

Attitudes And Barriers Towards Smoking Cessation Among Middle Aged And Elderly Women: A Qualitative Study In Family Practice

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Abstract

Background: Middle aged/elderly women seem to face many difficulties when trying to stop smoking.

Objectives: This study was undertaken in a family practice setting. The aim was to examine attitudes and barriers to smoking cessation among middle aged and elderly women.

Method: Thematic, qualitative interviews were performed with nine participants, both smokers and ex-smokers. All interviews were tape recorded and transcribed verbatim. The analyses were carried out with content analysis.

Results: Six themes represent the participants' perceptions about smoking: 1. added values from smoking; 2. added values from quitting; 3. smoke promoting context, fatalism and shame; 4. cultural and structural barriers; 5. expectations versus frustrations with the health care system; 6. better ways to conduct smoking cessation activities.

Conclusions: The interviews revealed a complex picture. There are several individual factors that determine how successful anti-smoking efforts will be. Problems related to the risk of weight gain during smoking cessation are important to discuss. The participants were sceptical of nicotine replacement therapy and ambivalent about the help and support they could get from the established health care system.

INTRODUCTION

Smoking cigarettes was not common among women until intense tobacco marketing specifically addressed to women started in the mid-nineteenth century [1]. In Sweden there was a peak in the number of smoking women around mid seventies. After that, smoking gradually decreased, especially among younger women. Such a trend was not seen among middle aged and elderly women [2]. Smoking cessation among women seems to be less successful than among men [3,4]. The reason for this is not obvious. Both sexes have shared the same anti-smoking messages. Some authors believe the gender difference is due to the greater use of moist snuff among smoking men [5]. This could be part of the explanation in Sweden but there are probably other explanations as well.

It is apparent that women have as strong a nicotine dependence as men. Several studies have also shown that

women get the same serious diseases as men after long-term smoking [6].

Both men and women need support to stop smoking. It is apparent that great efforts must be made to stop the "tobacco epidemic" by not forgetting middle aged/elderly women. After many years of smoking, this group is now developing the diseases caused by smoking and quitting rapidly decreases the risks [7]. The impression that middle aged and elderly women have greater difficulty in long-time smoking cessation is important to recognize and merits further discussion [8].

This qualitative study was developed in an attempt to get a deeper understanding of middle aged/elderly women's thoughts and ideas about smoking and smoking cessation. To date, few qualitative studies have been published on this topic.

METHODS

PARTICIPANTS AND DATA COLLECTION.

Thematic, qualitative interviews were performed with nine Participants, smokers and ex-smokers, 47-70 years of age. Table 1.

Figure 1

Table 1: Different characteristics of the nine Participants.

Informant	Age	Smoking history
1	47	Smoker
2	53	Smoker
3	57	Smoker
4	59	Smoker
5	70	Ex-smoker
6	49	Smoker
7	49	Ex-smoker
8	52	Ex-smoker
9	70	Ex-smoker

The participants were purposefully chosen in accordance with the developing design [9]. The purpose was to choose women that were as different as possible regarding social background, education, marital status and profession. Six were from the patient list of a physician, also one of the authors of this study and three participants were not patients. Three of the nine participants were blue collar workers, two were well-paid administrators, two had sickness pensions and two were retired. All participants received verbal information and were given time to consider participation before a secretary at the health centre called to obtain their consent.

To minimize the feeling of inferiority that could be reinforced at the health care centre and in accordance with the informant's own wishes, seven interviews were conducted in the participants' homes and one in the work place. In accordance with the informant's wish, the ninth interview was performed at the Department of Epidemiology and Public Health Sciences. Eight interviews were

conducted by the first author (GL), who at the time was the family doctor for five of the women. One interview was performed by the third author (AÖ).

All interviews were tape recorded and transcribed verbatim. Each interview lasted 1-1½ hours. An interview guide was used that covered the following themes: smoking background, gender perspectives, pros and cons regarding smoking, aspects on health services, and barriers to smoking cessation.

