Tobacco Cessation Interventions for Underserved Women

NATALIE HEMSING

*Research Associate, British Columbia Centre of Excellence for Women's Health,
Vancouver, British Columbia, Canada*

LORRAINE GREAVES

*Senior Investigator, British Columbia Centre of Excellence for Women's Health,
Vancouver, British Columbia, Canada*

NANCY POOLE

*Director, British Columbia Centre of Excellence for Women's Health,
Vancouver, British Columbia, Canada*

Despite high rates of smoking among some subgroups of women, there is a lack of tailored interventions to address smoking cessation among women. We identify components of a women-centered approach to tobacco cessation by analyzing 3 bodies of literature: sex and gender influences in tobacco use and addiction; evidence-based tobacco cessation guidelines; and best practices in delivery of women-centered care. Programming for underserved women should be tailored, build confidence and increase motivation, integrate social justice issues and address inequities, and be holistic and comprehensive. Addressing the complexity of women's smoking and tailoring appropriately could help address smoking among subpopulations of women.

KEYWORDS   smoking cessation, tobacco dependence treatment, underserved women, women-centered care

Address correspondence to Natalie Hemsing, Research Associate, British Columbia Centre of Excellence for Women's Health, E311-4500 Oak Street, Box 48, Vancouver, BC V6H 3N1, Canada. E-mail: nhemsing@cw.bc.ca

In many high-income countries, overall smoking prevalence, including prevalence among women, is declining. For example, 16.1% of women and men in Canada identify as current smokers according to a 2012 national survey; 13.9% of women identify as current smokers, as do 18.4% of men (CTUMS, 2012). Yet, smoking rates among specific subgroups of women remain high. For example, smoking is much higher among Indigenous and Aboriginal girls and women. In Canada, 39.1% of First Nations women, 34.2% of Metis women, and 48.9% of Inuit women are current smokers (Physicians for a Smokefree Canada, 2013). In the United States, 29.1% of American Indian and Alaskan Native women smoke (Centers for Disease Control and Prevention, 2012). In Australia, 44% of Aboriginal and Torres Islander women reported being current smokers (Australian Bureau of Statistics, 2012). Women who have experienced violence, abuse, or trauma are also at a greater risk for tobacco use. Smoking rates among women with posttraumatic stress disorder (PTSD) range between 39.2% (Helstrom, Bell, & Pineles, 2009) and 53.6% for women who are victims of sexual assault (Amstadter et al., 2009). Smoking rates among women using alcohol and other substances are also very high. Smoking rates of 53.5% have been reported for alcohol-dependent women, and 71.7% for drug-dependent women (Husky, Paliwal, Mazure, & McKee, 2007). In a substance use treatment center for women in Vancouver, Canada, in 2003, 79% of residential participants and 71% of day program participants reported being current smokers (Malmo, 2007).

Findings from several studies that examined gender differences in tobacco dependence and treatment suggest that some subpopulations of women might encounter more challenges in quitting than women in general or men. A study examining cessation rates and treatment response among 2,850 participants found that women, Blacks, and smokers with lower levels of education were less likely to successfully quit smoking, compared to men, Whites, and smokers with high levels of education (Piper et al., 2010). Husky and colleagues found that women with substance use disorders were significantly more likely to smoke than men (Husky et al., 2007). An evaluation of a tobacco cessation intervention for patients with serious mental illness showed a significant difference in treatment effectiveness by gender, with men achieving a higher cessation rate compared to women (69% vs. 31%) (Currie et al., 2008).

RESPONSES IN TOBACCO CONTROL

Evidence such as this raises important questions about effective smoking cessation treatment for women and girls, and subpopulations of women who are vulnerable to tobacco use. The prevalence of smoking among specific subgroups of women suggests that cessation approaches currently available are

not equivalently or adequately meeting the needs of these women. Hence, groups such as Aboriginal and ethnic minority women, women living on a low income, women who use other substances, and women who have experienced violence, abuse, or trauma are currently underserved. Smoking, for these women, is often closely linked to experiences of both social and economic disadvantage (Graham, 2009), and is also a means of managing difficult emotions and facilitating social cohesion (Greaves, 1996). Yet, tobacco cessation treatment interventions have failed to address the full context of women's smoking and social and economic determinants of women's health.

Generally, tobacco control efforts have focused on comprehensive approaches aimed at population-level interventions to achieve broad-based prevention and cessation impact. Approaches such as the MPOWER measures introduced by the World Health Organization (WHO, 2013) to support global tobacco control efforts reflect this multifaceted approach, and it is this type of approach that has led to the successful overall declines in prevalence in many countries. However, there is some evidence that population-based health approaches might not be as effective in reaching socially disadvantaged subgroups of women and men (Frohlich & Potvin, 2008). Within tobacco control, there is evidence that comprehensive approaches including tobacco taxation and smoking location restrictions are not experienced evenly by women (Greaves & Jategaonkar, 2006). Such broad approaches need to be supplemented with other, more specific approaches to address the trends and patterns of use among vulnerable groups, such as the subgroups of women discussed earlier.

Clearly there is a need for tailored interventions to address smoking cessation among women facing health disparities. Although many researchers have called for tailored interventions to increase effective cessation among women (Greaves et al., 2011; Ismailov & Leatherdale, 2010; Reynoso, Susabda, & Cepeda-Benito, 2005; Torchalla et al., 2012), few smoking cessation programs have been conceptualized in this way. At the same time, few programs reaching underserved girls and women, which are applying tailored, holistic, women-centered, or trauma-informed approaches, are proactively or effectively integrating tobacco cessation interventions into this programming. In response, this article explores the context of women's smoking and identifies the key components of a women-centered approach to tobacco cessation focusing specifically on the needs of groups of women not currently being reached with tobacco-related interventions.

To address the question of how better to reach and assist underserved women smokers, we saw the need to look beyond the evidence from the tobacco field, and to draw from and link literature on interventions from several areas of women's health. Thus this narrative review brings together existing research knowledge from three bodies of literature: (a) sex- and gender-related influences in tobacco use and addiction, (b) evidence-based clinical guidelines on treating tobacco dependence and preventing relapse,

and (c) best practices in the delivery of women-centered care to provide the foundation for a women-centered approach to tobacco cessation and relapse prevention. Articles and reports with material on women-specific tobacco control approaches, tobacco use and cessation among socially disadvantaged women, and sex and gender differences in tobacco use, cessation, and intervention response were located through online and academic database searches (including Google Scholar, CINAHL, EMBASE, MEDLINE, PsycINFO, Social Policy and Practice, Social Science Citation Index, Contemporary Women's Issues, Social Work Abstracts, and Studies on Women & Gender Abstracts), as well as searches of the collected literature databases at the British Columbia Centre of Excellence for Women's Health (the site of this project). Drawing on these various literatures, four key components of a women-centered approach to addressing tobacco use were drafted.

