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Homeless women's perspectives on smoking and smoking cessation programs: A qualitative study

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Abstract

Background: Individuals who are unsheltered or experiencing homelessness are more likely to smoke than those in the general population and have a higher prevalence of tobacco-related illnesses. Those who are unhoused make quit attempts at rates similar to the general population, however rates of successful quitting are much lower. Women bear a higher burden of smoking-related diseases and are less successful in their cessation efforts than men. Despite these increased risks and challenges, cessation programs specifically designed to meet the needs of women experiencing homelessness are extremely rare.

Methods: To examine perceptions of smoking cessation programs among women who are unstably housed, we conducted in-depth, semi-structured interviews with twenty-nine women experiencing homelessness or unstable housing who had histories of tobacco and substance use. Interviews explored the social context of smoking, as well as interest in, barriers to, and facilitators of quitting. We used a grounded theory approach to analyze the transcripts.

Results: Participants reported a number of structural barriers to cessation. They reported obstacles to participating in existing cessation programs, including chronic stress related to experiences of being unsheltered and fear of being exposed to neighborhood violence. These conditions were paired with a strong need to self-isolate in order to maintain personal safety, which runs counter to traditional group-based cessation programs.

Conclusion: A dissonance exists between current smoking cessation programs and the needs of women who are unsheltered or unstably housed. Alternative cessation treatment delivery models that address extremely high levels of chronic stress violence, and avoidance of group settings are needed, as are programs that provide options for safe participation.

Keywords

Homelessness; Cessation; Tobacco; Tailored programs; Qualitative research

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Declarations of Interest

The authors have no disclosures to report. All study procedures reported here were approved by the Institutional Review Board at the University of California, San Francisco.

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Introduction

Smoking rates among people who experience homelessness in the US are four times greater than in the general population (Baggett et al., 2013; Fazel et al., 2014). Individuals who are unhoused have a high prevalence of tobacco-related chronic illness, which are the leading cause of morbidity and mortality among people aged 45 years and older; for those younger than 45 years of age, the incidence of tobacco-related illnesses is 3 to 5 times higher than age-matched individuals in the general population (Baggett et al., 2015; Reddy et al., 2017). While the rates of quit attempts among those experiencing homelessness are similar to those of the general population, rates of successful quitting are much lower (Businelle et al., 2014; Vijayaraghavan et al., 2016). Studies have suggested that proximity to a shelter the week prior to quitting has increased likelihood of a quit attempt (Businelle et al., 2014) and that staying in the shelter as opposed to the street may be associated with quit attempts (Vijayaraghavan et al., 2016). Smoking cessation does not impact substance use (Apollonio, Philipps, & Bero, 2016) and among people experiencing homelessness, tobacco cessation may be associated with decreased number of days of drinking alcohol (Reitzel et al., 2014).

The majority of studies of tobacco use and cessation among people experiencing homelessness have included study samples that are predominantly male. However, sex differences are evident in smoking patterns, with women shown to be less successful in their cessation efforts than men (Nakajima & al'Absi, 2012; Pogun & Yararbas, 2009), due to both biological and psychosocial factors (Saladin et al., 2015; Allen et al., 2014; Paul et al., 2010). Psychosocial factors for these differences include evidence of the tobacco industry's targeting of low-income women in their marketing efforts (Brown-Johnson et al., 2014), further impacting smoking rates of women experiencing homelessness. Women experiencing homelessness often contend with high rates of violence and trauma, leading to self-isolation as a means of self-protection (Knight et al., 2014; Riley et al., 2014). This need for self-isolation can make it hard for some women experiencing homelessness to access group cessation programs taking place in their communities. Despite cessation challenges experienced by women, and the high risk of tobacco-related illnesses for those who experience homelessness, cessation programs designed specifically to meet the needs of unsheltered women are almost nonexistent.

Rates of drug use and mental illness are different between homeless women and homeless men. For example, 53% and 29% of homeless women use cocaine and methamphetamine respectively (Riley et al., 2020) compared to 9% and 8% of men (Harris et al., 2019). Compared to homeless men, homeless women report more mental health issues (Montgomery et al., 2017).

Clinical guidelines for smoking cessation treatment include both behavioral counseling and pharmacotherapy (Fiore, 2009). However, there are mixed results on how some of these guideline-recommended treatments work for women who are unhoused. A number of approaches, such as counseling and combined pharmacotherapy, have demonstrated improved cessation in the general population (Lancaster & Stead, 2017; Stead et al., 2016; Fiore, 2009). However, effects of some approaches, specifically nicotine replacement therapy, are not consistently effective in women (Saladin et al., 2012; Pauly, 2008; Perkins,

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2001). Limited studies have explored treatment approaches specific to women and none, to our knowledge, are specific to women who are unsheltered. Further, few interventions have been tested in very low-income populations, and even fewer have been tested in those experiencing homelessness (Bryant et al., 2011). Understanding the context of tobacco use in these populations could be particularly important to identify counseling approaches (i.e., content, mode of delivery) targeted to this population.