DATA ANALYSIS

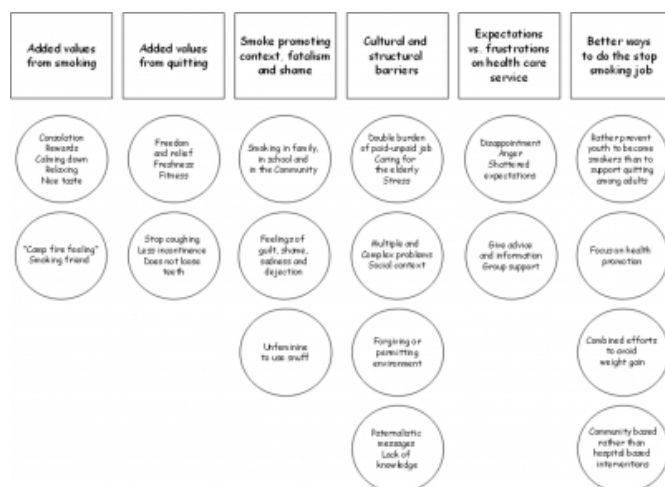
The analyses were carried out by using content analyses [10]. To increase trustworthiness, triangulation of the researchers was used [11]. The analyses were conducted in three steps. First, we read the transcripts in order to get an overall understanding of the content. Second, each author conducted a separate coding of the interview transcripts and marked the most important aspects of the information given by the Participants. In a third step, we met for mutual discussions and negotiations about the central themes that emerged.

RESULTS

Six different themes emerged from the analysis. They are presented in Figure 1 and capture the most striking features from the interviews. Two themes deal with added values from smoking and from quitting, two represent barriers and feelings that made it more difficult to stop smoking, and two deal with expectations and frustrations about the health care system and ideas how to improve its antismoking activities.

Figure 2

Figure 1: Themes and sub themes from the content analysis of nine interviews



ADDED VALUES FROM BEING A SMOKER

Several of the Participants talked about a special sense of group belonging. When smokers met in the schoolyard or elsewhere there was always a joyful atmosphere. They did not know if there was as much fun among non-smokers, but they believed that smokers had more fun. The non-smokers apparently did not have the same opportunity to “gather around the campfire”.

The taste and smell of coffee and alcohol was reinforced and problem-solving capacities improved.

ADDED VALUES FROM BEING A QUITTER.

A relieving sense of freedom appeared after the smoking cessation. Positive health aspects were also noted, including less cough, less incontinence, less dental problems and overall greater well-being.

SMOKE PROMOTING CONTEXT, FATALISM AND SHAME.

The Participants had childhood memories that smoking was permitted at their homes. Later in life, smoking was allowed in the schoolyard as a concession from authorities at school, parents and society as a whole. In adult life it became natural to smoke during work breaks.

Fatalistic feelings were described- “Everybody should die, so why not from smoking?”

The feeling of shame was strong when grandchildren commented on grandma's smoking.

CULTURAL AND STRUCTURAL BARRIERS.

The women in our study mentioned the hazards of weight gain after smoking cessation. The alternative of switching to moist snuff was not attractive. The Participants argued that increased responsibility for the care of elderly or sick relatives, and problems from the fact that many women had “double jobs”, both paid and unpaid at home made quitting smoking more difficult.

EXPECTATIONS VERSUS FRUSTRATIONS ON THE HEALTH CARE SYSTEM.

The Participants said that the organization of the health service was an obstacle in itself because it was so disease-oriented.

They were sceptical of the kind of help they could depend on from the official health care system. Several Participants argued that the most important factor was their own will to

stop smoking. Information from health care officials could be important, but everyone knew about the hazardous effects of smoking. Some of the Participants had tried nicotine replacement therapies without success and some of them experienced side effects.

BETTER WAYS TO DO IT

Several Participants emphasized the importance of their own will. “If you really want to stop you can”. However they also realized the need for support to overcome nicotine dependence and they wanted support tailored to their individual needs.

