of integration of tobacco-related information within the existing programs and services of these agencies. Interview guides were mailed to all participants before the interviews, so that they could familiarize themselves with the questions and have time to consider their responses. The data analysis included content analysis of the qualitative data and frequency distributions of the quantitative data. The participants in the interviews conducted in both phases were given a summary of the findings.

### **Profile of Participants**

The formal-education level of participants was quite low: 60% of the women indicated that they had not completed high school. The majority of participants (82%) had children and almost half (48%) were heads of single-parent families; 74% reported that they spent most of their time at home. Only one quarter of the women had paid employment, either full-time (14%) or part-time (12%). With few exceptions, those who were employed reported working in "low status" jobs, such as babysitter, garage attendant, or janitor. Some participants were in school or training (10%) or did volunteer work (15%). All participants were smokers, although some were engaged in cessation or reduction attempts. Typically, these women were heavy smokers. Most (76%) reported smoking more than 15 cigarettes a day, and 23% smoked more than one pack of cigarettes daily. Many of these women lived with other smokers, usually a partner or spouse. The vast majority (98%) of participants had lived in Canada for the past 10 years. Few belonged to multicultural groups, perhaps due to the relatively low incidence of smoking among women in the immigrant and refugee sectors. Many of the participants in New Brunswick were bilingual, although French was their first language. (Separate initiatives by Health Canada focused on francophone women, immigrant women, and aboriginal women.)

### **Findings**

A summary of findings is presented with exemplar quotations to illustrate some themes and sub-themes.

### *Factors Influencing Smoking (Phase 4)*

Disadvantaged women began smoking to project an image. The participants' stories about their first smoking experiences as adolescents focused on their attempts to establish an identity consistent with that of their peers, and usually at variance with the expectations of parents or other members of society. The picture changed when the participants talked about being adult smokers. In the reasons they gave for smoking, and the feelings they expressed about being smokers, the women revealed a deep ambivalence about a behaviour they knew was dangerous in the long term but which was compelling for the immediate sense of relief it brought to their daily lives. They spoke of the "hold" that smoking had on their lives. Addiction was a pervasive theme. Disadvantaged women experienced the psychological aspects of addiction and the physical manifestations of addiction and perceived that they smoked more after a cessation attempt.

Non-smokers who have never smoked, or even ex-smokers who are faithful at it – I don't think they fully understand how hard it is, and how much cigarettes play on your mind when you are not smoking. I've never been a drug addict, but it has to be along the same line.

I'm sorry I ever picked up that first cigarette again...I said just this one won't hurt; I'll never go back to smoking what I used to. But you're lying to yourself. You go back and you're smoking twice as much.

Due to the pressing nature of the participants' life circumstances, many were caught in a daily struggle for survival. Consequently, the long-term benefits of quitting had little relevance for them. Disadvantaged women continued to smoke to cope with the moment. Their lives were characterized by many stressors and few resources with which to respond to stressful situations. Coping mechanisms predominated in all the explanations women gave for their smoking behaviour. They smoked to cope with the stress, chaos, and crises in their lives.

Let people in government try to live on \$800 a month with two kids. See how far they get with it. Rent, heat, lights and all that. If my kid gets sick, I can't afford to go out and get medicine for him. But because I smoke, [they say], "Don't smoke any more. That's four dollars you're spending..." It's [smoking's] about the only thing that I can afford that does relax me...But I have quit in the past...and I didn't find I had a lot more money to do anything constructive with. I still couldn't go out and buy my own home.

Most women had multiple role demands that offered little space and time for themselves, and they smoked as a break from the monotonous, burdensome routine of their day. They smoked as an antidote to

boredom or inactivity, and to relieve their sense of isolation, loneliness, and limited social opportunities. These women also smoked for social and recreational reasons, because others were smoking, and they used cigarettes as a reward and for pleasure.

