A Qualitative Study of the Barriers to and Facilitators of Smoking Cessation Among Lesbian, Gay, Bisexual, and Transgender Smokers Who Are Interested in Quitting

Alicia K. Matthews, PhD,¹ John Cesario,² Raymond Ruiz,¹ Natalie Ross,³ and Andrea King, PhD⁴

Abstract

Purpose: Lesbian, gay, bisexual, and transgender (LGBT) individuals are significantly more likely to smoke compared with their heterosexual and cisgender counterparts. The purpose of this study was to explore barriers to and facilitators of smoking cessation readiness among LGBT smokers.

Methods: This descriptive study used a qualitative approach. Four 90-minute focus groups (eligibility criteria: age ≥ 21 , self-identify as LGBT, current smoker, interest in quitting smoking) were conducted. Participants also completed a brief survey that measured additional demographic characteristics and smoking behaviors. Topics explored included quit experiences, attitudes and beliefs, barriers to and facilitators of cessation, and cultural factors related to smoking behaviors. Established qualitative methods were used to conduct the focus groups and data analysis.

Results: The mean age of participants ($N=31$) was 37.1 years with the majority identifying as male (58.1%). The sample group was racially diverse: 32% were African American, 39% were White, and 29% were more than one race. Interest in quitting was high ($M=9.0$, range 0–10). Barriers to smoking cessation fell under the broad themes of individual-level factors, cultural factors, psychosocial factors, and access to treatment. Facilitators of smoking cessation included stage of readiness, health concerns, social stigma, a shift in social norms, financial costs, and improving dating prospects.

Conclusions: Interest in smoking cessation was high in this sample of LGBT smokers and influenced by a range of facilitators. Nevertheless, several general and culturally specific barriers to smoking cessation readiness were identified. The study results have implications for future research and the development of outreach, prevention, and treatment programs.

Keywords: barriers and facilitators to smoking cessation, cultural factors, lesbian, gay, bisexual, and transgender (LGBT), smoking.

Introduction

SMOKING RATES HAVE DECLINED dramatically over the past four decades with current smoking rates at $\sim 18.1\%$ among U.S. adults.¹ Despite a reduction of smoking prevalence rates in the general population, lesbian, gay, bisexual, and transgender (LGBT) individuals continues to smoke at elevated rates.^{2–4} A range of factors contributes to smoking disparities in the LGB communities, including targeting by the tobacco industry, lower access to smoking cessation services, and higher stress levels.^{5–8} The limited availability of culturally appropriate treatments is another contributing factor.⁹ A

systematic review of available tobacco treatment approaches for LGBT individuals highlighted the limited amount of information available regarding outcomes of LGBT smokers in treatment and emphasized the need for additional research to inform best practices in tobacco prevention and control in this population.¹⁰

Development of effective tobacco prevention and control efforts for at-risk populations is predicated on an understanding of the barriers to and facilitators of smoking cessation and the unique contextual factors that may also affect the initiation and maintenance of smoking behaviors.¹¹ Among treatment-seeking adult smokers, research

¹Department of Health Systems Science, College of Nursing, University of Illinois at Chicago, Chicago, Illinois.

²Department of Oncology, University of Illinois Hospital and Health Systems Sciences, Chicago, Illinois.

³Department of Research, Howard Brown Health Center, Chicago, Illinois.

⁴Department of Psychiatry and Behavioral Neuroscience, University of Chicago, Chicago, Illinois.

has shown that smoking cessation outcomes are strongly influenced by cognitive factors such as self-efficacy and stage of readiness for smoking cessation.¹² Psychosocial factors such as mood disturbance and stressful life circumstances have also been shown to be predictive of smoking cessation outcomes.¹³ LGB smokers are exposed to elevated levels of both general and minority-specific stress.⁸ Community norms and culturally specific factors (e.g., the salience of an LGB social identity) are also likely to play a role in smoking and other health risk behaviors.¹⁴ However, few studies have been conducted to examine the salience of general and LGBT-specific risk factors on the smoking behaviors of LGBT adults.

Specific aims

The purpose of this study was to explore general and LGBT-specific barriers to and facilitators of smoking cessation among LGBT smokers with the aim of informing future antitobacco campaigns and smoking cessation treatments.