A key objective of this project was to develop guidelines for providers who intervene with women who smoke. Therefore, following the review of the literature and drafting of the key components of a women-centered approach, a consultation meeting was held with a group of experts working in the women's health and tobacco control fields to review and discuss findings. Twenty-four participants from Canada, the United States, and Australia met in person or virtually in Vancouver, Canada, including researchers working in government and nongovernmental organizations, health care providers, and those working in community-based organizations with Aboriginal girls and women, and women in treatment for mental illness and addictions. Participants were invited to read the draft literature review, to contribute any additional literature, and to participate in a facilitated discussion on the acceptability and feasibility of applying a women-centered approach in their work. The literature review was finalized based on feedback from the meeting. In these ways—both through linking multiple bodies of research and by involving multisectoral reviewers—considerable clinical and practice wisdom was brought to the research evidence, and the synthesis into key components was honed and enhanced.

KEY COMPONENTS OF A WOMEN-CENTERED APPROACH

We identified four key components of a women-centered approach to tobacco cessation, and discuss this relative to the specific experiences and needs of underserved groups of women. We argue that programming (a) should be tailored or individualized; (b) should build confidence and increase motivation; (c) should integrate social justice issues; and (d) should be holistic and comprehensive. Integrating these components into tobacco dependence and relapse prevention programs for women might help address the high rates of tobacco use among specific subpopulations of women. In turn, integrating tobacco-specific content into programming already

incorporating these principles into their work with girls and women with related health and social concerns would mean that tobacco interventions are effectively linked with interventions on these other issues.

TAILORED AND INDIVIDUALIZED PROGRAMMING

A women-centered model of addressing tobacco use must focus on a woman's individual needs in the context of her particular life circumstances. Women who smoke come from diverse social and economic contexts, and an individualized intervention takes these differences into account and tailors responses accordingly. Women might have various reasons for smoking and challenges with quitting that need to be individually addressed, and might have different preferences in terms of the approach, method, or intensity of the intervention. Furthermore, underserved women might vary in their cessation needs based on other social and individual factors including mental health status, use of alcohol and other substances, and ethnicity and racial identity. Various methods and a flexible and tailored approach to intervening with these women is needed to properly address the context of women's smoking and support women's cessation efforts. Regardless of evidence of effectiveness, interventions should not be *imposed* on women who make an informed decision not to use them.

Acknowledging the Meanings of Smoking for Women

Girls and women smoke for various reasons, and smoking fulfills particular needs in women's lives (Greaves, 2015). Some of the common meanings of smoking for women are to control or cope with negative emotions or to establish identity (Greaves, 1996; Kouvonen, Kivimäki, Virtanen, Pentti, & Vahtera, 2005). Berlin and colleagues (2003) reported that women are more likely than men to smoke to be stimulated, to reduce tension, to relax, or to be social. A qualitative study with women who had experienced abuse, Indigenous women, and self-described feminists revealed that women smoke to manage social relationships, create an image, control emotions, exercise dependence, and form identity (Greaves, 1996). In qualitative research with mothers living on a low income, women reported smoking as a means of stress relief, to provide a break from caregiving, and for relief from work pressures (Graham, 1993).

Further, smoking for some subgroups of women might be normalized. For example, research with Aboriginal women in Australia reveals that smoking facilitates social belonging (Passey, Sheldrake, Leitch, & Gilmore, 2007). The women reported that because the majority of people in their community smoke, there is a sense of obligation or social pressure to smoke. Other socially disadvantaged groups, such as low-income women and men, often

live in social environments where smoking is normalized and other smokers are present (Thompson, Pearce, & Barnett, 2007). For women who live in very prosmoking environments and who smoke to form and enhance social bonds, special attention might be needed to enhance social support or provide peer supports during smoking reduction and cessation.

Girls also initiate smoking for specific reasons. A study among young people in Scotland revealed that girls typically begin smoking (along with drinking alcohol) as an act of resistance of the traditional "good girl" image and a means of creating an alternate social identity (Amos & Bostock, 2007). Girls also expressed that smoking was an important means of forming and strengthening relationships and coping with negative emotions (Amos & Bostock, 2007). In a study with adolescent girls in northern Canada, differences in tobacco use were observed for older and younger girls; among younger girls (12 years and younger) smoking was socially adaptive, whereas among older (16-year-old) girls, smoking was used to manage stress and negative emotions (Tilleczek & Hine, 2006). A qualitative study with Aboriginal adolescent girls in Canada found that girls began smoking out of curiosity, as well as to deal with various forms of stress, including stress at school and in their families and communities, and experiences of discrimination and racism (de Finney et al., 2013). In response, the authors noted the need for interventions that integrate alternative coping mechanisms for stressors, offer trauma-informed support, and are integrated in the community. Indeed the meanings of smoking have direct implication for cessation (Greaves, 2015), and understanding the meanings for beginning and continuing to smoke among girls and women can help shape more meaningful treatment responses.

Respecting Individual Differences and Preferences in Cessation Methods and Intensity

Interventions for underserved groups of women should provide women with choice and control regarding cessation methods and intensity, and variations in level of nicotine should also be considered when providing cessation interventions. One example of an individualized approach comes from research conducted with female war veterans by Katzburg and colleagues (Katzburg et al., 2009), who developed a toolkit that includes a menu of choices with multiple options for the type of program and content women feel would be most useful. In this way, each woman receives individual assistance for the specific features or experiences affecting her ability to quit.

There is some evidence to suggest that pharmacotherapies might have different effects on subpopulations of women. One study reported that women and smokers with lower levels of education benefited more from the combination of pharmacotherapies (bupropion and lozenge, or nicotine patch and lozenge) rather than use of a single form of pharmacotherapy

treatment for cessation (Piper et al., 2010). The authors noted that women have higher rates of nicotine metabolism than men, and might therefore require combined therapies to provide a steady release of nicotine when attempting to quit. They also noted that participants with less than a high school education smoked at the highest rate, and that the benefit of combined therapies for this subgroup might reflect greater nicotine dependence. There is also evidence that combined pharmacotherapy could improve cessation outcomes for people with a predefined illness (including cardiovascular disease, cancer, diabetes, and chronic obstructive pulmonary disease) (Steinberg et al., 2009) and with co-occurring heavy alcohol use (Ray et al., 2014).

Studies of specific pharmacotherapies demonstrate differences in effectiveness as well as the potential for harm among some subgroups. Varenicline appears to increase smoking cessation rates among both women and men, although there might be a higher likelihood of side effects among women, such as nausea (Ravva, Gastonguay, French, Tensfeldt, & Faessel, 2010), and further research might be required to test its efficacy and safety in subgroups of smokers who have specific comorbidities and risk patterns, such as mental illness. Combining various forms of nicotine replacement therapy (NRT), or using higher dose preparations of nicotine gum, patches, and lozenges might be helpful for highly dependent smokers, and a reduced dose of NRT might be appropriate for light smokers (Fiore, 2008). These findings could be applicable to groups of underserved women who are typically heavy smokers, such as women with mental illness or trauma and women with substance abuse issues. These variations in effectiveness and potential contraindications need to be considered when designing and implementing interventions for women. Medication and counseling are each effective alone, and should be provided as individual treatments whenever a woman is not interested in combined therapy (Fiore, 2008; Reynoso et al., 2005).