My spouse died when our child was almost a year old...and I hadn't been smoking then...I went through all of that, and a year later I started smoking again! But I think it was just out of loneliness...it was just me and him...I felt lonely and it gave me something to do for the evening. It was a comfort, yes, a coping thing. I was into crafts but that was an expense to keep up...it gives me strength to cope with life.

I don't have a man in my life. I don't have anybody telling me what to do, how to spend my money. My smoking is because I enjoy it. It's my choice to do that, and that's what I do.

Nevertheless, these disadvantaged women were ambivalent about smoking. In addition to stress management and social "benefits," participants reported seeing the detriments of smoking. They experienced the pain of social stigma and perceived a lack of control.

I don't like the way people look down on us [smokers]. It makes people who already have low self-esteem and don't feel good about themselves, it's adding to that. It's making them feel more awful, that they don't fit in, that they don't belong.

It's a funny feeling, you feel so bad about what you are doing to others, and yet you cannot seem to stop.

The women's discussions about smoking cessation also focused on low self-efficacy (i.e., their confidence in their personal ability to quit smoking), which they attributed to low self-esteem, previous unsuccessful attempts to quit, and multiple role demands.

Probably the one thing that would help me [quit] would be to get my self-esteem back up...because it is not good any more like it used to be. Like I diet so many times in my life and that doesn't help, and everything else. Like I feel bad about myself. There are a lot of different situations in my life, and maybe if I could better myself in certain ways...if I could get a job...

In lives centred on parenting and caregiving, many women found it impossible to deal with the stresses of cessation in addition to trying to meet their families' expectations. A pervasive theme was the way in which children influenced women's smoking behaviour. On the one hand, children and child care were often discussed as stressors associated with smoking or resumption of smoking. On the other hand, because of concerns about the effects of second-hand smoke, children were also cited as a reason for quitting; children provoked feelings of



guilt and anxiety, which motivated cessation attempts but which also were exacerbated when these attempts failed.

I tried to stop for two days, but I couldn't stand the kids. I couldn't stand myself.

The proudest thing would be...not more for myself, but for my kids...if one day they say to me, Mum, I'm some proud of you because you don't smoke. To me that would be the biggest accomplishment.

Most were aware of the harmful effects of smoking on the fetus; during pregnancy many women stopped smoking, or attempted to stop or cut down.

I was so excited at being pregnant...[I] just stopped. I didn't crave for it. I was so wrapped up in having a healthy child that I didn't want to take any risks. [Now] if I don't have it, I feel really irritable. I feel like I'm missing something.

Some women made links between smoking and weight. While this was not a prevalent theme, a number of them feared cessation because of concerns about weight gain. In contrast, a few wanted to stop smoking because they were too thin. Thus smoking for some participants was bound up with the "women's issue" of body image.

#### *Factors Influencing Cessation (Phase 4)*

Participants were unanimous in their dislike of smoking. All participants stated that they would like to be ex-smokers, and almost all had attempted to stop at least once. However, participants were variously motivated with regard to changing their smoking behaviour. The level of impact of anti-smoking messages in the media was related to the woman's Stage of Change (Prochaska, Velicer, Guadagnoli, Rossi, & DiClemente, 1991). Overall, media messages on the negative health effects of smoking had little impact on the participants' smoking behaviours. However, different stages of behavioural change were reflected in participants' reactions to anti-smoking messages. Stages 1 and 2 smokers (i.e., precontemplation and contemplation) were typically dismissive of media messages. The messages did not seem to "connect" with their own smoking behaviour. In contrast, some stages 3 and 4 smokers (i.e., preparation and action) applied the messages to their personal behaviour. Several participants who were beginning to take action (cutting down in preparation for cessation) indicated that they sometimes used media messages to strengthen their motivation.

I would probably watch it, wondering if I should turn it off... Yes, I'm listening... I feel I should quit because I don't want to be that bad! It bothers me at first, but after I forget about it I'm OK. But if I keep it in my mind, I know I should quit, get it over with... you know, I don't want to die!

