Caught in the tapestry of tobacco: Why I smoke

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Faced with the knowledge that smoking is dangerous, women continue to smoke cigarettes, and the number is growing. In contrast, breast cancer is being diagnosed earlier, and women are listening to the call for mammograms and examination screenings. Why then, are women not listening to the call to never start or stop smoking? In nursing today it has become necessary to put forth a greater effort to call attention to the toll of lung cancer and other smoking related diseases. There is significant disparity in smoking groups targeted for research. One particular group has been ignored in past research, the middle-aged woman. Research is needed to understand why women use tobacco products in this group and to find what is needed to discourage smoking. In this article, we explore nursing research in the area of middle-aged women and tobacco use. Interlaced throughout the literature review is the story of a 57 year old female and her experiences with smoking.

Keywords: tobacco use; smoking; middle-aged women; research; nursing practice

The effects of tobacco are well documented, but despite a wealth of evidence, women globally continue to smoke at alarming rates. Tobacco use among women is a growing problem throughout the world. Women comprise 20% of the world’s more than one billion smokers and in developing countries there is a 3.4% annual rise in use of tobacco products by women (World Health Organization [WHO], 2010). It has been reported that women who smoke are more resistant to treatment compared to men and have greater difficulty with cessation (McKee, Maciejewski, Falba, & Mazure, 2003).

In 2007 in the US, 19.8 million women smoked and in Australia one in six adults smoked (Australian Institute of Health and Wellness [AIWH], 2010; Centers for Disease Control and Prevention [CDC], 2007). Of growing concern is the use of other forms of tobacco such as smokeless tobacco and shisha. In Lebanon and Jordan, 30 and 20% respectively of girls and women use tobacco in a form other than cigarettes (WHO, 2010). Due to the narrowing in the gap of smoking between women and men, women today are now sharing a much larger burden of smoking related diseases. Reports suggest that women have more difficulty quitting and experience higher relapse rates than men who smoke (Sheahan, 2002; WHO, 2010). McKee et al. (2003), noted that women who experience a significant stressful event, such as a negative financial event or change in residence are more likely to relapse or fail to quit than men.

As nurses it has become paramount that we assist with discouraging and deglamorizing tobacco use. Reductions in deaths from breast cancer are a direct result of increased attention to this disease process. The significant decrease in death from breast cancer can be attributed directly to the increased awareness of breast cancer prevention (CDC, 2007). This same attention must be given to lung cancer. In nursing today it has become necessary to put forth a greater effort to call attention to the toll of lung cancer and other smoking-related diseases in middle-aged women. There is a need for nursing research that focuses on this population of women and the meaning smoking has for them.

The lacing of a female’s story, age 57, and literature review:

The allure of the cigarette is provocative; why does something so dangerous seem so comforting? Those who do not smoke may not understand the attraction of cigarette use. On a fall day, outside a coffee shop, sitting at a small iron table underneath a blue umbrella in a big city near the park, I do the unthinkable. A colorful package of cigarettes rests on the table. After tapping the pack on the table to wake them and provoke flavor, I slide one easily from the pack. My cigarette lighter is pink that hides within my purse, but I prefer the matches from the classy restaurant down on Summer Street. The little box of matches is beautiful, black with gold writing, and inside are golden tipped wooden...
will become a predominantly female disease (WHO, 2010).

A major health concern is that tobacco dependent women are experiencing difficulty with cessation (Andrews & Heath, 2003). In 2000, 70% of smokers reported the desire to quit and 41% were successful at quitting for at least 1 day. According to the CDC (2001), more than 75% of women who smoke want to quit and report having tried to quit during the previous year. The WHO (2001) stated that while male rates of smoking have peaked, female rates are still rising. It was further predicted by the WHO (2010) ‘that while 9.3% of the female population currently smokes, this percent will rise to 20% by 2025’ (p. 25).