In order to aid the development of tailored programs aimed at meeting population-specific needs (Pasick et al., 1996), we sought unsheltered women's experiences with and perspectives on cessation programs. Specifically, we wanted to understand women's previous successes and failures in cessation programs and barriers to future engagement in tobacco cessation programs.

Methods

Setting

The current study took place within an existing larger study aimed at understanding the impact of social determinants of health and substance use, including tobacco use, on the cardiovascular health of unsheltered and unstably housed women (Riley et al., 2020). Data for the larger study were collected between June 2016 and January 2019. Participants were eligible if they were assigned female sex at birth (due to differences in cardiac dysfunction between people born men and women), were age 18 years or over, and had a life history of being unsheltered (e.g., slept in a shelter, on the street, in public, or a place not meant for human habitation), or unstably housed (e.g., chose housing based on a need to flee violence, or stayed with other people because there was no other place to sleep). The larger study recruited 245 women from shelters, free-meal programs, low-income hotels and street encampments in San Francisco, California. It defined substance use as the use of tobacco, cannabis, alcohol, cocaine, methamphetamine, heroin and opioid analgesics by both toxicology and self-report. Individuals who self-reported a history of tobacco use were eligible for the current study.

We invited a subsample of 29 current and former smokers to participate in separate in-depth qualitative interviews regarding smoking and smoking cessation during regular study visits. These in-person interviews were conducted in a clinical building. We engaged in purposive sampling (Etikan et al., 2016) in order to recruit women with diverse substance use histories, which enabled us to explore the intersections between substance use cessation and tobacco cessation.

All study procedures reported here were approved by the Institutional Review Board at the University of California, San Francisco.

Data collection and analysis

A multidisciplinary research team familiar with tobacco use in unsheltered populations developed the in-depth, semi-structured interview guide. Interviews focused on the following topics: social context of smoking, quit attempts for tobacco and other substances, use of smoking cessation resources, the experience of being unsheltered or unstably housed,

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the impact of smoke free policies, perspectives on cessation programs. Participants in the subsample engaged in approximately hourlong recorded interviews with a trained qualitative researcher. Participants were reimbursed $45 for their time. Audio recordings of interviews were transcribed and underwent a multi-phased analysis. During the initial phase, two analysts utilized grounded theory methods to develop an iterative codebook based on themes identified in the transcripts. Next, the team engaged in focused coding of each transcript, meeting weekly to achieve concordance between analysts. Disagreement over assignment of codes was resolved through discussion with the qualitative research team. Finally, each transcript was coded a second time to ensure consistency. All data were coded in Atlas.ti analytic software.

For the purpose of this manuscript, multiple sections of coded data were further analyzed (e.g., codes related to programs, cessation, stress, anxiety, triggers were coded an additional time). This subsequent analysis resulted in an engagement with Link and Phelan (1995) fundamental cause theory, in which they argue that an association between socioeconomic status and disease persists because of social conditions such as lack of support, stress, and stigma. Rather than emphasizing individually-based risk factors, we instead examined the social conditions within which cessation challenges occur. By applying a fundamental causes framework, we were better able to understand the extent to which participants were able to avoid the risks associated with tobacco use.

Findings

We identified five themes classifying respondents' perspectives on tobacco cessation and the use of cessation programs, all describing psychosocial barriers to quitting: chronic stress as a trigger to smoking, resistance to authority, logistical challenges with participating in cessation programs, need to isolate, and pessimism about effectiveness of current smoking cessation programs.

Chronic stress as trigger

The majority of participants described extremely high levels of ongoing stress, as exemplified by P01's account:

I: You said that the reason you smoked is that you were a nervous wreck.

P: Yeah. I have a problem relaxing…A lot of times I just feel like I'm coming out of my skin. It's like –recently I fell, broke my wrist, 'cause I'm in a hurry to go home. Why? Why did I hurry? I've got nothing at all except my cat. She'll be there when I get home, so there's no big hurry, I don't know what I'm rushing about.

In addition to stressors and triggers linked with interpersonal contexts, which are recognized in the general population, participants identified stressors uniquely linked to homelessness. These included risks or trauma associated with sex work, interactions with police, threats of violence, theft, physical pain from sleeping on the streets, and financial concerns. The stress experienced by women experiencing homelessness, then, was often structurally produced, a product of environment rather than individual behavior.

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Some women denied that stress played a major role in their daily lives, as was the case with P12:

I: Do you feel like your smoking is tied to stress?

P: No. Sometimes. I don't know. Just on bad days…everybody has some. Everybody stress on something…

I: Have you had stressful things happen in the past?