Addressing the Link Between Smoking and Stress

Women smokers have higher levels of perceived stress and affective mental disorders such as depression and anxiety than men, and negative affect is strongly linked to tobacco use. For example, more depressive symptoms have been reported among women in Europe who are heavy smokers than among nonsmoking women (Payne, Ma, Crews, & Li, 2013). Women are more likely than men to report severe withdrawal symptoms while attempting to quit and to resume smoking due to stress (Burgess et al., 2009; Leatherdale & Shields, 2009). Many smokers believe that smoking helps them to cope with stress. In fact, addiction to nicotine might increase stress and anxiety, the symptoms of which are then alleviated by smoking (Johnson et al., 2000).

Furthermore, stress, and the use of smoking to cope with stress, might be particularly salient for groups of underserved women such as women living on a low income and ethnic minority women. A study in Denmark found that smokers who had reported a previous quit attempt and who were of low socioeconomic status were more likely to report relapse due to depression, tension or nervousness than participants reporting higher socioeconomic status (Pisinger & Godtfredsen, 2007). Several studies with Aboriginal girls and women and young women indicate that women often take up and continue to smoke to cope with stress (Amos & Bostock, 2007; de Finney et al., 2013; Passey, Gale, & Sanson-Fisher, 2011). Intervention approaches need to recognize the link between smoking and stress, particularly for underserved groups of women, and consider how best to help women address and manage these stressors while supporting reduction and cessation efforts.

Tailoring Approaches for Diverse Women

Racial and ethnic differences in attitudes and beliefs about smoking could influence treatment. For example, in some groups, smoking might represent a means of coping with stress due to acculturation. A qualitative study with Aboriginal girls reveals that smoking is often a tool for coping with racial discrimination and the effects of colonialism (de Finney et al., 2013). Similarly, a study with Black adolescent girls identified high rates of racial discrimination among girls, which was highly correlated with smoking (Guthrie, Young, Williams, Boyd, & Kintner, 2002). When the researchers removed the effects of stress in their analysis, they found that the relationship between discrimination and smoking was reduced, suggesting that smoking is a means of coping with stress from racial discrimination for these girls. A qualitative study with pregnant Australian Aboriginal women who smoke found that women experience significant social and economic issues in their lives, including racism and discrimination, that limit their interest in or capacity to quit smoking, and that many women value smoking for stress relief and relaxation (Wood, France, Hunt, Eades, & Slack-Smith, 2008).

Several studies discuss the role of social support and social capital in reducing tobacco use among ethnic minority women. A study with primarily female (73%) Latinos showed that participants who reported higher rates of perceived positive support from a partner demonstrated the highest cessation rates (Brothers & Borrelli, 2011). In addition, a community-based intervention for Black women found that enhancing social support by offering group sessions and ongoing individual support from a community worker was associated with improved measures of social support, which predicted smoking cessation outcomes (Andrews, 2004). Together, these studies suggest that integrating social support in tobacco dependence treatment might be particularly beneficial for diverse subgroups of women. However, a recent

review also notes the dearth of research into smoking cessation programs that include social support for Aboriginal communities (DiGiacomo et al., 2011).

There is some evidence that diverse subgroups of women are interested in receiving different types of smoking cessation support. Ussher, West, and Hibbs (2004) found that preference for format and approach of a smoking cessation intervention varies by racial group and socioeconomic status among a sample of pregnant women who smoke. Ethnic minority groups reported greater preference for behavioral support, whereas low socioeconomic groups of women reported preference for "buddying" approaches. A U.S.-based cross-sectional analysis reveals lower use of NRT among Black, Latino, and Asian American women and men, compared to White women and men (Fu et al., 2008). Although reasons for these differences have not been further investigated, they might reflect preferences as well as barriers in accessing these forms of cessation support. In general, women tend to prefer programs that prioritize support for women, and choice or control of program components (Katzburg, Farmer, Poza, & Sherman, 2008).

Few studies examine the relative efficacy of smoking cessation interventions for different racial and ethnic groups of women, although several studies demonstrate the impact of a tailored program within a specific community, including an intervention to improve spiritual and social support to quit smoking among Black women in public housing (Andrews, Felton, Wewers, Waller, & Tingen, 2007) and an online behavioral intervention that tailored motivational and smoking cessation information according to the participant's race or ethnicity, sex, and age (Swartz, Noell, Schroeder, & Ary, 2006). Providing an individualized approach to tobacco cessation involves recognizing differences in tobacco use and preferences for treatment among diverse women, and offering tailored and culturally sensitive programming to meet these differences.

BUILD CONFIDENCE AND INCREASE MOTIVATION

Compared to men, women are more likely to regret smoking initiation (Fong et al., 2004). Women are also more likely than men to perceive both higher risks and higher benefits associated with quitting than males (McKee, O'Malley, Salovey, Krishnan-Sarin, & Mazure, 2005) and therefore particular attention to increasing motivation might be required. One study found that perceptions of risk were associated with treatment outcomes for women; as ratings of perceptions of risk increased, women were four times more likely to relapse than men (McKee et al., 2005). Compared with men, women were more likely to expect withdrawal effects and weight gain (Hendricks et al., 2014). An evaluation by Holmberg-Schwartz (1997) shows that the more confident women are about not smoking in a variety of situations, the fewer

cigarettes they smoke per day. Developing skills for managing withdrawal symptoms and cravings and avoiding smoking in specific situations might help to increase confidence in a woman's ability to quit (Manfredi, Cho, Crittenden, & Dolecek, 2007). Although these findings are drawn from studies with the general population of women, there is also some evidence from studies with underserved groups of women that suggest the need to consider confidence and motivation when designing tobacco control interventions.

Addressing Readiness

Tailoring treatment programs to women's readiness to change could enhance motivation to reduce or quit smoking. Findings from a study assessing stage of change in a sample of 554 low-income patients from primary care medical clinics reveal that women are less likely than men to be contemplating making changes in their smoking (O'Hea, Wood, & Brantley, 2003). Particularly for women who are not ready to make a quit attempt, or for those who have recently relapsed, interventions that are designed to promote readiness to quit could be especially important (Fiore, 2008; Garay, DiClemente, & Delahanty, 2010). Smoking reduction could perhaps be encouraged as a first step toward cessation for some smokers who are not yet ready to quit. There is some evidence that this might be a useful approach for women overall; for example, among Canadian adults who have quit smoking, women are more likely than men to use gradual reduction as a strategy for cessation (Ismailov & Leatherdale, 2010).