SMOKING AND WOMEN
There is significant disparity in smoking groups targeted for research. Historically, tobacco use has not been an issue for women. The numbers of quality research projects addressing the needs of women are severely lacking. Most tobacco research focuses on (a) teenagers, (b) pregnant women, (c) the success or failure of smoking cessation interventions, and (d) who is best at delivering or administering smoking cessation interventions (Andrews & Heath, 2003). Research in the area of smoking has to a large extent overlooked middle-aged women. Giarelli (2006) in a review of studies to examine the effectiveness of nursing delivered smoking cessation interventions discovered a severe deficiency regarding this group with only two studies targeting women alone.

There have been numerous hazards identified that precede smoking relapse or impede smoking cessation in women. Historically one misconception was that early publicity concerning the health effects of smoking appeared in magazines more likely to be read by men than women (Malone, 2006). It took several decades before smoking cessation messages reached other groups. Another misconception was that women did not develop the chronic diseases or health issues associated with tobacco use. Men began smoking first and smoked longer than women. Because health consequences typically follow the change in smoking prevalence by 20–30 years, the predictable rise in smoking related illnesses occur based on changes in smoking habits.
This lack of understanding of tobacco use led to the misconception that women did not develop these health consequences (Andrews & Heath, 2003).

Perceptions of smoking have changed significantly. Smoking is no longer socially acceptable and a stigmatization is seen toward a woman who smokes (Andrews & Heath, 2003). According to McKee et al. (2003) life event stress is a positive predictor of relapse and continued smoking in women. There are few research reports available on what prompts a desire to change smoking behavior. Cessation is a complex behavioral change and men and women have different cessation experiences.

The allure of the cigarette is something inside me. In the stillness of the evening or on a springtime afternoon, I can slip away and smoke alone. I do not want others to know; it is a little secret that I share with the crisp cigarette and the matches. Dying does not frighten me for my work is done. I have raised my children and have done a good job, and after all, can one occasional cigarette harm me? This is for me, and no one else can know; it is a few minutes of pleasure alone bringing calmness as the smoke curls from the tip. It is my dirty little secret. I am, after all, harming no one but myself … if that at all.

THE EFFECTS OF TOBACCO ADVERTISING ON SMOKING

In 2005, cigarette companies spent $13 billion in cigarette advertising and promotional expenses (CDC, 2007). According to the WHO (2010) increased marketing by tobacco companies has stalled smoking cessation by women. Tobacco companies historically have been effective in linking smoking with the themes of liberation, emancipation, sophistication and independence (Andrews & Heath, 2003; WHO, 2010).

Prior to 1920 women who smoked were shunned and ridiculed, but in the 1930’s, and particularly with the outbreak of World War II (WWII), more women smoked as they entered the workforce and could afford to smoke. Smoking became more fashionable and the accepted norm for both men and women (Gardner & Brandt, 2006). In the 1930’s the tobacco industry began cigarette advertising that heavily targeted women.

According to Gardner and Brandt (2006) promotion by the tobacco industry is the single most important initiator of cigarette smoking in women. Advertisers initially used women in cigarette commercials to make smoking appealing to men. Overtime smoking began to represent glamour, attractiveness, sex appeal, and social distinction. Smoking as a desirable female behavior began with the advent of WWII (Gardner & Brandt, 2006).

The tobacco industry has the benefit of nine decades of experience in enticing women in developed countries to smoke and numerous tobacco producers have developed a cigarette brand that specifically targets women (CDC, 2007; WHO, 2010). Marketing ads and promotions are dominated by themes of social desirability and independence (WHO, 2010). Tobacco companies developed media campaigns that sponsored women’s fashions and other artistic, athletic, and political events. Tobacco companies attempt to align themselves with women’s causes by manipulative marketing tactics and providing funds for women’s sports, women’s professional organizations, films and television, and women’s magazines (WHO, 2010).

Globally the consumption of tobacco among women is increasing steadily (Andrews & Heath, 2003; WHO, 2010). Tobacco companies are becoming successful in targeting women in underdeveloped countries to smoke, as a result of decades of experience in enticing women in developed countries to smoke (Andrews & Heath, 2003; Sarna et al., 2008; Sheahan, 2002). Without effective research, legislation, tobacco control and gender specific interventions the smoking prevalence among women of all socioeconomic status, race and ethnicity will triple over the next generation (Andrews & Heath, 2003).