The Participants were critical of hospital-based smoking cessation programmes. At hospitals they handle people with different diseases but the smoker must get help to stop before he or she gets ill and that is why it is not obvious or necessary that this work should be done at the hospitals. Many different societal organizations that are working with people's health and wellbeing are suited for this. Focus on health promotion including physical fitness, good food habits and other aspects of good health could be successful in assisting smoking cessation.

One opinion expressed was that smoking cessation activities in groups would be of great benefit while other Participants advocated treatment through individual counselling. Another idea was to have a person who could act as a support or “coach” in the efforts to stop smoking.

DISCUSSION

WEIGHT GAIN

This study revealed several different factors that are of importance in the smoking cessation process (Fig1). One is the well-known issue of weight gain which was discussed by all of the Participants. Several studies have shown a moderate weight gain when quitting smoking and a slight weight loss when starting to smoke [12]. There are probably both changes in basal metabolism and energy balance that explains this. A craving for sugar and fat characterizes the period after the smoking cessation process has started [13]. No difference in physical activity has been shown between those gaining weight and those who do not, but there have been differences in energy intake. A study from Kawachi et al showed that a moderate increase in physical activity could minimize weight gain [14]. Good results may come from a cognitive behaviour approach that aims to help women handle a slight increase in body weight [15]. The associated

increase in body weight has not been shown to increase the risk for cardiovascular disease [16].

HARM REDUCTION

The use of moist snuff as a “harm reduction strategy” is under debate [17]. The Participants in this study were not interested because it is “unfeminine” to use moist snuff. The concept of femininity elucidates this issue [18]. As described by Harding, perceptions and ideas about appropriate behaviour for men and women are embedded in any given culture. These perceptions are integrated into individuals and become a guide for action and behaviour. The perceptions are not stable and fixed but are changeable along with time and social context. The middle aged/elderly women in this study have presumably incorporated a certain kind of femininity that does not include the use of snuff. In the next generation of women this might have changed so that snuff becomes a common part of women's life.

There could be other circumstances that make it more difficult for women than men to stop smoking. More women than men have low paid jobs and low socio-economic status. Several studies have shown that those women smoke more and have greater difficulties in smoking cessation [19]. The care of the elderly and of sick relatives could be much time-consuming and is probably stressing women still more.

NICOTINE REPLACEMENT THERAPY

Problems with the use of ordinary nicotine replacements devices were also discussed in the interviews. Perhaps medical staff and pharmacists rely too much on the written information that is enclosed in the package. There is probably more need for discussion and follow up of treatment from the health services. It is also essential to realize that women face different physiological experiences when using administered nicotine replacements such as chewing gum or patches. According to studies of Perkins et al, women have less nicotine adherence than men, behavioural factors are more important. Women are also more dependent on the smell of tobacco smoke, so using nicotine patches or gum may not be as effective as for men [3].

HEALTH CARE SYSTEM

The Participants' view of the role of the health care system was ambiguous. They appreciated the information about different health problems as a counter-weight to the mass media messages. However, much of the information was

already well-known; the same as “opening already opened doors”. The provided information was almost always about the negative effects of smoking and less focus was on the positive effects of smoking cessation. It is possible that women are more susceptible for these negative messages as depressive states are common among smoking women [20].

The Participants expected information and help to stop smoking that was not so disease-oriented. Much of that would be preferable if performed “outside the hospitals”. Staff from the health care system could be medical consultants if needed. A changing view from disease orientation to health promotion could make it easier to stop smoking. This is not in opposition to the work carried out by their family physician; both sides of antismoking activities are needed and cooperation between the physician and different other organizations could further enhance the results of the stop smoking activities.

METHODOLOGICAL CONSIDERATIONS

The knowledge obtained from this study emanates from nine middle-aged/elderly women's notions and perceptions of tobacco smoking. As the sample was intentionally small and purposely chosen, we do not claim generality from a statistical point of view. Instead, we argue that our findings may be applicable to other social contexts with similar characteristics. It is thus a theoretical generalisation, drawn from a concrete level of qualitative data to a more abstract theoretical level [11].