One harm reduction strategy that has been used to support underserved women is Start Thinking About Reducing Second-hand Smoke (STARSS) developed by AWARE (2007) in Ontario, Canada. This program includes worksheets and tips to support low-income mothers in managing their tobacco use. The intention is not for women to quit smoking, but instead to support women in making progress toward the management of second-hand smoke in the home using a nonjudgmental harm reduction approach. Programs that allow for a range of goals and skills development, tailored to the circumstances of women, allow them to gain confidence as they experience success on their own terms (Merkur, 2008). Working with women to increase motivation and identify barriers to and opportunities for change might help to build their confidence and ultimately improve their chances of achieving smoking cessation or reduction goals.

Another potential strategy for addressing readiness is Motivational Interviewing (MI), an evidence-based collaborative conversation style for strengthening a person's own motivation and commitment for making positive changes in health behaviors (Rollnick, Miller, & Butler, 2008). To influence outcomes effectively, training is important for the person who delivers MI interventions, as it is a communications approach that combines relational and technical components (Fiore, 2008; Miller & Rose, 2009).

Motivational Interviewing approaches use a relational stance, consistent with trauma-informed and other safe, empowering approaches consistent with the needs of women smokers with mental health and trauma histories (Urquhart & Jasiura, 2012).

Social Support

Social support is a broad concept with several different aspects that build confidence in a woman's ability to quit smoking, including structural support (e.g., social integration/loneliness, proportion of smokers in one's social network) and functional social support (e.g., emotional support such as empathy, and instrumental support such as helping with chores) (Westmaas, Bontemps-Jones, & Bauer, 2010). Interventions and programs focused on enhancing social support might be useful in helping a woman quit smoking, but it is important to recognize that the woman might not have a supportive partner, family, or group of friends in her life. As noted previously, women living in socially disadvantaged circumstances could inhabit prosmoking contexts that make it difficult to quit smoking (Thompson et al., 2007). These women might require social support from people located outside of their network of family and friends to help facilitate reduction and cessation. Furthermore, abuse, control, and power dynamics could all affect how different individuals in a woman's life respond to her decision to quit smoking; it is essential that a smoking cessation intervention acknowledge this complexity while also ensuring women's safety (Bottorff, Oliffe, Kalaw, Carey, & Mroz, 2006; Greaves, Kalaw, & Bottorff, 2007). Greaves and colleagues (2011) suggest that the issues of partner smoking be addressed using a "delinked" approach—by working with the woman and her partner separately to explore individual smoking behavior and approaches to cessation.

To build confidence, a women-centered smoking cessation program offers opportunities for women to provide informal forms of support for one another in addition to any support they might be receiving from their partner, family, or friends. Social support interventions for low-income women who smoke have been shown to have a positive impact on smoking reduction or cessation as well as other outcome measures, such as coping, social network, and health behaviors (Andrews, 2004; Baird, Cooper, Margetts, Barker, & Inskip, 2009; Stewart et al., 2010; Westmaas et al., 2010). Several studies among Aboriginal women and ethnic minority women have identified social support and community involvement as key components for addressing tobacco dependence (Andrews, 2004; Brothers & Borrelli, 2011; de Finney et al., 2013). Women-centered approaches should provide opportunities for connecting women with supportive peers and community members, as well as recognize the role and impact of existing relationships on smoking cessation efforts.

INTEGRATE SOCIAL JUSTICE ISSUES AND ADDRESS INEQUITIES

Women who experience multiple social and economic pressures due to poverty, income inadequacy, unemployment, and low education might be unable or unmotivated to quit smoking because housing, food security, and child care are higher priorities or because smoking serves multiple purposes that help women to navigate these complex realities (Greaves, 1996; Greaves et al., 2011). Aboriginal women in particular are more likely to experience challenges such as inadequate housing and lack of food security that might influence their desire and ability to quit smoking (Monette et al., 2011; Power, 2008). As a starting point, clinicians should acknowledge the difficulties involved in quitting smoking, particularly for women experiencing other forms of disadvantage, and include steps through which women might gain awareness and acknowledgment of the factors that challenge smoking cessation (Greaves et al., 2011). The availability of a variety of different cessation aids for no cost, including NRT, could also increase uptake (Greaves et al., 2011). A women-centered approach that engages women and offers individualized care for tobacco dependence supports women in advocating for those issues that are important to them and their communities.

Reducing Stigma

The presence of increasingly restrictive smoking policies, as well as heightened awareness of the health effects of both active smoking and exposure to second-hand smoke, have created a denormalized atmosphere where people who smoke are often segregated from those who do not, and could give rise to efforts to use stigma, blame, and shaming to reduce or prevent smoking (Bell, McCullough, Salmon, & Bell, 2010; Ritchie, Amos, & Martin, 2010). This might be especially true for women who are visibly pregnant or who are mothers of young children (Greaves et al., 2011; Physicians for a Smokefree Canada, 2013). Smoking-related stigma can take a variety of different forms, including unpleasant or demoralizing social interactions such as negative comments or nonverbal gestures that imply criticism (Bell et al., 2010) or even poorer access to employment (WHO, 2008) and housing (Chapman & Freeman, 2008).

Women who smoke are more likely to be experiencing social and economic disadvantage. Therefore the stigma associated with smoking could serve to further isolate these women and hinder access to cessation supports (Bell, Salmon, Bowers, Bell, & McCullough, 2010; Burgess, Fu, & Van Ryn, 2009; Thompson et al., 2007). Messages from health care providers encouraging women to quit smoking should be supportive in nature, rather than punitive, to maximize positive benefit (Merkur, 2008). Awareness of stigma could be incorporated into the five A's brief clinician intervention for smoking cessation: Ask about smoking status; Advise patient to quit smoking;

Assess willingness to quit; Assist by providing counseling, pharmacotherapies, or other supports; and Arrange follow-up with the patient (Greaves et al., 2011; Grossman, Donaldson, Belton, & Oliver, 2008). If relapse does occur, the clinician can help alleviate feelings of shame or guilt by reassuring the patient that quitting might take multiple attempts and that relapse can still be a positive learning experience (Fiore, 2008).

HOLISTIC CARE

A women-centered approach must consider women's health in a holistic sense, rather than focusing on women's smoking behavior alone. Women should be encouraged to identify which health concerns are most important for them to address and what they might be able to do for themselves to improve their health (Merkur, 2008). A woman who connects with a health care provider due to smoking should be provided with assistance for other substance use, trauma, and mental health recovery. As a starting point, care providers should acknowledge and support practices the woman is already doing, or is motivated to do, to improve her health.