Methods

Sample

Data were collected as part of a larger project aimed at developing and testing a culturally targeted smoking cessation intervention for LGBT adult smokers.¹⁵ Data for the current focus group analyses were collected during the intervention development phase of the study. Focus group recruitment and data collection took place between March and November of 2011. Eligibility included (1) aged 21 and older, (2) self-identify as LGBT, (3) current smoker, and (4) interest in quitting smoking (“How interested in quitting smoking are you?” responses ranged from 1 to 10; individuals scoring 5 or more on a 10-point scale were eligible). Of the 61 individuals screened for participation, 58 were eligible and 31 agreed to participate in the study (50.8%). Ineligibility ($N=3$) was associated with identifying as something other than LGBT. Focus group participants had not participated in any other phase of the study.

Recruitment and enrollment

Participants were recruited through a variety of outreach methods. The majority of participants reported hearing about the study from posted flyers or from provider referrals from a large LGBT-serving healthcare center in Chicago (41.6%), followed by word of mouth from other focus group participants (26.7%), internet postings (15.0%), and a variety of other methods that included posted flyers in community settings and newspaper ads (16.7%). Interested participants contacted the study coordinator by phone. Eligible and interested individuals were scheduled for a focus group. Focus groups were held at a large LGBT health center. The study was approved by the Institutional Review Board of the University of Illinois at Chicago.

Data collection procedures

The focus group sessions were held at a community-based organization serving the needs of LGBT communities. Recruitment for focus groups happened on a continuous basis. To minimize no-show rates, recruitment continued until 10 participants met general eligibility requirements.

Given that the smoking cessation groups for the larger randomized clinical trial would be aimed at LGBT smokers in general, no special efforts were made to conduct homogeneous focus groups based on demographic factors such as race/ethnicity, gender identity, or sexual orientation. Focus groups ($N=4$) were conducted with an average of 8 participants each (range 5–11). As participants arrived for each scheduled focus group session, written informed consent was obtained by research staff members and participants completed a brief (5–10 minutes) self-administered paper-and-pencil survey measuring demographics and smoking behaviors. Standard demographic questions, including age, race/ethnicity, education, and relationship status (partner/spouse), were asked. Sexual orientation was measured by a single item, “Are your sexual partners typically members of the same sex, opposite sex, or both?” Individuals reporting a transgender identity and a heterosexual orientation were eligible for inclusion. Gender identity was measured by a single question (“Do you consider yourself to be Male, Female, Transgender—FTM, Transgender—MTF, or other?”). A brief smoking behavior survey was developed for use in this study to examine smoking behaviors, including the use of other tobacco products (cigars, smokeless [dip, snuff, chew, etc.], and pipe tobacco), numbers of smokers in their social networks, prior history of quit attempts and quit attempt methods, and stage of readiness for smoking cessation.

After completion of the self-administered portion of data collection, participants were guided through the focus group process, which was conducted according to established focus group methodology.^{16,17} These methods include using trained moderators (A.K.M.) to guide the structured discussion, the presence of a trained notetaker, established techniques for establishing rapport and group interactions, audio recording of interviews and immediate postsession facilitator debriefing to highlight important findings, and careful review of transcribed audiotapes. The development of the moderator’s guide was guided by the extant literature and covered general and culturally specific triggers for smoking, smoking contexts, community norms, quit experiences, barriers to and facilitators of smoking cessation, and the relationship between minority stress and smoking. A single trained moderator conducted each focus group and was assisted by a notetaker. Focus groups were audio-recorded and transcribed professionally. Saturation (i.e., the point at which no additional themes are generated in subsequent rounds of data collection)¹⁶ was reached in themes and participant opinion with our sample of 31 participants. Focus group participants received a \$25 gift card.

Data analysis

Frequencies, means, and standard deviations were used to summarize the survey data using SPSS, version 19 (IBM Corporation, Armonk, NY). Qualitative data were coded and managed using a computer software package.¹⁸ Two raters reviewed the transcripts for key themes across groups. While keeping the original evaluation questions in mind, statements were categorized into themes. Coding categories were then used to summarize key ideas in the combined focus groups, as described by Stewart and Shamdasani.¹⁷

Results

Participant characteristics

Tables 1 and 2 display participant demographic and smoking characteristics. The mean age of participants was 37.1 years. The majority of smokers were daily smokers (90%) and reported preferring a mentholated brand of cigarette (64.5%). Almost half (48.4%) of participants reported living in a household with at least one other smoker. Rates of a past-year quit attempt were high (80.6%). A planned next 6-month quit attempt was reported by 38% of smokers. Cold turkey was a common quitting strategy (45%) with only 51.6% reporting any prior use of nicotine replacement therapies.

Summary of qualitative results

Key qualitative findings are described in the next section and organized based on broad categories of barriers and facilitators (see Table 3 for a summary). As appropriate, illustrative quotes were obtained from participants across each of the four focus groups.

Individual-level barriers to cessation

Self-efficacy for quitting.