The disadvantaged women studied had ambivalent feelings about smoking restrictions. Although virtually all participants acknowledged the need for restrictions and agreed that non-smokers have rights, most contended that smokers also have rights that should be protected. Smoking restrictions helped a few participants to curtail their smoking. However, the anti-smoking environment generated feelings of guilt, anger, and isolation in other participants.

Most disadvantaged subjects had low expectations of support from health professionals and health agencies. Although many had talked with their physicians, they showed an overwhelming lack of confidence in their physicians as sources of meaningful help; very few physicians had offered appropriate information, counselling, or support. Other health professionals, such as nurses, were rarely mentioned as supporters. One woman said: "My doctor wouldn't know. I called the nurse. She said she didn't know about nicotine and the doctor didn't either." These women rarely contacted health agencies such as the Lung Association or the Cancer Society for support in smoking cessation, due to their geographic isolation, their lack of awareness of these agencies' public-education function, and their scepticism.

Participants frequently mentioned lack of social support as a key barrier to smoking cessation. Lack of support from partners and immediate family posed the biggest problem. Lack of support from friends and acquaintances was also cited as a barrier:

I used to have temper fits and everything... I was a contrary person. My husband said, "You're going to have to take up smoking again. I can't live with you."

Friends? They all begged me not to quit. My girlfriend said to me, "You're some friend, telling me not to smoke." I said, "Go ahead, it doesn't bother me if you smoke." They said, "No, we don't want you with us if you don't smoke"... I had a hard time.

Participants unanimously acknowledged the positive role played by social support during cessation attempts.

My father, he's a reformed smoker, he's my hero. Every time I quit smoking, his praise was good. He never put me down for smoking, but whenever I would go and tell him I hadn't had a cigarette in a few days his praise made me feel better.

The question of how to provide social support for smoking cessation was prominent in discussions with these women. In their view, self-help mutual-aid groups and dyads could help disadvantaged women to cease or curtail smoking. The role of peer support groups in facilitating smoking cessation was a central theme in responses by almost all of the 126 participants. They were interested in mutual-aid groups in which peers would assume leadership and determine the program content. Some women indicated that although they would not choose to be part of a peer support group they would welcome the support of a peer "buddy."

Encouraging me, being with the women, knowing they're trying the same thing you're trying...they got the same problems and same kind of symptoms...same kind of feelings you're going through.

I'm too much of a loner for a group. I'm a homebody. I just like to visit family and friends. But to have a friend that would be giving up with me, I'd like that. When I'm craving for a cigarette I'll call her...let's go for a walk, or something. Take your mind off it.

Social support was seen as an adjunct to, rather than a replacement for, personal motivation. Most of these disadvantaged women believed that personal determination and will-power are essential elements of cessation success.

I think it's important to have support from your family. But I think it's an individual thing. It all depends on how much you want it. How strong you are. Like I can't expect my family or friends to stop smoking or cut down or not smoke around me.

It is noteworthy that similar themes emerged in the individual and group interviews with 260 other disadvantaged women, in central and western Canada.

### *Provision of Cessation Programs by Support Agencies (Phase 6)*

The women who used "non-traditional support" agencies such as women's centres trusted these agencies, seeing them as appropriate potential deliverers of accessible cessation programs and services. One woman said, "I've gained a wealth of information going there. We help each other; it's changed my life around." Participants indicated that they would use agency-based smoking cessation programs if these were offered and accessible. They favoured a wide range of comprehensive programs that address the multidimensional aspects of their lives and reflect their different needs at different times. Participants identified diverse cessation supports, including programs, information

seminars, and referrals to professionals, as appropriate if offered with existing agency services. Like the women interviewed in Phase 4, most (82%) wanted support groups and emphasized the benefits of experiential knowledge of peers: "If [speakers] haven't smoked before, I wouldn't get much out of them."