Integrated Approaches to Mental Health, Substance Use, and Smoking Cessation

Both the experiences of substance use and mental health disorders are influenced by gender (Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005; Stewart, 2007). For example, women have a high prevalence of depression and psychological distress, and their mental health status might be closely linked to their satisfaction in multiple life roles as a parent, spouse, and paid worker (Farr, Bitsko, Hayes, & Dietz, 2010; Kouvonen et al., 2005). As previously noted, the majority of women with mental illness or substance use disorders smoke; therefore, integrated approaches are required. Although it is a common belief among clinicians and others that people in treatment for mental health or substance use issues cannot quit smoking or would be at greater health risk if they tried to do so (Prochaska, 2010), evidence suggests that people in treatment for substance use, particularly women, are interested in quitting smoking (Poole, Greaves, & Cormier, 2003; Reid et al., 2007). Integrated treatments, including smoking cessation interventions provided concurrently during addictions treatment (Prochaska, Delucchi, & Hall, 2004) and mental health services (McFall et al., 2010; Prochaska, 2010), have been shown to enhance the effectiveness of treatment. Even if services for co-occurring issues are not formally integrated, it is important that providers who intervene with women who smoke make connections and integrate support on the issues likely to be linked to smoking by women such as other substance use and mental health. For example, a women-centered

approach might involve offering to discuss links among substance use, mental health, and gender and tobacco use, and not presupposing where the woman wishes to start in addressing these concerns.

Trauma-Informed Support

Covington (2008) described trauma as both a negative event (e.g., experiencing or witnessing violence) and a particular response of fear and helplessness in response to that event. Trauma is often a gendered experience, as women are more likely than men to experience physical and sexual abuse, often from their intimate partners (Covington, 2008). Smoking cigarettes might be a more common response to trauma or psychological distress among women than men (Cisler et al., 2011). Even as a trauma-informed approach is increasingly being incorporated into other health and social services such as treatment for substance use (Morrissey et al., 2005; Urquhart & Jasiura, 2012) and homeless shelters (Hopper, Bassuk, & Olivet, 2010), there is a dearth of programs and research studies on smoking cessation treatments for women with experiences of trauma. However, integrated trauma-informed services have been shown to have better treatment outcomes than standard care for mental health and substance use and could reduce the risk of trauma-based relapse (Hopper et al., 2010; Morrissey et al., 2005; Stewart et al., 2011). Because of the high prevalence of trauma among women, and because forcing disclosure of a trauma history can be retraumatizing, Elliott et al. (2005) recommended that trauma-informed approaches be universally applied. Numerous examples and models of trauma-informed approaches exist; however, such interventions commonly include elements such as enhancing personal and environmental safety, maximizing a woman's choice and control, focusing on empowerment, and using a strengths-based approach to develop coping skills (Poole & Greaves, 2012). Multilevel staff training is also central to implementing a trauma-informed program (Hopper et al., 2010; Morrissey et al., 2005).

CONCLUSION

Tobacco cessation approaches are required that acknowledge and respond to the complex contexts of women's smoking. Approaches are required that are both comprehensive and flexible to the specific needs of women, rather than attempting to address women's cessation with a single approach. Given the contributions from various fields about how to approach tobacco use and cessation, women-centered approaches to care, and the importance of gender and social context, it seems that programs that are individualized, build confidence and increase motivation, integrate social justice issues, and are holistic and comprehensive might be most appropriate for responding to the issue of tobacco use among underserved groups of women.

Responding to the need for the further design and implementation of women-centered tobacco cessation strategies, these components have informed the development of *Liberation! Helping Women Quit Smoking: A Brief Tobacco Intervention Guide*, which offers guidelines for practitioners and clinicians for engaging in a conversation with women about tobacco use and reduction or quitting (Urquhart, Jasiura, Poole, Nathoo, & Greaves, 2012). Recognizing that many practitioners might need information and training about tobacco use and cessation among subgroups of women vulnerable to tobacco use, this guide makes the links between smoking and other forms of disadvantage, including mental health issues, trauma, socioeconomic status, and substance use issues. The guidelines emphasize shifting and refining the communication style between health care providers and women, and preparing and supporting women to quit within the larger context of their lives. It offers suggestions for service providers to engage in collaborative conversations with women about smoking that are empowering, are trauma-informed, reduce stigma, and are tailored to women's experiences. The guidelines are to be used by service providers and women accessing services in diverse contexts, including community mental health, transition houses, and primary health care settings.

The *Liberation* guide represents the initial innovative step in combining these four promising components, yet further comprehensive intervention development and evaluation are required that address the social context of women's smoking and reduce women's vulnerability to tobacco use. In particular, there is a need for further integration and application of these principles in a range of interventions. Such tailored approaches, in conjunction with population-based comprehensive tobacco control policies, are needed to more effectively and sensitively address various subgroups of women who are vulnerable to tobacco use.

FUNDING

REFERENCES

Amos, A., & Bostock, Y. (2007). Young people, smoking and gender: A qualitative exploration. *Health Education Research*, *22*, 770–781. doi:10.1093/her/cyl075

Amstadter, A., Resnick, H., Nugent, N., Acierno, R., Rheingold, A., Minhinnett, R., & Kilpatrick, D. (2009). Longitudinal trajectories of cigarette smoking following rape. *Journal of Traumatic Stress*, *22*, 113–121. doi:10.1002/jts.v22:2

Andrews, J. O. (2004). Sister to sister: A community partnered tobacco cessation intervention in low income housing developments. *Dissertation Abstracts International*, *65*(12), 6286B. (UMI No. 3157115)

Andrews, J. O., Felton, G., Wewers, M. E., Waller, J., & Tingen, M. (2007). The effect of a multi-component smoking cessation intervention in African American women residing in public housing. *Research in Nursing & Health*, *30*(1), 45–60. doi:10.1002/(ISSN)1098-240X

Australian Bureau of Statistics. (2012). *Smoking: Gender indicators*. Canberra, Australia: Author.

AWARE. (2007). STARSS (Start Thinking About Reducing Secondhand Smoke). Retrieved from http://www.aware.on.ca/starss.

Baird, J., Cooper, C., Margetts, B. M., Barker, M., & Inskip, H. M. (2009). Changing health behaviour of young women from disadvantaged backgrounds: Evidence from systematic reviews. *The Proceedings of the Nutrition Society*, *68*(2), 195–204.