Attempts to control and eliminate tobacco use have been met with fierce resistance from the tobacco industry. Tactics used by the industry to resist government regulation of tobacco products include public relation campaigns, and creating controversy about established facts. Cigarette producers have ignored the harm caused by cigarettes and have engaged for decades in efforts to silence critics, distort science, influence public opinion and control policy (Yussuf & Dagli, 2000; WHO, 2010). According to Andrews and Heath (2003), this resistance is further demonstrated ‘by the lack of voice and recognition
of lung cancer in women as compared to breast cancer, which has a well-developed and effective advocacy community’ (p. 223).

**Gender Issues in Smoking Behavior**

Across the lifespan, the smoking habits of females and males differ in characteristics and dependence. According to Piper et al. (2004), a boy who starts smoking during adolescence will smoke an average of 16 years and a girl who begins smoking during adolescence will smoke for approximately 20 years. Piper et al. (2004) further identified that an individual who smokes regularly will have greater difficulty with cessation.

In a study describing the characteristics of older female smokers Donze, Ruffieux, and Cornuz (2007), found that this group of women differed from those of the general population. The explanation given was that while smoking is partly a social behavior for this group, the main reason given for smoking was relaxation. Sheahan (2002) noted that women were more sensitive to the pleasurable effects of cigarette smoking as a stimulus than men.

Current populations that are heavily targeted for smoking cessation programs and tobacco control are pregnant women and adolescents (Andrews & Heath, 2003; WHO, 2010). Women as a group have been overlooked in tobacco control and cessation programs. Since the recognition of the hazards of smoking in the mid-twentieth century, smoking has been investigated in men but there is a dearth of information on middle-aged women (Sarna & Bialous, 2006). Numerous studies suggested that habits and attitudes toward smoking differ in males and females (Andrews & Heath, 2003; Giarelli, 2006; Westmaas, Wild, & Ferrence, 2002). Many middle-aged women are able to maintain smoking cessation for years and then relapse. The meaning of being able to smoke needs to be explored in this group. Most cessation programs are identified as being gender neutral, but the majority is in fact geared toward men (Giarelli, 2006). From an extensive review of literature it appears that middle-aged women have been ignored and their unique life circumstances forgotten.

It has been suggested that women will initially stop smoking for the benefit of someone else. However, this reason does not maintain cessation for a lifetime (Westmaas et al., 2002). Although it has been demonstrated that stopping smoking for the benefit of someone else does not work; most advertisements, commercials and cessation programs revolve around this theme. In fact Westmaas et al. (2002) found that encouraging women to stop smoking for the benefit of someone else was detrimental. Westmaas et al. (2002), further noted that women react negatively to such influence attempts because of the implications that by smoking they are somehow deficient in fulfilling the stereotyped female role of being concerned about others and children.

Because tobacco smoking began as a man’s issue: tobacco research, cessation programs, and tobacco control policy contain numerous inherent and invisible biases. There is a need to look for what has been overlooked: for what has not been noticed in these women’s lives. The issues surrounding smoking are not the same for women as they are for men. There are gender differences in tobacco use and nicotine addiction. As the rate of smoking and tobacco use among women increases globally, women’s perceptions and perspectives should be recognized and valued as truth for them. Women may not be aware that there are alternatives or other options and that there is something wrong with the way things are.

**Tobacco Research in Nursing**

Smoking in middle-aged women has received little attention in nursing. Nurses have been less visible than other healthcare providers in research that addresses nicotine use, specifically cigarette use. According to Sarna and Bialous (2006) ‘relatively few articles on tobacco cessation are published in nursing journals and there are few nurse authors focused on these topics’ (p. 3). This invisibility of nursing research is confusing considering the involvement of nurses in other areas of health promotion (Sarna & Bialous, 2006).