Participants had firm ideas about the types of cessation support and delivery modes that would be appropriate for those who access the services of community agencies focused on disadvantaged women. Printed materials (pamphlets, brochures) on cessation were not rated highly by these participants – although pamphlets were one of the cessation supports most frequently offered by the agencies, according to interviews with agency representatives during Phase 5. Most women recommended that information on health risks for both smokers and non-smokers (i.e., second-hand smoke) be made available. Several participants suggested that information on the relationship between smoking and other women's issues (e.g., body image, self-esteem, child-rearing) be incorporated into existing programs and services.

### **Discussion**

Most participants in the Atlantic region were recruited through women's centres and other community-based organizations that serve women. The ease with which recruitment was accomplished indicates that women's networks support this type of research. The women's organizations appear to serve different clientele; for example, two centres located in low-income housing projects gave us access to poor and hard-to-reach, formerly homeless women. This approach to recruitment attracted a diversity of disadvantaged women – single parents, and the poor, the unemployed, the uneducated, and the geographically isolated. Recruitment through women's organizations also provided an environment that was familiar to these disadvantaged women, thereby increasing their willingness to participate.

In combination, the individual interview and the focus group elicited data that encompassed and penetrated the key issues faced by these women. The individual interview featured intensive discussions; the interviewer was able to keep the conversation on track, pursue ideas, probe for detail, and encourage a coherent and comprehensive response to the research questions. Many women found it easier to talk about sensitive issues, such as stress and smoking, in one-on-one consultations. Although focus-group data provided a less in-depth and coherent account of the social and psychological factors associated with this health behaviour, the discussion was rich in breadth. Participants

responded to each other's comments and expanded on ideas. The group gave both participants and researchers a panoramic view of disadvantaged women's experiences, knowledge, attitudes, and feelings.

Consistent with one principle of participatory and feminist research – that research should benefit participants – almost all women indicated that the consultations had been a positive experience for them. They found that the consultations were stimulating and challenging, provided a welcome outing, offered an opportunity for expression, acknowledged their expertise, heightened their desire to quit smoking, and raised hopes for cessation support. However, this kind of personal reflection and sharing of perspectives can have a consciousness-raising effect, which can be painful as well as educative. For disadvantaged women who experience smoking as a profoundly controlling addiction, such reflection might generate stronger feelings of powerlessness. The interviewers were sensitive to this possibility.

Conventional research on women's smoking emphasizes individual factors such as lifestyle, attitudes and knowledge, and the immediate social environment including family and friends. In contrast, a feminist approach examines broad societal and structural issues such as low-status jobs (Graham, 1989; Greaves, 1990b; Health Canada, 1995b). Because smoking may be a response to gender and class inequalities (Daykin, 1993; Graham, 1989; Greaves, 1990a), a structuralist explanation that considers the social determinants of individual behaviour (Reutter, 1995) is appropriate. In our study, participants' smoking was inextricably linked with the inequities and obstacles in their lives.

Barriers to quitting smoking were closely related to the social and economic realities of these women's lives, such as isolated environments and inadequate work and educational opportunities. For example, most participants had not finished high school. These women are at particular risk because education level predicts cessation success for women more than for men (Freund, D'Agostina, Belanger, Kannel, & Stokes, 1992).

The disadvantaged women in this study smoked to cope with the chaos and crises in their lives. Economically disadvantaged persons are more likely to be exposed to environmental stressors (CPHA, 1993; Williams, 1990), and persons with high levels of stress are more likely to smoke (Romano et al., 1991). Health-inhibiting behaviours, such as smoking, are adopted by the poor to manage the stress induced by diminished access to resources (Reutter, 1995). Women also smoke to cope with other gender-related stresses (Graham, 1987; Greaves, 1993). For example, Graham (1989) found that cigarette smoking was a way



for low-income mothers to cope with the stresses and isolation encountered in caring for their young children. Furthermore, motherhood can limit women's ability to complete cessation programs (Jensen & Coombs, 1994). Participants also smoked to relieve their child-care and household routines and for pleasure. British studies reveal that women smoked not only as part of their daily routine and to provide a "time out" (Graham, 1993), but because it was the only luxury available on low incomes (Graham, 1987).