Bell, K., McCullough, L., Salmon, A., & Bell, J. (2010). "Every space is claimed": Smokers' experiences of tobacco denormalisation. *Sociology of Health & Illness*, *32*, 914–929. doi:10.1111/j.1467-9566.2010.01251.x

Bell, K., Salmon, A., Bowers, M., Bell, J., & McCullough, L. (2010). Smoking, stigma and tobacco "denormalization": Further reflections on the use of stigma as a public health tool. *Social Science & Medicine*, *70*, 795–799. doi:10.1016/j.socscimed.2009.09.060

Berlin, I., Singleton, E., Pedarriosse, A., Lancrenon, S., Rames, A., Aubin, H., & Niaura, R. (2003). The modified reasons for smoking scale: Factorial structure, gender effects and relationship with nicotine dependence and smoking cessation in French smokers. *Addiction*, *98*, 1575–1583. doi:10.1046/j.1360-0443.2003.00523.x

Bottorff, J. L., Oliffe, J., Kalaw, C., Carey, J., & Mroz, L. (2006). Men's constructions of smoking in the context of women's tobacco reduction during pregnancy and postpartum. *Social Science & Medicine*, *62*, 3096–3108. doi:10.1016/j.socscimed.2005.11.058

Brothers, B. M., & Borrelli, B. (2011). Motivating Latino smokers to quit: Does type of social support matter? *American Journal of Health Promotion*, *25*(Suppl. 5), S96–S102. doi:10.4278/ajhp.100628-QUAN-220

Burgess, D. J., Fu, S. S., Noorbaloochi, S., Clothier, B. A., Ricards, J., Widome, R., & Van Ryn, M. (2009). Employment, gender, and smoking cessation outcomes in low-income smokers using nicotine replacement therapy. *Nicotine & Tobacco Research: Official Journal of the Society for Research on Nicotine and Tobacco*, *11*, 1439–1447. doi:10.1093/ntr/ntp158

Burgess, D. J., Fu, S. S., & Van Ryn, M. (2009). Potential unintended consequences of tobacco-control policies on mothers who smoke: A review of the literature. *American Journal of Preventive Medicine*, *37*, S151–S158. doi:10.1016/j.amepre.2009.05.006

Centers for Disease Control and Prevention. (2012). Current cigarette smoking among adults—United States, 2011. *Morbidity and Mortality Weekly Report, 2*, 889–894.

Chapman, S., & Freeman, B. (2008). Markers of the denormalisation of smoking and the tobacco industry. *Tobacco Control*, *17*, 25–31. doi:10.1136/tc.2007.021386

Cisler, J. M., Amstadter, A. B., Begle, A. M., Resnick, H. S., Danielson, C. K., Saunders, B. E., & Kilpatrick, D. G. (2011). A prospective examination of the relationships between PTSD, exposure to assaultive violence, and cigarette smoking

among a national sample of adolescents. *Addictive Behaviors*, *36*, 994–1000. doi:10.1016/j.addbeh.2011.05.014

Covington, S. (2008). Women and addiction: A trauma-informed approach. *Journal of Psychoactive Drugs*, *40*(Suppl.), 377–385. doi:10.1080/02791072.2008.10400665

CTUMS. (2012). *Canadian Tobacco Use Monitoring Survey (CTUMS) 2012*. Ottawa, Canada: Health Canada.

Currie, S. R., Karltyn, J., Lussier, D., De Denus, E., Brown, D., & El-Guebaly, N. (2008). Outcome from a community-based smoking cessation program for persons with serious mental illness. *Community Mental Health Journal*, *44*, 187–194. doi:10.1007/s10597-007-9113-8

de Finney, S., Greaves, L., Janyst, P., Hemsing, N., Jategaonkar, N., Browne, A., & Poole, N. (2013). "I had to grow up pretty quickly": Cultural and gender contexts of Aboriginal girls' smoking. *Pimatisiwin*, *11*(1), 151–170.

DiGiacomo, M., Davidson, P. M., Abbott, P. A., Davison, J., Moore, L., & Thompson, S. C. (2011). Smoking cessation in indigenous populations of Australia, New Zealand, Canada, and the United States: Elements of effective interventions. *International Journal of Environmental Research and Public Health*, *8*, 388–410. doi:10.3390/ijerph8020388

Elliott, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology*, *33*, 461–477. doi:10.1002/jcop.20063

Farr, S. L., Bitsko, R. H., Hayes, D. K., & Dietz, P. M. (2010). Mental health and access to services among US women of reproductive age. *American Journal of Obstetrics and Gynecology*, *203*, 542.e1–542.e9. doi:10.1016/j.ajog.2010.07.007

Fiore, M. C. (2008). A clinical practice guideline for treating tobacco use and dependence: 2008 update: A U.S. public health service report. *American Journal of Preventive Medicine*, *35*, 158–176. doi:10.1016/j.amepre.2008.04.009

Fong, G. T., Hammond, D., Laux, F. L., Zanna, M. P., Cummings, K. M., Borland, R., & Ross, H. (2004). The near-universal experience of regret among smokers in four countries: Findings from the international tobacco control policy evaluation survey. *Nicotine & Tobacco Research*, *6*, 341–351. doi:10.1080/14622200412331320743

Frohlich, K. L., & Potvin, L. (2008). Transcending the known in public health practice: The inequality paradox. The population approach and vulnerable populations. *American Journal of Public Health*, *98*, 216–221. doi:10.2105/AJPH.2007.114777

Fu, S. S., Kodl, M. M., Joseph, A. M., Hatsukami, D. K., Johnson, E. O., Breslau, N., . . . Bierut, L. (2008). Racial/ethnic disparities in the use of nicotine replacement therapy and quit ratios in lifetime smokers ages 25 to 44 years. *Cancer Epidemiology Biomarkers & Prevention*, *17*, 1640–1647. doi:10.1158/1055-9965.epi-07-2726

Garay, M. M., DiClemente, C. C., & Delahanty, J. C. (2010). Quitting smoking and beating nicotine addiction. In J. M. S. S.-Y. Yoon (Ed.), *Women and the tobacco epidemic: Challenges for the 21st century* (2nd ed., pp. 153–173). Geneva, Switzerland: World Health Organization.

Graham, H. (1993). *When life's a drag: Women, smoking and disadvantage*. London, UK: Her Majesty's Stationery Office.

Graham, H. (2009). Women and smoking: Understanding socioeconomic influences. *Drug and Alcohol Dependence*, *104*(Suppl. 1), S11–S16. doi:10.1016/j.drugalcdep.2009.02.009

Greaves, L. (1996). *Smoke screen: Women's smoking and social control*. Halifax, Canada: Fernwood.

Greaves, L. (2015). The meanings of smoking to women and their implications for cessation. *International Journal of Environmental Research and Public Health*, *12*, 1449–1465. doi:10.3390/ijerph120201449

Greaves, L., & Jategaonkar, N. (2006). Tobacco policies and vulnerable girls and women: Toward a framework for gender sensitive policy development. *Journal of Epidemiology and Community Health*, *60*(Suppl. 2), ii57–ii65. doi:10.1136/jech.2005.045393

Greaves, L., Kalaw, C., & Bottorff, J. L. (2007). Case studies of power and control related to tobacco use during pregnancy. *Women's Health Issues: Official Publication of the Jacobs Institute of Women's Health*, *17*, 325–332. doi:10.1016/j.whi.2007.06.001

Greaves, L., Poole, N., Okoli, C., Hemsing, N., Qu, A., Bialystok, L., & O'Leary, R. (2011). *Expecting to quit: A best practices review of smoking cessation interventions for pregnant and postpartum girls and women* (2nd ed). Vancouver, Canada: British Columbia Centre of Excellence for Women's Health.