Malone (2006) performed a review of coverage of tobacco control in the American Journal of Nursing (AJN). In the early 1900’s, infrequent mentions of tobacco were made in nursing journals. Between 1914 and 1942, although there were indications that tobacco use was harmful, few articles were evident because there was not a firmly established link between tobacco and
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In the 1930’s and 1940’s the focus was more on the unfavorable image of smoking. According to Malone (2006) ‘an outcry arose in 1932 when R.J. Reynolds Tobacco Company featured a nurse in uniform in an advertisement for Camel cigarettes’ (p. 35). The concern was that this image poorly represented the profession, and the American Nurses Association issued a strong complaint to the tobacco industry (Malone, 2006). The fact that the tobacco industry used nurses in their cigarette advertisement was significant because the advertisement forever linked tobacco symbolically with healthcare.

Between 1942 and 1945 not a single article on tobacco use appeared in AJN. This was a time when cigarettes were part of WW II, and the demand for cigarettes grew at an unprecedented rate (Malone, 2006). Regular cigarette advertisements were carried by AJN and other nursing journals. According to Malone (2006) medical journals and nursing journals were used to promote tobacco use and contributed to the increasing social acceptability of cigarettes. Cigarette advertising in AJN stopped in 1954 but there continued to be a lack of articles that addressed tobacco use.

In the 1960’s articles in AJN pertaining to tobacco use continued to be limited, with just one or two articles appearing every 2 years. This absence is significant since the evidence of the harmful effects of tobacco use were accumulating rapidly. This lack was even more evident in 1964 when the US Surgeon General’s report was published and identified the link between lung cancer and cigarette smoking (CDC, 2001). The coverage of tobacco from mid 1990 until recently has been more comprehensive.

Wells, Sarna, and Bialous (2006) developed a reference list of numbers and types of data-based articles that focused on nursing involvement in tobacco cessation published between 1996 and 2005. The number of papers that focused on nursing involvement in tobacco cessation increased eight-fold from 1996 to 2005, with less than five articles in 1996 to more than forty in 2005.

Wells et al. (2006) identified ‘one hundred and seventy five data-based papers that met the criteria, that is, the paper focused on smoking cessation and involved nurses’ (p. 16). While the list developed was thorough it is evident that middle-aged women are a drastically underserved population. Most of the studies identified focused on the nurse as a provider of cessation interventions, or on pregnancy and postpartum tobacco use. The studies that focused on women were the women’s initiative for non-smoking; from this initiative two focused on women with cardiovascular disease, one on the use of nicotine replacement therapy and the last on a smoking cessation intervention. Other studies included both men and women and across all age groups.

Tobacco control efforts have been directed toward increasing cessation efforts of active smokers. Despite the efficacy of nurses in providing tobacco cessation interventions, nursing research in this area has been minimal (Sarna & Bialous, 2006). There is little evidence that nursing organizations have collectively played a major role in addressing tobacco control (Malone, 2006). Malone (2006) noted, ‘although some individual nurses have carried the anti-tobacco banner … there is little evidence that nursing as a profession has sought seriously to address tobacco use and control in a sustained systematic way’ (p. 53).

According to the WHO (2001) smoking rates among nurses and other health professionals remain high. Like other women, nurses have been heavily targeted by the tobacco industry. Marketing of tobacco products is incredibly successful when added to the addictiveness of tobacco. Advertising by the tobacco industry has suggested to women that smoking is a badge of bravery under pressure, and portrays smoking as representing new freedom and equality for women.

Sarna et al. (2008) described the changes in smoking and trends in participants in the Nurses’ Health study cohorts over 27 years. The Smoking Trends in the Nurses’ Health study is the largest and longest running study of health among women in the world. Sarna et al. (2008) identified that ‘smoking trends among nurses are important to monitor as smoking negatively affects their health and decreases their likelihood of providing cessation interventions to patients’ (p. 374).

Nurses, who smoke, similar to the general population, have struggled with quitting. In the 70’s registered nurses (RN’s) smoked at a higher rate than that of most women in the United States.
Active smokers in 1976 were 33.2% 13.5% in 1989 and 8.4% in 2002/2003 (Sarna et al., 2008). This decline in smoking trends among nurses reflects that of the smoking rate among women in developed countries over the last 23 years.