Over half of the participants were single parents; this group of women smokers has been neglected in research (Health Canada, 1995b). Women who smoke are more likely than non-smoking women to be caregivers, with or without a partner (Graham & Blackburn, 1990; Milham & Davis, 1991). Participants' smoking behaviour was linked to their loneliness and isolation. Other women have reported that smoking helps them cope with loneliness and lack of social support (Massie, 1993). Lower-income women are less involved with relatives and are more isolated than middle-class women (Oakley & Rajan, 1991). In fact, low-income groups report smaller social networks and less social support (Millar & Stephens, 1993; Manga, 1993). Financial stresses, in the absence of sufficient social support, are detrimental to well-being (Viinamaki, Koskela, Niskanen, & Arnkill, 1993).

Smoking is also an integral component of certain social situations such as visiting friends or communicating with partners (Graham & Blackburn, 1990). Many participants reported that they had smoking spouses and partners who were non-supportive of their cessation attempts. Women who quit smoking are more likely to have non-smoking partners (Wakefield, Gillies, Graham, Madeley, & Symonds, 1993) and supportive partners/spouses (Schoenbach et al., 1992). Participants believed that social support would help them to cut down or cease smoking. Lower rates of smoking relapse have been associated with the positive influences of social support (Carmody, 1990; Gruder et al., 1993).

Many disadvantaged women are in positions of powerlessness. These participants connected their smoking to lack of control of their environment, believed that smoking cessation requires will power, and reported low self-esteem and self-efficacy. Continued smoking has been linked to low self-esteem (Greaves, 1990b) and to low self-efficacy (Schoenbach et al., 1992). The poor may experience powerlessness and a low sense of control, mastery of their environment, and self-esteem (Ross & Mirowsky, 1989; Wallerstein, 1992; Williams & House, 1991). Support, particularly from peers, can empower people (Labonté, 1993)

and enhance self-efficacy and self-esteem (Gottlieb & Selby, 1989; Katz, 1993). It is not surprising that these participants wanted support from peers in mutual-aid groups and dyads. Women are more likely than men to participate in self-help mutual-aid groups and support groups (Gottlieb & Peters, 1991); men emphasize the importance of self-help programs in smoking cessation, whereas women seek social support (Greaves, 1990a). There are other gender differences in women's experiences with social support. Reciprocity in relationships (e.g., in peer-support groups) influences women's more than men's support satisfaction (Antonucci & Akiyama, 1987), and women benefit more from supportive interactions (Shumaker & Hill, 1991).

In contrast to participants' positive view of their peers, most did not perceive professionals as supportive. Health professionals who believe that smoking-cessation advice or programs are ineffective (Wakefield et al., 1993), or who offer insensitive or judgemental advice (Bryce & Enkin, 1984), will not have an encouraging impact on cessation. Although professionals are typically valued for the informational support they provide (Dakof & Taylor, 1990), the socialization of health professionals as "expert" providers can inhibit empathy and collaboration with consumers (Stewart, Banks, Crossman, & Poel, 1994). Furthermore, the gaps in economic status and education between disadvantaged women and health professionals pose barriers to trust.

Consistent with their experiences with the formal health-care system, these disadvantaged women did not make use of traditional cessation programs. During our interviews with representatives of women's cessation programs in Phase 3, we discovered that few cessation programs were appropriate for, or available to, disadvantaged women in Canada. Most programs and resources for smoking cessation do not consider gender differences and germane issues (Gritz, 1991; Health Canada, 1995b). In fact, the participants in our study favoured having information on women's issues incorporated into programs and services. Cessation programs should also include discussions of stresses related to class, such as the inequalities inherent in being poor women (Greaves, 1990a), should focus on empowerment strategies (Daykin, 1993), and should be delivered through women's organizations (Health Canada, 1993b). Certainly, the disadvantaged women in this study, who used women's centres and other women's organizations, viewed them as credible potential deliverers of cessation support. However, the representatives of these agencies (Phase 5) reported that they operated on limited funds and with limited staff, and that stable resources would be required before they could launch such programs.