“Everyone says it’s the power of your mind, which I believe because I quit hardcore drugs. I believe in the power of the mind, but why can’t I quit smoking? That’s the one thing I can’t quit.”

TABLE 1. DEMOGRAPHIC CHARACTERISTICS OF FOCUS GROUP PARTICIPANTS (*N* = 31)

	n (%)
Age, mean (SD)	37.1 (11.9)
Gender	
Female	7 (22.5)
Male	18 (58.1)
Transgender—MTF	3 (9.7)
Transgender—FTM	3 (9.7)
Primary sexual attraction	
Opposite sex	4 (12.9)
Same sex	23 (74.2)
Both sexes	4 (12.9)
Race	
White	12 (38.7)
Black/African American	10 (32.3)
More than one race	9 (29.1)
Ethnicity	
Non-Hispanic/Latino	23 (74.2)
Hispanic/Latino	8 (25.8)
Education	
Less than high school	1 (3.2)
High School or GED	8 (25.7)
Some college	12 (38.7)
College degree	6 (19.4)
Some grad school	2 (6.5)
Graduate degree	2 (6.5)
Partner/spouse	
No	14 (45.2)
Yes	12 (38.7)
Missing	5 (16.1)

FTM, female to male; GED, General Educational Development; MTF, male to female; SD, standard deviation.

TABLE 2. SMOKING CHARACTERISTICS OF FOCUS GROUP PARTICIPANTS (*N* = 31)

Smoking variables	n (%)
Average number of days smoking	
Daily	28 (90.3)
5–6 days per week	3 (9.7)
Use other tobacco products	
Cigar	14 (45.2)
Smokeless tobacco	3 (10.0)
Pipe tobacco	2 (6.7)
Smoke mentholated brand	
Yes	20 (64.5)
Number of smokers in household	
1 adult (the participant is the only smoker)	15 (48.4)
2 adults	10 (32.3)
3 or more adults	5 (16.1)
Missing	1 (3.2)
Partner/spouse smokes (<i>n</i> = 26)	
Yes	8 (30.7)
Friends smoke	
Most or all	7 (22.6)
Many	9 (29.0)
Some	10 (32.3)
Few or none	5 (16.1)
Coworkers smoke	
Most or all	4 (12.9)
Many	4 (12.9)
Some	4 (12.9)
Few or none	9 (29.0)
Not applicable	10 (32.2)
Made a quit attempt in past 12 months	
Yes	25 (80.6)
Stage of readiness to quit	
Often think about quitting, but no plans	5 (16.1)
Plan to quit in next 30 days	3 (9.7)
Plan to quit in next 6 months	12 (38.7)
Cutting back. Ready to set quit date	9 (29.0)
Quit smoking	2 (6.5)
Quit attempts (lifetime)	
0	5 (16.1)
1–4 attempts	17 (54.8)
5–10 attempts	6 (19.4)
11 or more	2 (6.5)
Missing	1 (3.2)
Longest period of abstinence	
0 to 23 hours	4 (12.9)
24 hours to 1 week	7 (22.6)
More than 1 week to 1 month	5 (16.1)
More than 1 month to 6 months	7 (22.6)
More than 6 months	3 (9.6)
Not applicable	5 (16.1)
Reported smoking cessation methods ^a	
Nicotine replacement therapies (NRT)	16 (51.6)
Zyban/Wellbutrin	4 (12.9)
Group/individual counseling	5 (16.1)
Hypnosis	4 (12.9)
Cold Turkey	14 (45.1)

^aCategories are not mutually exclusive.