The fact that the interviewer of the eight first interviews is also the family physician of those interviewed might be considered as a source of bias by limiting open discussion. Therefore, in an attempt to confirm the content from previous interviews, the third author, who does not know the women nor has any professional contact with them, conducted the ninth interview. We did not find any disagreements in the information collected by the two interviewers. Therefore, we conclude that the participants felt free to tell about their experiences of health care, doubts about smoke cessation programmes and so forth. In spite of the considerations above, we found the interviews informative and well suited for a qualitative analysis.

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References

1. Richmond R. You've come a long way baby: Women and the tobacco epidemic. *Addiction*. 2003 May;98(5):553-7
2. Sweden statistics. Percentage of daily smokers among adults (age 16-84). 2004.
3. Perkins KA. Smoking cessation in women. Special considerations. *CNS Drugs*. 2001;15(5):391-411.
4. Mackay J, Amos A. Women and tobacco. *Respirology*. 2003 Jun;8(2):123-30.
5. Foulds J, Ramstrom L, Burke M, Fagerstrom K. Effect of smokeless tobacco (snus) on smoking and public health in Sweden. *Tob Control*. 2003 Dec;12(4):349-59.
6. Gramenzi A, Gentile A, Fasoli M, D'Avanzo B, Negri E, Parazzini F, et al. Smoking and myocardial infarction in women: a case-control study from northern Italy. *J Epidemiol Community Health*. 1989 Sep;43(3):214-7.
7. McElduff P, Dobson A, Beaglehole R, Jackson R. Rapid reduction in coronary risk for those who quit cigarette smoking. *Aust N Z J Public Health*. 1998 Dec;22(7):787-91.
8. Royce JM, Corbett K, Sorensen G, Ockene J. Gender, social pressure, and smoking cessations: the Community Intervention Trial for Smoking Cessation (COMMIT) at baseline. *Soc Sci Med*. 1997 Feb;44(3):359-70.
9. Lincoln YS, Guba EG. *Naturalistic inquiry*. Sage Publications Inc, Newbury Park, London, New Delhi; 1985.
10. Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*. 2004;24:105-12.
11. Guba EG. Annual review paper: criteria for assessing the trustworthiness of naturalistic inquiries. *Educational Communication and Technology: A Journal of Theory, Research and Development*. 1981;29 (2):75-91.
12. Caan B, Coates A, Schaefer C, Finkler L, Sternfeld B, Corbett K. Women gain weight 1 year after smoking cessation while dietary intake temporarily increases. *J Am Diet Assoc*. 1996;96:1150-5.
13. Talcott GW, Fiedler ER, Pascale RW, Klesges RC, Peterson AL, Johnson RS. Is weight gain after smoking cessation inevitable? *J Consult Clin Psychol*. 1995 Apr;63(2):313-6.
14. Kawachi I, Troisi RJ, Rotnitzky AG, Coakley EH, Colditz GA. Can physical activity minimize weight gain in women after smoking cessation? *Am J Public Health*. 1996 Jul;86(7):999-1004.
15. Perkins KA, Marcus MD, Levine MD, D'Amico D, Miller A, Broge M, et al. Cognitive-behavioral therapy to reduce weight concerns improves smoking cessation outcome in weight-concerned women. *J Consult Clin Psychol*. 2001 Aug;69(4):604-13.
16. Burnette MM, Meilahn E, Wing RR, Kuller LH. Smoking cessation, weight gain, and changes in cardiovascular risk factors during menopause: the Healthy Women Study. *Am J Public Health*. 1998 Jan;88(1):93-6.
17. Bolinder G. Swedish snuff: a hazardous experiment when interpreting scientific data into public health ethics. *Addiction*. 2003 Sep;98(9):1201-4; discussion 4-7.
18. Harding S, Keynes M. *The science question in feminism*.: Open University Press; 1986.
19. Stewart MJ, Gillis A, Brosky G, Johnston G, Kirkland S, Leigh G, et al. Smoking among disadvantaged women: causes and cessation. *Can J Nurs Res*. 1996 Spring;28(1):41-60.
20. Borelli B, Bock B, King T, Pinto B, Marcus BH. The impact of depression on smoking cessation in women. *Am J Prev Med* 1996;(12):378-87

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