In 2006, the prevalence of smoking in the Americas and Europe was 17 and 22% respectively and in Sweden the rate of women smoking was much higher than that of men (WHO, 2010). Since the mid-twentieth century smoking has been recognized as a critical healthcare issue. Smoking is now recognized not just as a bad habit or, a lifestyle choice but as tobacco dependence (Sarna & Bialous, 2006). Doolan and Froelicher (2006) stated that ‘certain special populations have unique needs and consideration in regard to smoking cessation, among these are women and older adults’ (p. 29). Few programs have assessed the motivations, preferences, and barriers underlying women smokers’ quit attempts.

There is a distinct need to shift the focus away from the habits and practices of men to one that recognizes women's unique experiences and to strive to achieve a more equitable approach to smoking cessation. This shift in focus away from men will lead to increased awareness and understanding of how cigarette use presents itself in women, resulting in a more aggressive and assertive approach to care (Arslanian-Engoren, 2002). By generating new knowledge derived by studying women, attention will be focused on the detrimental effects that stereotypes and biases in healthcare support. Without challenges to dominant ways of knowing, women's healthcare needs will remain socially and medically marginalized (Arslanian-Engoren, 2002).

Last week, I went to the dentist; I was feeling good that day. As I sat in the chair, a handsome young man came into the room; he was all of 25 years old. I have a son that age. As a professional woman, I am near the top of my career ladder. Well educated and successful, labeled by society as a middle-aged woman, and sometimes as useless in today’s world. No longer able to produce children, to compete with women on television who are scantily clad and described as alluring, I wonder what my meaning is now. He was talking while I was thinking … about implants and crowns. And then he said the magic words: ‘If you were my mother, I would …’ I failed to hear the rest of his sentence. Taken aback by being put in a category, not as a successful person, but as a mother figure, a paying mother figure; I was crushed. As he left, I picked up my purse and walked out the door politely telling the receptionist I would return but knowing I would not. It was that afternoon; I stopped at the park and retrieved my pink lighter and a hidden extra long, extra light cigarette that was hidden in the zipper compartment of my purse. What just happened, I asked aloud, and why do I feel so bad?

**Summary**

Examining the vast literature about smoking and tobacco use leads to the conclusion that there is a gap in knowledge concerning these issues in middle-aged women. Oppressive healthcare practices relating to women have always been present and continue to evolve (Wittmann-Price, 2004). Most smoking cessation programs have evolved from a patriarchal system. Developing policy as well as cessation interventions and programs without the input of middle-aged women is a major barrier to providing care for this population.

Only recently has there been a shift away from using men as the exemplar for disease management and clinical decision making toward considering the healthcare issues of women. Increasing the awareness of issues within smoking that cause discrepancies and inequities in women’s healthcare will generate interventions that will decrease morbidity and mortality from smoking-related diseases. Healthcare providers must be attuned to the cues of middle-aged women to discern the subtle nuances, discrepancies, and inequities associated with tobacco use.

It must be a priority within nursing research to examine and uncover what sustains and maintains smoking in middle-aged women. There is a need to understand why women in this group use tobacco products and to find what is needed to discourage smoking. As the rate of smoking and tobacco use among women increases globally, women's perceptions and perspectives should be recognized and valued as truth for them. Women may not be aware that there are alternatives or other options and that there is something wrong with the way
things are. Research is essential in revealing false assumptions and bringing into new awareness what it is like to be a middle-aged woman who smokes and has difficulty with cessation.

And every time I light up, I know it is bad for me. And I throw away the pack and my matches. But then, something happens, either good or bad, and I reward or comfort myself with a few minutes alone with my friend – the slim white wrapper and tobacco. I do not know why it is important to me. I can tell it things I cannot tell my husband who is my best friend and it offers me unconditional comfort. You would never dream I do it; I would never tell you. Help me to understand if you will. Tell me why I smoke.

References