TABLE 3. SUMMARY OF QUALITATIVE FINDINGS

<i>Main theme</i>	<i>Qualitative findings</i>	<i>Quotation</i>
Individual-level barriers to cessation	Self-efficacy for quitting was low	"I believe in the power of the mind, but why can't I quit smoking?"
	Desire for social acceptance contributed to smoking	"I want to be accepted because I know this crowd and everyone smokes..."
	Testosterone may increase health risk behaviors	"One of the side effects of being on testosterone is smoking and drinking and being more reckless..."
Cultural barriers to cessation	Permissive community norms were viewed as barriers to quit attempts	"My gay friends don't really care [if I smoke]."
Psychosocial barriers to cessation	Bar culture is believed to contribute to higher LGBT smoking rates	"...part of it may be a sort of a byproduct of the bar scene."
	Rebellion was one response to antismoking attitudes	"...I just stick it in their face."
	Smoking was used to cope with stress	"It calms me down if I had a really stressful day."
	Minority stress related to coming out was linked to smoking	"I was in an antigay household."
	Minority stress related to gender presentation was linked to smoking	"I'm hyperaware of my gender expressions."
Limited access to treatment	Minority stress due to intersecting minority status was linked to smoking	"...I...was experiencing all the discrimination from all of those layers."
	The costs associated with smoking cessation treatments were barriers	"...[treatment]...it is financially inaccessible."
	Lack of provider assistance in accessing services was viewed as a barrier	"Only if you ask them [health care providers], then they give you information about quitting smoking."
Facilitators of smoking cessation readiness	Stage of readiness to quit was high among many of the smokers	"I've said this before but I really want to be done with these things (cigarettes). I want to be done and to never go back."
	Issues associated with health and physical appearance increased interest in quitting	"I know it (smoking) is aging me."
	Social stigma associated with smoking was common	"I say a lot of society today is so antismoking."
	Shifts in social norms made smoking less socially acceptable	"I think it's just society in general has decided that smoking is bad."
	Financial cost of cigarettes was identified as a motivator for quitting	"Just give it up, save money, and do something else with it besides spend it on tobacco."
	Increased dating prospects were viewed as a reason for quitting	"If I'm dating someone...I will not do it for the sake that I don't want them to know I smoke."

LGBT, lesbian, gay, bisexual, and transgender.

Self-efficacy is the perceived capability of the individual to make a health behavior change and is associated with quitting success rates.¹² In this sample, low self-efficacy and anxiety about setting a quit date were influenced by a history of past failed quit attempts and high observed relapse rates among friends and family members. Nearly half (45%) of the participants reported going cold turkey as a means of quitting in prior attempts. Success rates for unaided quit attempts are low compared with those quit attempts supported by nicotine replacement therapies,¹⁹ thus creating a cycle of increasing pessimism and low-self efficacy for quitting, which was expressed by focus group participants.

Desire for social acceptance.

"I want to be accepted because I know this crowd and everyone smokes cigarettes It's cool now, I'm accepted as a member of the crowd."

"Let's go out and smoke a couple cigarettes, now let's go back in."

"You have buddies and everything telling you, 'Come on, smoke one. One cigarette won't hurt you. So, I would.'"

A desire to feel a part of a social group, especially during their early years of engaging with the LGBT community, was noted as a reason to begin smoking and serves as an ongoing barrier to smoking cessation. A common theme among younger smokers (participants in their 20s and 30s) was that they wanted to feel a part of a larger group and their place in the group felt threatened if they were not part of the group that went outside the bar for a cigarette. To avoid this discomfort, they would join the smoking group. Sometimes, they would "bum" a cigarette, but it was often members of the social group that "pressured" them to smoke. For younger participants, this pattern of smoking outside bars with friends was cited as their initiation to regular smoking and the source of the fear that they will become socially isolated if they quit.

Hormone use.

"I feel like within the past year or so my smoking has increased significantly. I think it is because I started on testosterone. One of the side effects of being on testosterone is smoking and drinking and being more reckless with your body."

Recent data suggest that smoking rates are significantly elevated among transgender individuals.^{20,21} Levels of stress due to stigma and discrimination are hypothesized as contributing factors.²² However, one member of our focus group discussed the role of hormone use (testosterone) on his risk-taking behaviors after transitioning from female to male. Although nearly 20% of the sample identified as transgender, only a single individual reported endogenous testosterone use.

Cultural barriers to cessation

Permissive community norms.

"I'm in a 21–31 age demographic and I would have to say that out of that community everybody I know is probably like 80% of them smoke."

"Yeah, it's a bit more accepting—it's not that it's completely—acceptable, it's that it's more acceptable [than in the straight community]."

"My gay friends don't really care [if I smoke]. It's not big for them."

"While it's nice as a smoker to have a no judgement space, it is slightly problematic when you do want to quit because that is not the most supportive environment to try to quit smoking."

Younger focus group participants described high rates of smoking among peers in their age group and commented on the strong presence of smoking among LGBT youth and young adults. Overall, focus group participants felt that the norms around smoking in the LGBT community were more permissive and nonjudgmental compared with the general population. Some participants linked the permissive attitudes as a cultural value—"live and let live"—while others indicate that whether an individual smokes is not a major concern for the LGBT community. While more permissive norms surrounding smoking have benefits for individuals while they are smoking, these same norms served as barriers to efforts to quit smoking due to the lack of pressure to quit and the ubiquity of smoking in their peer and social networks.

Bar culture.

"He made a good point before, part of it may be sort of a byproduct of the bar scene. To have a drink and a smoke."