P: Yeah but I forgot about them. That's over.

P12 asserted that her stress did not set her apart, and described strategically forgetting stressful events of the past. However, most participants described experiencing chronic stress and tied this directly to their smoking behaviors. This stress served as a persistent trigger to smoking and made it difficult to succeed in cessation efforts, with or without the help of a program.

Resistance to authority

Many participants reported that they saw themselves as resistant to authority, an identity that reflects the lack of control associated with the experience of being unsheltered. Given the centrality of authority to the drug cessation programs they had experienced in the past, they were reluctant to participate in a tobacco cessation program. Many participants perceived these programs to have an authoritarian structure similar to the drug treatment programs many had undergone previously. Several participants stated that their self-identified resistance to authority was a key barrier to participating in smoking cessation programs, as represented by P18's explanation:

To me programs are like authority, and I resent authority. So that's how I look at 'em.

When asked if they could envision a program without this authoritative element, some participants stated that authoritative relationships were a necessary component of what had made programs effective in the past. P20 described her sense that programs based on the principles of harm reduction, with its deemphasis of authoritative dynamics, were not as effective for her as more rigid programs:

Sometimes tough love works better. They have to bam things into people's heads one way or another.

Logistical challenges with participating in cessation programs

While the majority of participants were resistant to participating in tobacco cessation programs, several reported that they would like to attend a cessation program meeting, but faced specific barriers to doing so. These barriers were logistical in nature, such as a lack of transportation options, inability to attend the same group due to moving around frequently, and scheduling challenges. P06 identified the difficulties of making it to a cessation group while also managing her chronic health condition:

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> I'm not going to meetings. I'm having a difficult time getting that into my day. There's a meeting down the street from me on Tuesdays, but I generally just get home from dialysis, and then I would have to just turn around and go to the meeting. And it's like, no. I can't do it. It's hard.

For P06, fitting an in-person meeting into her schedule was more than she felt she could handle given other constraints on her time.

The majority of these women expressed frustration at not having access to more time and location options. P05 represented this:

I: What made you decide to stop going?

P: Well I ended up moving…it was a time period, like the moving around. That's all it was. But if it was more accessible…

P05 was not able to consistently attend a regularly occurring in-person smoking cessation meeting due to frequent moves, a condition intrinsically tied to the experience of homelessness.

Some women who were actively using drugs found that the rhythm of daily drug use interfered with their ability to make it to a cessation program of any kind. For instance, P13 described her desire to participate in a cessation program, but her inability to do so given the logistical demands of her active drug use:

I: It sounds like you're wanting to go to these meetings, but they're just too hard to get to, because of location?

P: Yeah, I do. But see, if I could just kind of stop using…that's the whole thing. If I stopped using, I would be able to get to the meetings…instead of smoking or copping, I'd be on a bus going to a meeting.

P13 described a paradox in which if she could stop using substances, she would be able to catch the bus that would take her to a cessation program.

Need to isolate

Many participants identified the need to isolate as a self-preservation strategy. This was driven by concerns about unsafe, violent encounters tied to the experience of being unsheltered. P24 described the stress and risk associated with engaging in the sex work that she perceived as necessary for survival:

> I was getting a little old to work a street corner. So that alone is pretty stressful too, you know. You have to deal with men all the time. Some of 'em aren't so nice, you know.

For many, the need to self-isolate extended to the idea of accessing smoking cessation programs. In particular, a number of participants wanted to avoid personal interactions they might experience when participating in a group. P14 expressed a concern about how

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participating in a cessation group would necessitate interaction with people she used to encounter on the streets:

> I was sick of people out there in the streets, bein' around these –I call 'em scandalous –people.

Frequently, a desire to isolate was motivated by fears of drug relapse, even when the interview question posed was in regard to the context of tobacco use. For instance, P01 shared the following:

> I've been into nine residential programs, okay? And I still did cocaine. I still did it. After nine programs. So –no programs for smoking, no. I cannot deal with it. I'm a failure at programs…Being around all those people that are drug addicts still, and all they do is talk about drugs and when you leave, that's what you want to do, is some more coke. Let's go get some coke. I mean, I went to this place…where they have therapy…after the group got out, we'd meet outside and go –hey, where's your coke dealer? He's [across town], let's go. And so we'd end up snorting coke all night. It was like, what good is this therapy? It just makes me want to use even more 'cause that's all you talk about.

Participation in a cessation program, then, put P01 in direct relationship with those who were actively using drugs, which she feared might trigger a relapse.

On the other hand, a number of ex-smoker participants reported having successful experiences with cessation programs in the past and identified the emotional support they received from empathetic staffand other group members as a key component to their success with cessation, as described by P16:

A person who's been there, did that, and then left it alone? That's who I want to connect with.

For P16, empathetic relationships with peers and staff within cessation programs served as an important motivator to participation in groups.