## Conclusion

Disadvantaged women's smoking was found to be inextricably linked with the social context and stresses of their lives. Comprehensive smoking cessation programs should focus on their social, economic, and cultural environment, rather than on their health behaviour alone, and should be accessible in terms of cost, culture, location, literacy, and child care. Interventions should mobilize support from family and friends, encompass support from peers and health professionals, and foster efficacy, empowerment, and esteem. In this context, disadvantaged women should be offered the opportunity to participate as partners in the design and evaluation of cessation programs that address their priority concerns and in policy changes pertaining to social and health programs.

## References

- Antonucci, T.C., & Akiyama, H. (1987). An examination of sex differences in social support in mid and late life. *Sex Roles, 17*, 737-749.
- Bryce, R.L., & Enkin, M.W. (1984). Lifestyle in pregnancy. *Canadian Family Physician, 30*, 2127-2130.
- Canadian Public Health Association (1993). Reducing inequalities in health. *CPHA Digest, 9*, 5-8.
- Carmody, T.P. (1990). Preventing relapse in the treatment of nicotine addiction: Current issues and future directions. *Journal of Psychoactive Drugs, 22*(2), 211-238.
- Clancy, C.M., & Massion, C.T. (1992). American women's health care: A patchwork quilt of gaps. *Journal of the American Medical Association, 268*, 1918-1920.
- Coambs, R.B., Li, S., & Kozlowski, L.T. (1992). Age interacts with heaviness of smoking in predicting success in cessation of smoking. *American Journal of Epidemiology, 135*(3), 240-246.
- Dakof, G.A., & Taylor, S.E. (1990). Victims' perceptions of social support: What is helpful from whom? *Journal of Personality and Social Psychology, 58*, 80-89.
- Davies, R.M. (1990). *Women and smoking in the United States: How lung cancer became an "Equal Opportunity" disease*. Presented at the Seventh World Conference on Tobacco and Health. Perth, Australia, April 1-5.
- Daykin, N. (1993). Young women and smoking: Towards a sociological account. *Health Promotion International, 8*, 95-102.
- Dresser, R. (1992). Wanted: Single, white male for medical research. *Hastings Centre Report, Jan.-Feb.*, 24-29.
- Freund, K.M., D'Agostina, R.B., Belanger, A.J., Kannel, W.B., & Stokes, J. (1992). Predictors of smoking cessation: The Framingham study. *American Journal of Epidemiology, 135*, 957-964.