"Well, I don't know. But it's just seem like going to bars every weekend, socializing at bars every weekend, where you usually step out and have a cigarette."

"I would say like if you walk up to a guy or they'll ask you for a cigarette; it's a conversation piece or something like that to break the ice."

The prominence of the bar culture in the LGBT community was discussed extensively as a factor contributing to higher rates of smoking. Members reported that they were more likely to smoke while they were drinking and that they smoked more heavily while drinking in bars. Indoor smoking is prohibited in Illinois. Focus group participants reported that when a friend went outside the bar to smoke, they would go along and typically have a cigarette as well, even if they were not experiencing a desire to smoke. In addition, cigarettes were described as a type of "social lubricant," in that asking for a cigarette is an easy

way to talk to someone inside or outside the bar. Some members implicated the tobacco industry for the high accessibility of cigarettes in the community. For example, many participants recalled receiving free samples in bars. Several participants noted that if they were going to be successful in quitting smoking, they would have to stay out of the bars and reduce their alcohol intake.

Psychosocial barriers to cessation

Rebellion against antismoking attitudes.

"And you're not supposed to use the 'F-bomb' down there but I just said, 'F&%* you'. I'm a grown man why should I do what you want me to and why should you ostracize me because I smoke?" I just stick it in their face."

Participants acknowledge that antismoking attitudes that they experience in the general population counterintuitively serve as barriers to smoking cessation. Anger and frustration associated with receiving negative comments or looks harden their resolve to live their lives as they choose without being socially bullied by others. This sentiment was only mentioned by a few individuals, but the majority of participants acknowledged the resentment they felt about personally targeted antismoking comments. This resentment was accompanied by the impulse to "stick it in their faces" by making angry comments or continuing to smoke when asked to put out a cigarette.

Coping with stress.

"It calms me down if I had a really stressful day. I get that nice glass of wine and a cigarette and then it is fine."

"I agree with the stress part. I've been more stressed this past year dealing with a lot of family issues. Thank God I have my own place now, but a lot of stressors were there and it made me smoke more."

The use of smoking as a means to cope with stress has been long established in the literature²³ and was reported as a primary barrier to smoking cessation in this sample. When asked about alternative strategies for coping with stress, respondents were not able to generate many alternatives that they believed worked as quickly and effectively as smoking. Many of the individuals reporting a prior quit attempt reported stress as being a primary contributor to a relapse. Ironically, relapsing and returning to smoking contributed to feelings of guilt and frustration, which led to further stress about their inability to quit.

Minority stress: coming out.

"When I was in my teens I was confused about my lifestyle. I was in an antigay household. I remember my mom said to me when I was 14, 'if you don't get a girlfriend soon or start hanging out with girls or at least start expressing an interest in them, I'm going to take you to a psychiatrist'. It was terrible and so that creates a lot of stress for teens who are already stressed just being a teenager. By the time I left home and went to college at 17 I drank, smoked and did everything I could to drown the stress I was dealing with."

Sexual minority stress is one explanation for poor physical and mental health outcomes among LGB individuals.²⁴ Social stigma based on one's sexual identity can produce

chronic stress and increase the likelihood of engaging in health risk behaviors such as smoking.⁸ The stress associated with coming out, especially within one's family of origin, is a unique stressor not experienced by heterosexual individuals. Additional minority stress variables discussed by group members included familial rejection, attempts at concealment of one's sexual orientation or gender identity, and, to a lesser degree, internalized homonegativity. Each of these variables was perceived to be associated with smoking initiation, maintenance, or relapse.

Minority stress: gender presentation.

"The certain area I lived in wasn't a real nice area and I had to be more masculine or guarded to go from one neighborhood to another. From my neighborhood, to my sexuality and my stress it was a lot. I smoked more."

"I'm hyperaware of my gender expressions via like my hand mannerisms, the way that I speak, the way that I walk, the way that I stand. Waiting for a train I can't be swishy with my hips sticking out to one side in a certain neighborhood. I'm live in [Neighborhood name]. I need to stand on both feet."

Personal safety is often a concern in violence-plagued urban cities. However, concerns of safety can be exacerbated for transgender and other gender-nonconforming individuals. Gender nonconformity is associated with higher rates of discrimination and risk for violence, especially among gay and bisexual men and transgender women.^{25,26} Participants described the need to monitor their gender expressions especially in lower-income neighborhoods where fears of violence due to nonconformity were ever present. This increase in vigilance was associated with stress and members reported the use of cigarettes to both reduce stress and appear more masculine.

Minority stress: intersectionality.