Grossman, J., Donaldson, S., Belton, L., & Oliver, R. H. (2008). 5 A's smoking cessation with recovering women in treatment. *Journal of Addictions Nursing*, *19*(1), 1–8. doi:10.1080/10884600801896918

Guthrie, B. J., Young, A. M., Williams, D. R., Boyd, C. J., & Kintner, E. K. (2002). African American girls' smoking habits and day-to-day experiences with racial discrimination. *Nursing Research*, *51*, 183–190. doi:10.1097/00006199-200205000-00007

Helstrom, A., Bell, M., & Pineles, S. (2009). Feeling better and smoking less: The relationship between trauma symptoms and smoking over time. *Cognitive Therapy and Research*, *33*, 235–240. doi:10.1007/s10608-008-9183-0

Hendricks, P. S., Westmaas, J. L., Ta Park, V. M., Thorne, C. B., Wood, S. B., Baker, M. R., . . . Hall, S. M. (2014). Smoking abstinence-related expectancies among American Indians, African Americans, and women: Potential mechanisms of tobacco-related disparities. *Psychology of Addictive Behaviors*, *28*(1), 193–205. doi:10.1037/a0031938

Holmberg-Schwartz, D. (1997). *Catching our breath: A journal about change for women who smoke*. Winnipeg, Canada: Women's Health Clinic.

Hopper, E., Bassuk, E. L., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. *The Open Health Services and Policy Journal*, *3*, 80–100. doi:10.2174/1874924001003020080

Husky, M. M., Paliwal, P., Mazure, C. M., & McKee, S. A. (2007). Gender differences in association with substance use diagnosis and smoking. *Journal of Addiction Medicine*, *1*, 161–164. doi:10.1097/ADM.0b013e318142d06c

Ismailov, R. M., & Leatherdale, S. T. (2010). Smoking cessation aids and strategies among former smokers in Canada. *Addictive Behaviors*, *35*, 282–285. doi:10.1016/j.addbeh.2009.10.013

Johnson, J. G., Cohen, P., Pine, D. S., Klein, D. F., Kasen, S., & Brook, J. S. (2000). Association between cigarette smoking and anxiety disorders during

adolescence and early adulthood. *JAMA: The Journal of the American Medical Association*, *284*, 2348–2351. doi:10.1001/jama.284.18.2348

Katzburg, J. R., Farmer, M. M., Poza, I. V., & Sherman, S. E. (2008). Listen to the consumer: Designing a tailored smoking-cessation program for women. *Substance Use & Misuse*, *43*, 1240–1259. doi:10.1080/10826080801914204

Katzburg, J. R., Yano, E. M., Washington, D. L., Farmer, M. M., Yee, E. F. T., Fu, S., . . . Sherman, S. E. (2009). Combining women's preferences and expert advice to design a tailored smoking cessation program. *Substance Use & Misuse*, *44*, 2114–2137. doi:10.3109/10826080902858433

Kouvonen, A., Kivimäki, M., Virtanen, M., Pentti, J., & Vahtera, J. (2005). Work stress, smoking status, and smoking intensity: An observational study of 46 190 employees. *Journal of Epidemiology and Community Health*, *59*(1), 63–69. doi:10.1136/jech.2004.019752

Leatherdale, S. T., & Shields, M. (2009). *Smoking cessation: Intentions, attempts and techniques health reports* (Vol. 20, pp. 1–9). Ottawa, Canada: Statistics Canada.

Malmo, G. (2007). Addressing tobacco dependency in women's substance use treatment. In N. Poole & L. Greaves (Eds.), *Highs & lows: Canadian perspectives on women and substance use* (pp. 323–331). Toronto, Canada: Centre for Addiction and Mental Health.

Manfredi, C., Cho, Y. I., Crittenden, K. S., & Dolecek, T. A. (2007). A path model of smoking cessation in women smokers of low socio-economic status. *Health Education Research*, *22*, 747–756. doi:10.1093/her/cyl155

McFall, M., Saxon, A. J., Malte, C. A., Chow, B., Bailey, S., Baker, D. G., & Lavori, P. W. (2010). Integrating tobacco cessation into mental health care for posttraumatic stress disorder: A randomized controlled trial. *Journal of the American Medical Association*, *304,* 2485–2493.

McKee, S. A., O'Malley, S. S., Salovey, P., Krishnan-Sarin, S., & Mazure, C. M. (2005). Perceived risks and benefits of smoking cessation: Gender-specific predictors of motivation and treatment outcome. *Addictive Behaviors*, *30*, 423–435. doi:10.1016/j.addbeh.2004.05.027

Merkur, S. (2008). Promoting tobacco awareness and smoking cessation for working women. In A. Linos & W. Kirch (Eds.), *Promoting health for working women* (pp. 267–291). New York, NY: Springer.

Miller, W. R., & Rose, G. S. (2009). Toward a theory of motivational interviewing. *American Psychologist*, *64*, 527–537. doi:10.1037/a0016830

Monette, L. E., Rourke, S. B., Gibson, K., Bekele, T. M., Tucker, R., Greene, S., & Bhuiyan, S. (2011). Inequalities in determinants of health among Aboriginal and Caucasian persons living with HIV/AIDS in Ontario: Results from the positive spaces, healthy places study. *Canadian Journal of Public Health*, *102*, 215–219.

Morrissey, J. P., Jackson, E. W., Ellis, A. R., Amaro, H., Brown, V. B., & Najavits, L. M. (2005). Twelve-month outcomes of trauma-informed interventions for women with co-occurring disorders. *Psychiatric Services*, *56*, 1213–1222. doi:10.1176/appi.ps.56.10.1213

O'Hea, E. L., Wood, K. B., & Brantley, P. J. (2003). The transtheoretical model: Gender differences across 3 health behaviors. *American Journal of Health Behavior*, *27*, 645–656. doi:10.5993/AJHB.27.6.7

Passey, M., Gale, J., & Sanson-Fisher, R. (2011). "It's almost expected": Rural Australian Aboriginal women's reflections on smoking initiation and maintenance: A qualitative study. *BMC Women's Health*, *11*(1), 55.

Passey, M., Sheldrake, M., Leitch, K., & Gilmore, V. (2007). Impact of case man-
      agement on rural women's quality of life and substance use. *Rural & Remote
      Health*, 7, 710.

Payne, T. J., Ma, J. Z., Crews, K. M., & Li, M. D. (2013). Depressive symptoms among
      heavy cigarette smokers: The influence of daily rate, gender, and race. *Nicotine
      & Tobacco Research*, 15, 1714–1721. doi:10.1093/ntr/ntt047

Physicians for a Smokefree Canada. (2013). *Smoking among Aboriginal Canadians*.
      Ottawa, Canada: Author.