- Gottlieb, B., & Peters, L. (1991). A national demographic portrait of mutual aid participants in Canada. *American Journal of Community Psychology*, 19(5), 651-666.
- Gottlieb, B.H., & Selby, P.M. (1989). *Social support and mental health: A review of the literature*. National Health Research Development Program (NHRDP) unpublished funded review. University of Guelph, Ontario.
- Graham, H. (1987). Women's smoking and family health. *Social Science & Medicine*, 25, 47-56.
- Graham, H. (1989). Women and smoking in the United Kingdom: The implications for health promotion. *Health Promotion*, 3, 371-382.
- Graham, H. (1993). Women's smoking: Government targets and social trends. *Health Visitor*, 66(3), 80-82.
- Graham, H., & Blackburn. (1990). *Smoking among working class mothers*. Department of Applied Social Studies, University of Warwick, England.
- Greaves, L. (1990a). The meaning of smoking to women. In *Global War: Proceedings of the 7th World Conference on Tobacco and Health*. Australia.
- Greaves, L. (1990b). *Background paper on women and tobacco: An update*. Ottawa: Health Canada.
- Greaves, L. (1993). *Discussion paper on women and tobacco*. Unpublished background brief to Women and Tobacco Initiative. Ottawa: Health Canada.
- Gritz, E. (1991). Women and smoking: Educating them to stop. *World Smoking and Health*, 16, 3-7.
- Gruder, C.L., Mermelstein, R.J., Kirkendol, S., Hedeker, D., Wong, S.C., & Schreckengost, J. (1993). Effects of social support and relapse prevention training as adjuncts to a televised smoking-cessation intervention. *Journal of Consulting and Clinical Psychology*, 61, 113-120.
- Health Canada. (1993a). *Canada's health promotion survey 1990: Technical report*. Ottawa: Supply and Services Canada.
- Health Canada. (1993b). *National roundtables: Report of the Women and Tobacco Initiative*. Unpublished.
- Health Canada. (1994). *Strategies for population health: Investing in the health of Canadians*. Meetings of Ministers of Health. Ottawa: Author.
- Health Canada. (1995a). *Survey on smoking in Canada, Cycle 4*. Ottawa: Government of Canada.
- Health Canada. (1995b). *Women and tobacco: Second National Workshop*. February 16-18, Ottawa.
- Jensen, P.M., & Coombs, R.B. (1994). Health and behavioural predictors of success in an intensive smoking cessation program for women. *Women and Health*, 21(1), 57-71.
- Katz, A.H. (1993). *Self-help in America: A social movement perspective*. New York: Twayne Publishers.
- Kirkland, S. (1994). Post-menopausal hormone use and ischemic heart disease. Unpublished Ph.D. Thesis, University of Toronto.

- Labonté, R. (1993). *Health promotion and empowerment: Practice frameworks* (Issues in Health Promotion Series #3). Toronto: Centre for Health Promotion, University of Toronto, and ParticipACTION.
- Manga, P. (1993). Socio-economic inequalities. In *Canada's Health Promotion Survey 1990: Technical Report* (pp. 263-274). Ottawa: Supply and Services Canada.
- Massie, M. (1993). *Tobacco and young women: Exploratory qualitative research*. Ottawa: Health Canada.
- McLanahan, S., Sorensen, A., & Watson, D. (1989). Sex differences in poverty. *Journal of Women in Culture and Society*, 15(1), 102-122.
- Milham, S., & Davis, R. (1991). Cigarette smoking during pregnancy and mother's occupation. *Journal of Occupational Medicine*, 33(4), 468-473.
- Millar, W., & Hunter, L. (1990). The relationship between socioeconomic status and household smoking patterns in Canada. *American Journal of Health Promotion*, 5(1), 36-43.
- Millar, W.J. (1992). Factors associated with smoking prevalence among Canadians. *Health Reports*, 4, 7-23.
- Millar, W.J., & Stephens, T. (1993). Social status and health risks in Canadian adults: 1985 and 1991. *Health Reports* 1993, 5(2), 143-156.
- National Cancer Institute of Canada. (1995). *Canadian Cancer Statistics 1995*. Toronto: National Cancer Institute of Canada.
- National Council of Welfare. (1994). *Poverty profile: 1992*. Ottawa: Supply and Services Canada.
- Nova Scotia Department of Health. (1993). *Report of the Nova Scotia Nutrition Survey*. Halifax: Nova Scotia Heart Health Program, Nova Scotia Department of Health, and Health and Welfare Canada.
- Oakley, A., & Rajan, L. (1991). Social class and social support: The same or different? *Sociology*, 25(1), 31-59.
- Penning, M.J., & Chappel, N.L. (1993). In S.T. Fowler & D. Graham (Eds.), *Canada's Health Promotion Survey 1990: Technical Report*. Ottawa: Supply and Services Canada.
- Phillips, S. (1995). The social context of women's health: Goals and objectives for medical education. *Canadian Medical Association Journal*, 152(4), 507-511.
- Prochaska, J.O., & DiClemente, C.C. (1983). Stages and processes of self change in smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology*, 5, 390-395.
- Prochaska, J.O., Velicer, W.G., Guadagnoli, E., Rossi, V.S., & Di Clemente, C.C. (1991). The process of smoking cessation: An analysis of precontemplation, contemplation, and preparation. Stages of change. *Multivariate Behavioral Research*, 26, 83-107.
- Reutter, L.I. (1995). Socioeconomic determinants of health. In M.J. Stewart (Ed.), *Community nursing: Promoting Canadians' health*. Toronto: W.B. Saunders.