"It's multilayered between just being a transgender in the first place, then being black, then being gay, and then being super effeminate. All those multiple layers. I woke up at 23 [after transitioning] and was experiencing all the discrimination from all of those layers. So the stress, I could feel my blood pressure running up and I feel like I smoke more now to cope with that."

Bowleg et al.²⁷ reported that there are disproportionately high rates of discrimination, harassment, and marginalization among individuals who are racial/ethnic and sexual minorities, and this may be especially true for sexual minority women of color.²⁸ Participants of color and transgender individuals discussed high levels of stress associated with belonging to multiple marginalized identity groups and the direct relationship between those stressors and the use of tobacco as a coping method.

Limited access to treatment

Costs.

"I have to say that's the main reason I haven't quit smoking.... Because [treatment] it is financially inaccessible."

"While cigarettes are expensive, quitting smoking is way more expensive and so when you have marginalized communities that usually also inherently implies financial difficulties as well so I think that's a really important piece."

A range of evidence-based approaches are available to assist individuals with smoking cessation.²⁹ Despite the effective-

ness of treatments and the desire of most smokers to quit, smokers in the general population report barriers to accessing treatments.³⁰ Commonly reported barriers among smokers in the general population include lack of health insurance coverage, high copayments costs, requirements for prior authorization, and limitations on the number and duration of treatments, which might reduce use of these treatments and, therefore, reduce cessation. With the exception of concerns about preauthorizations, the majority of these factors were reported by individuals in the current sample.

Lack of provider assistance.

"Only if you ask them [health care providers], then they give you information about quitting smoking."

Provider-level factors were also noted as barriers to accessing appropriate smoking cessation treatments. Focus group participants reported concerns about the lack of LGBT-specific or culturally competent services. Few focus group participants were aware of any ongoing LGBT-specific smoking cessation services being offered in their area. Another area of concern was the lack of provider assistance in proactively linking patients with available treatments. Participants noted that they are routinely asked about smoking by nurses or physician assistants when they are being checked in for a healthcare appointment. However, they indicated that the healthcare provider rarely commented on their smoking or offered assistance with smoking cessation services/treatments unless specifically asked.

Facilitators of smoking cessation readiness

Stage of readiness.

"I've said this before but I really want to be done with these things (cigarettes). I want to be done and to never go back."

"It's countering my own self-hatred and really going into the realm of loving myself more. Doing good things for myself instead of damaging things."

Study participants were recruited based on a stated interest in quitting smoking. As such, a high level of readiness to quit smoking was endorsed by all participants. Stage of readiness for quitting is strongly associated with changes in smoking behaviors.³¹ Members indicated that they have long recognized the need to stop smoking and are now strongly committed to quitting. Participants reported prior quit attempts, but many acknowledged that they had quit in response to pressures from others (i.e., partner); however, a common consensus was that their next quit attempt would be for themselves. When asked how they had come to view this quit attempt as a personal goal, several individuals responded that they were making other positive life changes and it was time to stop smoking as well.

Health and physical appearance.

"For me, I have to quit because I want to continuously be in good health."

"On a superficial level, I'm a 42 year old single gay man. I know it (smoking) is aging me."

Health was frequently noted as a motivator to quit smoking. Health concerns discussed included lung and respiratory problems and complications due to HIV/AIDS or diabetes.

However, most participants reported a desire to breathe better during daily activities such as walking and climbing stairs and while exercising. In addition, participants mentioned concern for how cigarette smoking has affected how they are aging, specifically the appearance of their hair and skin.

Social stigma.

"I say a lot of society today is so antismoking. I was in the elevator with some woman and she goes "Oh my God someone's smoking" I knew she was referring to me. I was wearing cologne, I was chewing gum or sucking on a mint, I was trying to camouflage. She made such a big deal about it pretending she was about to pass out."

"I just think mainstream society is so antismoking because my parents are like pretty affluent and with their circle of friends smoking is so taboo. I was outside sneaking a smoke and when I came back in everyone was like 'oh my God he smells like smoke' like if I was death."

"Because there is a stigma associated to poverty, to being of the lower socioeconomic level, to being uneducated, all those things that I think the general population associates smoking to. So I don't want them to think that about me."

There was strong consensus among focus group participants regarding the social stigma associated with smoking in the larger society. They described the day-to-day harassment that they experience—both verbal and nonverbal—associated with their smoking. Older participants, who have been smoking for many decades, remarked that smoking had once been a nonstigmatizing behavior, but has now become a "low-class thing to do." Social stigma has resulted in efforts to hide their smoking from others, something they referred to as "being a closeted smoker." Although negative social interactions regarding their smoking had previously been described as a barrier to smoking cessation, conversely, a desire to avoid stigma was described as a motivator for quitting.