Piper, M. E., Cook, J. W., Schlam, T. R., Jorenby, D. E., Smith, S. S., Bolt, D. M.,
      & Loh, W.-Y. (2010). Gender, race, and education differences in abstinence
      rates among participants in two randomized smoking cessation trials. *Nicotine
      & Tobacco Research*, 12, 647–657. doi:10.1093/ntr/ntq067

Pisinger, C., & Godtfredsen, N. S. (2007). Is there a health benefit of reduced tobacco
      consumption? A systematic review. *Nicotine & Tobacco Research*, 9, 631–646.
      doi:10.1080/14622200701365327

Poole, N., & Greaves, L. (Eds.). (2012). *Becoming trauma informed*. Toronto,
      Canada: Centre for Addiction and Mental Health.

Poole, N., Greaves, L., & Cormier, R. A. (2003). Happenings: Integrating treatment
      for tobacco and other addictions at the Aurora Centre of the British Columbia
      Women's Hospital and Health Centre. *Canadian Journal of Nursing Research*,
      35, 95–102.

Power, E. M. (2008). Conceptualizing food security for Aboriginal people in Canada.
      Canadian Journal of Public Health, 99(2), 95–97.

Prochaska, J. J. (2010). Integrating tobacco treatment into mental health settings.
      Journal of the American Medical Association, 304, 2534–2535.

Prochaska, J., Delucchi, K., & Hall, S. M. (2004). A meta-analysis of smok-
      ing cessation interventions with individuals in substance abuse treatment
      or recovery. *Journal of Consulting and Clinical Psychology*, 72, 1144–1156.
      doi:10.1037/0022-006x.72.6.1144

Ravva, P., Gastonguay, M. R., French, J. L., Tensfeldt, T. G., & Faessel, H. M. (2010).
      Quantitative assessment of exposure-response relationships for the efficacy
      and tolerability of Varenicline for smoking cessation. *Clinical Pharmacology
      & Therapeutics*, 87, 336–344. doi:10.1038/clpt.2009.282

Ray, L., Courtney, K., Ghahremani, D., Miotto, K., Brody, A., & London, E. (2014).
      Varenicline, low dose naltrexone, and their combination for heavy-drinking
      smokers: Human laboratory findings. *Psychopharmacology*, 231, 3843–3853.
      doi:10.1007/s00213-014-3519-0

Reid, M., Fallon, B., Sonne, S., Nunes, E. V., Lima, J., Jiang, H., . . . Rotrosen, J. (2007).
      Implementation of a smoking cessation treatment study at substance abuse
      rehabilitation programs: Smoking behavior and treatment feasibility across var-
      ied community-based outpatient programs. *Journal of Addiction Medicine*, 1,
      154–160. doi:10.1097/ADM.0b013e31813872e4

Reynoso, J., Susabda, A., & Cepeda-Benito, A. (2005). Gender differences in smoking
      cessation. *Journal of Psychopathology and Behavioral Assessment*, 27, 227–234.
      doi:10.1007/s10862-005-0638-2

Ritchie, D., Amos, A., & Martin, C. (2010). "But it just has that sort of feel about it,
      a leper": Stigma, smoke-free legislation and public health. *Nicotine & Tobacco
      Research*, 12, 622–629. doi:10.1093/ntr/ntq058

Rollnick, S., Miller, W. R., & Butler, C. (2008). *Motivational interviewing in health care: Helping patients change behavior*. New York, NY: Guilford.

Steinberg, M. B., Greenhaus, S., Schmelzer, A. C., Bover, M. T., Foulds, J., Hoover, D. R., & Carson, J. L. (2009). Triple-combination pharmacotherapy for medically ill smokers: A randomized trial. *Annals of Internal Medicine*, *150*, 447–454. doi:10.7326/0003-4819-150-7-200904070-00004

Stewart, D. E. (2007). Social determinants of women's mental health. *Journal of Psychosomatic Research*, *63*, 223–224. doi:10.1016/j.jpsychores.2007.07.002

Stewart, M. J., Greaves, L., Kushner, K. E., Letourneau, N. L., Spitzer, D. L., & Boscoe, M. (2011). Where there is smoke, there is stress: Low-income women identify support needs and preferences for smoking reduction. *Health Care for Women International*, *32*, 359–383. doi:10.1080/07399332.2010.530724

Stewart, M. J., Kushner, K. E., Greaves, L., Letourneau, N., Spitzer, D., & Boscoe, M. (2010). Impacts of a support intervention for low-income women who smoke. *Social Science & Medicine*, *71*, 1901–1909. doi:10.1016/j.socscimed.2010.08.023

Swartz, L., Noell, J., Schroeder, W., & Ary, D. (2006). A randomized control study of a fully automated internet based smoking cessation programme. *Tobacco Control*, *15*(1), 7–12. doi:10.1136/tc.2003.006189

Thompson, L., Pearce, J., & Barnett, J. R. (2007). Moralising geographies: Stigma, smoking islands and responsible subjects. *Area*, *39*, 508–517. doi:10.1111/j.1475-4762.2007.00768.x

Tilleczek, K. C., & Hine, D. W. (2006). The meaning of smoking as health and social risk in adolescence. *Journal of Adolescence*, *29*, 273–287. doi:10.1016/j.adolescence.2005.07.002

Torchalla, I., Okoli, C., Bottorff, J. L., Qu, A., Poole, N., & Greaves, L. (2012). Smoking cessation programs targeted to women: A systematic review. *Women & Health*, *52*(1), 32–54. doi:10.1080/03630242.2011.637611

Urquhart, C., & Jasiura, F. (2012). Collaborative change conversations: Integrating trauma-informed care and motivational interviewing with women. In N. Poole & L. Greaves (Eds.), *Becoming trauma informed* (pp. 59–70). Toronto, Canada: Centre for Addiction and Mental Health.

Urquhart, C., Jasiura, F., Poole, N., Nathoo, T., & Greaves, L. (2012). *Liberation! Helping women quit smoking: A brief tobacco intervention guide*. Vancouver, Canada: British Columbia Centre of Excellence for Women's Health.

Ussher, M., West, R., & Hibbs, N. (2004). A survey of pregnant smokers' interest in different types of smoking cessation support. *Patient Education and Counseling*, *54*(1), 67–72. doi:10.1016/s0738-3991(03)00197-6

Westmaas, J. L., Bontemps-Jones, J., & Bauer, J. E. (2010). Social support in smoking cessation: Reconciling theory and evidence. *Nicotine & Tobacco Research*, *12*, 695–707. doi:10.1093/ntr/ntq077

Wood, L., France, K., Hunt, K., Eades, S., & Slack-Smith, L. (2008). Indigenous women and smoking during pregnancy: Knowledge, cultural contexts and barriers to cessation. *Social Science & Medicine*, *66*(11), 2378–2389.

World Health Organization. (2008). Policy on non-recruitment of smokers. Retrieved from http://www.who.int/employment/who_we_need/en/.

World Health Organization. (2013). *MPOWER in action: Defeating the global tobacco epidemic*. Geneva, Switzerland: Author.