Pessimism about effectiveness of current smoking cessation programs

While most women we interviewed expressed the desire to stop smoking, few were optimistic about the utility of a smoking cessation program. Most had participated in drug cessation programs in the past and drew upon their experiences in these programs to form opinions about the relative value of smoking cessation programs. The majority of respondents expressed feelings of self-reliance, indicating that they would only be able to quit smoking if they made up their minds to do so. They felt that no program could help them arrive at that stage of readiness:

> To me it's like –mind over matter, if you're gonna [quit], you're gonna [quit]. If you're not, you're not. That's my feeling (P22).

Some were skeptical that they would learn anything in a smoking cessation program that pertained directly to them, maintaining that everyone has a different path to cessation, as described by P03:

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> I wouldn't go to a support [group]–I mean, what they gonna tell me? I mean, seriously! I don't think so, 'cause, 'Well, when I stopped smokin', I done this and this and this.' For everyone it's different.

Each of these themes emphasizes the role that structural factors play in the success or failure of tobacco cessation efforts. A social determinants of health framework maintains that "social factors such as socioeconomic status and social support are likely fundamental causes of disease that…maintain an association with disease even when intervening mechanisms change" (Link & Phelan, 1995). The barriers to successful cessation experienced by the participants in this study were reflective of broader structural conditions tied specifically to their social status as women experiencing homelessness.

At the same time, these environmental factors exist in a dynamic relationship with participants' mental and emotional wellbeing. While some women understood their cessation challenges through a prism of structural forces, they also emphasized the extent to which their sense of self played a role in their decisions. Cessation programs that can attend to both psychosocial and structural factors, rather than focusing exclusively on individualistic approaches —such as motivation to quit —will be better equipped to meet the needs of this unique population.

Conclusion

The women interviewed for this study described high levels of chronic stress and fear related to the risks associated with being unsheltered or unstably housed. They intentionally self-isolated to minimize exposure to violence or triggers to substance use relapse and they linked this to smoking. Unique barriers to smoking cessation identified by women who are unhoused or unstably housed reflect a disconnect between their lived experience and accommodations that are made in standard smoking cessation programs.

Our results are consistent with prior research that identifies stress as a main trigger for tobacco use (Ansell, Gu, Tuit &, Sinha, 2012). However, the level and chronicity of stress in this population is exceptionally high, amplifying the problem to the point where current programming may not address the needs of this very high-risk population. Further, while traditional cessation programs tend to focus on interpersonal stressors, this approach overlooks the structurally produced stressors associated with the experience of being unsheltered, such as violence and fears of interactions with police. Participants described strategically forgetting stressful events of the past. As the success of models that address substance use and PTSD such as Seeking Safety (Najavits, 2002) suggest, addressing the intersections of past traumas and substance use do not need to rehash the details of stressful events in order to be effective.

Consistent with prior research, our work showed that support from empathetic treatment staffand peers is important. However, this population experienced a tension distinct to disempowered individuals, which is resistance to authority. Participants drew on their previous experiences with cessation programs, some of which were mandated drug cessation programs, in order to inform their willingness to participate in future tobacco cessation programs. Hopper (2003) and others (Wasserman & Clair, 2011) have analyzed the power

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structures inherent in the homelessness service industry, which may sometimes undermine the agency of the individuals seeking those services.

Additionally, women who are unhoused also experience an extraordinarily high rate of trauma and violence, leading to a very real need to socially isolate. Social isolation in the general population is typically predictive of negative health outcomes (Shankar et al., 2011), but among women experiencing homelessness, social isolation can be a protective behavior, adopted in unsafe social environments (Knight et al., 2014; Riley et al., 2014). This limits interaction and precludes the opportunity to receive needed support.

Given the disparate social context of unsheltered women compared to the general population of people who smoke tobacco, on which most cessation programs are based, adaptations of standard programs may better meet the unique needs of this population. For example, offering alternatives to attending group cessation programs within unsafe or triggering environments might remove barriers to participation. Further research is needed to ascertain whether mobile and web-based programs, which have proven effective in the general population (Taylor et al., 2017; Vogel et al., 2019), are first efficacious among unsheltered individuals, and second accessible. These offsite programs would allow for the maintenance of social isolation that many women have worked hard to build. In addition, offering travel vouchers and childcare so that women can leave their home environments and attend cessation programs elsewhere could aid in providing opportunities to build healthier communities through the cessation process (Goldade et al., 2011). While this analysis focused on barriers to counseling approaches as an intervention, additional qualitative research is needed on the relative benefits of alternative cessation models, such as alternative delivery models, in this specific population. In summary, our study findings revealed barriers to cessation that were directly tied to being unsheltered, which underscore the urgent need for making tailored adaptations in order to be effective in improving cessation efforts among this population.

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