- Romano, P.S., Bloom, J., & Syme, S.L. (1991). Smoking, social support, and hassles in an urban African-American community. *American Journal of Public Health, 81*(11), 1415-1422.
- Romans, S.E., McNoe, B.M., Herbison, G.P., Walton, V.A., & Mullen, P.E. (1993). Cigarette smoking and psychiatric morbidity in women. *Australia and New Zealand Journal of Psychiatry, 27*(3), 399-404.
- Ross, C.E., & Mirowsky, J. (1989). Explaining the social patterns of depression: Control and problem solving – or support and talking? *Journal of Health and Social Behavior, 30*, 206-219.
- Schoenbach, V.J., Orleans, C.T., Wagner, E.H., Quade, D., Salmon, M., & Porter, C.Q. (1992). Characteristics of smokers who enrol and quit in self-help programs. *Health Education Research, 7*(3), 369-380.
- Shumaker, S., & Hill, D. (1991). Gender differences in social support and physical health. *Health Psychology, 19*(2), 102-111.
- Statistics Canada. (1991). *General social survey*. Ottawa: Government of Canada.
- Statistics Canada. (1993). *Profile of urban and rural areas – Part A: Canada, provinces and territories*. Ottawa: Minister of Industry, Science and Technology, Cat. No. 93-339.
- Statistics Canada. (1994). *Health status of Canadians: Report of the 1991 General Social survey*. General Social Survey Analysis Series. Ottawa: Minister of Industry, Science and Technology.
- Stephens, T. (1994). *Smoking among aboriginal people in Canada*. Ottawa: Health Canada.
- Stewart, M., Banks, S., Crossman, D., & Poel, D. (1994). Partnerships between health professionals and self-help groups: Meanings and mechanisms. *Prevention in Human Services, 11*(2), 199-240.
- Stewart, M.J. (1993). *Integrating social support in nursing*. Newbury Park, CA: Sage.
- U.S. Department of Health and Human Services. (1989). *Reducing the health consequences of smoking: 25 years of progress. A report for the Surgeon General*. Rockville, MD: DHSS Pub No. (CDC) 89-8411.
- Viinamaki, H., Koskela, K., Niskanen, L., & Arnkill, R. (1993). Unemployment, financial stress and mental well-being: A factory closure study. *European Journal of Psychiatry, 9*(2), 95-102.
- Wakefield, M., Gillies, P., Graham, H., Madeley, R., & Symonds, M. (1993). Characteristics associated with smoking cessation during pregnancy among working-class women. *Addiction, 88*, 1423-1430.
- Wallerstein, N. (1992). Powerlessness, empowerment, and health: Implications for health-promotion programs. *American Journal of Health Promotion, 6*(3), 197-205.
- Walters, V. (1992). Women's views of their main health problems. *Canadian Journal of Public Health, 83*(5), 371-374.
- Williams, D. (1990). Socioeconomic differentials in health: A review and redirection. *Social Psychology Quarterly, 53*, 81-99.

Williams, D., & House, J. (1991). Stress, social support, control and coping: A social epidemiological view. In B. Bandura & I. Kickburch (Eds.), *Health promotion research* (pp. 147-172). Copenhagen: WHO.

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