Shifts in social norms.

"We don't want it [smoking] anymore, we don't want it in our buildings, we don't want it outside the door, and we don't want the cigarette butts at the curb."

"I don't see it as a gay or straight issue. I think it's just society in general has decided that smoking is bad."

Participants discussed their awareness of the shifts in social norms regarding smoking. Evidence of the change in social norms included voiced concerns from other people about secondhand smoke exposure, broadening antismoking legislation, and the visibility of antismoking messages in the media. There were mixed opinions about whether these shifts in social norms were only in the heterosexual community or included the LGBT communities as well. However, all agreed that the individual rights of a smoker were seen as secondary to the rights of others to avoid unwanted contact with secondhand smoke.

Financial costs.

"To me, I've had it. Just give it up, save money, and do something else with it besides spend it on tobacco."

The high cost of cigarettes was repeatedly identified as a motivator for quitting. Many large urban municipalities, in-

cluding Chicago, are raising taxes on tobacco products to reduce youth initiation and to increase cessation rates among adults. Clearly, public policy associated with taxation is effective in reducing the smoking behaviors of adolescents and adults^{32,33}; however, to date, the majority of participants reported making changes in their smoking in response to higher prices, but not necessarily quitting. For example, participants described cutting down the number of daily cigarettes smoked, switching to a less expensive brand of cigarette, or buying individual cigarettes or loose squares on the street or in some corner stores. These patterns mimic national trends.³²

Increased dating prospects.

"If I'm dating someone and I want to go have a cigarette, I will not do it for the sake that I don't want them to know I smoke."

"It's not a habit that I want to broadcast or have others join. It's my little secret."

The majority of focus group participants reported not wanting to date another smoker and that they reported concerns for how their own cigarette smoking has been affecting their dating prospects. They described experiences of having individuals they were interested in dating explicitly say that they were not interested in dating a smoker. Consequently, many individuals described hiding their smoking due to concerns that it would not be accepted by a future partner. Although expressing resentment about having to hide their smoking, it was readily acknowledged as a disadvantage on the dating scene and as a strong motivator to quit smoking.

Discussion

Study participants described a range of general and culturally specific factors influencing their smoking behaviors. As noted in the Results section, barriers to smoking cessation were discussed that were similar to those in the general population, including low self-efficacy for quitting, a desire for social inclusion and acceptability, and rebelliousness. Similarly, several facilitators were described that have been reported in the general literature, including health, physical appearance, and a shift in social norms regarding smoking.³⁴ However, culturally specific barriers and facilitators were also discussed, including community norms, the bar culture, and minority stress variables. Taken together, the study findings have implications for clinical practice and intervention development aimed at impacting individual and community-level drivers of smoking behaviors.

Clinical implications of study findings

As with the majority of smokers, study participants were interested in quitting and a majority had made a recent quit attempt. The cost of smoking cessation services was raised as a significant barrier to smoking cessation by focus group participants. With the passing of the Affordable Care Act, more LGBT-identified individuals will have access to healthcare insurance. Smoking cessation services (including medications) are covered by the Affordable Care Act as a free preventive health service.³⁵ In

addition to providing direct care, healthcare providers play an important role in motivating quit attempts.²⁹ Studies suggest that provider advice and assistance are effective strategies for changing smoking behaviors.³⁶ Focus group participants reported that smoking status is routinely collected as part of the clinical encounter; however, few providers follow-up and offer assistance with smoking cessation. Increasing assistance with smoking cessation should be a priority for providers as study participants reported several risk factors for poor smoking cessation outcomes. For example, while the majority of participants had made a recent quit attempt, 45% of recent quit attempts were cold turkey. Success rates for cold turkey quit rates are lower compared with treatment with nicotine replacement or other pharmacological therapies.^{19,37} Positively, more than half of the sample reported the use of nicotine replacement therapy or some other type of pharmacological treatment for quitting (e.g., Zyban). Clinical providers should encourage the use of nicotine replacement or other pharmacotherapies to increase the success of smoking cessation attempts among their patients.

Another identified risk factor for poor smoking cessation outcomes was the reported regular use of mentholated cigarettes. Sixty-four percent of the sample reported that they regularly smoked a mentholated brand of cigarette. These findings are consistent with prior research suggesting that a higher proportion of LGBT adults smoke a mentholated brand of cigarette.³⁸ Menthol use in the current sample (64.5%) was higher than that in the published literature (39.6%),³⁹ likely due to the relatively high percentage of racial/ethnic minorities in the sample, a population with known elevated rates of menthol cigarette use.³⁹ Mentholated cigarettes have been associated with higher nicotine dependency and more difficulty in smoking cessation.⁴⁰ Increasing education about the efficacy of pharmacological approaches and access to evidence-based treatments may help to improve cessation outcomes. Interest in quitting was influenced by a desire to improve one's health. Given that improved health was cited as a facilitator of smoking cessation, receptivity to provider advice and assistance with smoking cessation should be high.

Almost half of the sample reported at least one other smoker in the home, which is a risk factor for relapse among smokers making a quit attempt.⁴¹ As such, providers should consider assessing for partner smoking status and recommending a joint quit attempt to increase support, reduce risk for relapse, and lessen secondhand smoke exposure. Finally, research is limited regarding the health consequences of smoking in combination with hormone therapies for transgender patients.⁴² Among cisgender women, it is generally recommended that patients who are receiving hormonal therapies quit smoking⁴³ and providers working with this population should routinely assess smoking status and interest in assistance with quitting. An increase in smoking and engagement in other risk behaviors following initiation of testosterone was reported by one focus group participant. It is unclear whether this finding is unique to this one individual or whether the use of testosterone is associated with increased health risk behaviors among transgender men. Until additional research is obtained, changes in health risk behaviors should be routinely monitored in this clinical population.

Implications for treatment development

The development of effective smoking cessation treatments for LGBT smokers is a crucial component in the eradication of smoking disparities in these underserved populations. Culturally targeted smoking cessation interventions for racial and ethnic minority populations¹¹ and LGBT groups^{10,44,45} show promise for improving cessation outcomes. Targeted interventions are improved with adequate understanding of the drivers of health risk behaviors in certain population groups and the mechanisms that influence those behaviors.⁴⁶ Research has shown that psychosocial variables related to smoking cessation may differ among groups and that considering cultural variation improves substance abuse treatment outcomes.⁴⁷ A range of minority stress variables were discussed, including those associated with coming out, gender identity and presentation, and challenges associated with belonging to multiple marginalized groups. Treatment intervention approaches will need to help participants learn a range of coping responses not only to the immediate stressors associated with smoking cessation but also chronic stressors such as discrimination that may serve as triggers to relapse.

Some developmental work has been conducted on testing the benefits of community-based and culturally tailored smoking cessation treatments for LGBT smokers.¹⁰ Although promising, additional research will be needed to determine the best practices and benefits of culturally tailored versus non-tailored approaches to smoking cessation treatments for LGBT smokers. Study participants provided input on their needs and preferences for a smoking cessation treatment program. Eight major themes were discussed: (1) access to nicotine replacement therapy, (2) culturally targeted materials, (3) ongoing support, (4) information about health risks associated with smoking, (5) options for alternative cessation goals such as cutting down or (6) switching to electronic cigarettes, (7) affordable treatments, and (8) access to culturally competent facilitators. Participants described support as a crucial component in smoking cessation and described varying preferences for support type. Most commonly mentioned types included pairing up with a buddy who is also quitting smoking, group and individual counseling, and phone calls, texts, and/or e-mails to serve as reminders of staying quit. Evaluation studies are needed to determine the effectiveness of these strategies for enhancing social support for smoking cessation among LGBT treatment-seeking smokers.

Limitations

Our study included a small sample of the target population from a single geographical location, thus additional studies are required. Study participants were recruited based on their interest in quitting smoking and the results may not apply to less motivated smokers. Finally, the no-show rate for the focus groups was high. Although generalizability is not a goal of qualitative research, nonparticipants may have other opinions or experiences germane to understanding barriers to and facilitators of smoking cessation. A brief quantitative survey was used to measure some descriptive information, including demographics and smoking behaviors. The primary emphasis of the study was qualitative in nature and it was not meant to be an exhaustive assessment of smoking behaviors. However, a more comprehensive assessment of smoking

behaviors, including number of cigarettes smoked daily, would have strengthened this descriptive study.

Conclusions

The study findings contribute to the extant literature on smoking cessation among LGBT individuals by identifying a range of barriers to and facilitators of smoking cessation among this population. This information can be used to target smoking cessation interventions to the general and LGBT-specific maintenance of smoking behaviors. Additional research is needed to determine the influence of these factors on outcomes associated with evidence-based and culturally appropriate smoking cessation interventions for LGBT smokers.

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Address correspondence to:

Alicia K. Matthews, PhD
Department of Health Systems Science
College of Nursing
University of Illinois at Chicago
845 South Damen Avenue
Chicago, IL 60612

E-mail: aliciak@uic.edu