Social Support in Smoking Cessation Among Black Women in Chicago Public Housing

LORETTA P. LACEY, DrPH, RN
CLARA MANFREDI, PhD
GEORGE BALCH, PhD
RICHARD B. WARNECKE, PhD
KAREN ALLEN, RN, PhD
CONSTANCE EDWARDS, RN, MS

Five of the authors are with the University of Illinois at Chicago. Dr. Lacey is Associate Professor of Community Health Sciences, School of Public Health, and Associate Professor of Public Health Nursing, College of Nursing; Dr. Manfredi is Associate Director of Special Populations Research, Prevention Research Center; Dr. Balch is visiting Associate Professor of Marketing; Dr. Warnecke is Director, Survey Research Laboratory, and Professor of Sociology and of Epidemiology and Biometry; and Ms. Edwards is a doctoral candidate in the School of Public Health. Dr. Allen is Assistant Professor, School of Nursing, University of Maryland.

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Tearsheets requests to Dr. Loretta Lacey, Community Health Sciences, School of Public Health, University of Illinois at Chicago, 2035 West Taylor St., (M/C 923), Chicago, IL 60612, telephone 312-996-8578.

Synopsis

To accomplish significant reductions in smoking by the year 2000, special populations with relatively low rates of smoking cessation must be reached and helped to quit smoking. These populations are most often groups in which traditional approaches to smoking cessation have not been successful.

Focus groups were conducted with black women who were residents of Chicago public housing developments. The purposes were to assess factors related to smoking and the women's willingness to participate in cessation programs.

The findings reveal several barriers to smoking cessation. These barriers are linked to the difficult daily existence and environment of these women and to a lack of social support that would help them to achieve smoking cessation. The barriers include (a) managing their lives in highly stressful environments, (b) major isolation within these environments, (c) smoking as a pleasure attainable with very limited financial resources, (d) perceived minimal health risks of smoking, (e) commonality of smoking in their communities, (f) scarcity of information about the process of cessation available to them, and (g) belief that all they need is the determination to quit on their own.

The women emphasized that smoking cessation would be more relevant to them if part of broader social support efforts geared to improve their lives. The public health system may need to consider such strategies to engage this group of women.

IN THE QUEST for a smoke-free society by the year 2000, some segments of the U.S. population lag behind. For example, smoking prevalence rates among young women with no more than high school education and low income are high, while smoking is declining in the total population (*1–3*). Smoking is more prevalent among black than white women because blacks have not stopped smoking as rapidly as whites (*1–4*). Existing health promotion programs that incorporate cessation have not attracted the same participation or achieved the same success among black women with low socioeconomic status (SES) as they have among black and white women whose incomes are higher (*5,6*). Additionally, participation in group efforts among members of this population has been problematic (*7*). Clearly, programs tailored to this segment of the population are needed.

To attract greater participation from this group of smokers, these programs must have a broader focus than cessation alone. Boyd-Franklin (*8*) and Trotman and Gallagher (*9*) document the benefits of social support groups for black women based on the sharing of their common experience and their willingness to exchange emotional, spiritual, and social assistance. Social support groups may be especially important for low-SES urban black women because they tend to experience a type of isolation that creates fear and stress and distrust of their environment. These factors limit their chances

to build or join social networks and foster dependence on smoking to reduce loneliness, reduce stress, and provide affordable pleasure.

This paper reports formative research toward a smoking cessation program that is socially support-based and tailored to the needs of low-SES black women. The focus groups that we describe were originally designed to assess factors related to smoking cessation and participation in such programs. However, as the groups progressed, it became clear that there are powerful environmental factors related to smoking that inhibit participation in the kinds of programs currently offered.

We began to discover how the social environment of these women, particularly their social isolation and limited sources of social support, is inextricably linked to their smoking. It became clear that successful cessation programs must mobilize social support that will provide ways of coping with these environmental factors to enhance cessation. Cessation programs that address these larger issues will be more effective.

Background

Investigation of the factors associated with smoking among low-SES black women was prompted by the outcomes of an intervention that proved satisfactory for the general Chicago population but was less effective for low-SES black women who are residents of Chicago public housing developments. The original study (*7*) used a self-help manual,"Freedom From Smoking in 20 Days," and a series of televised segments on the local evening news that followed the contents of the manual. A supplement to the main intervention was introduced in public housing developments. This supplemental intervention was implemented by lay health educators, who conducted a series of specially designed classes on smoking cessation for women 18–39 years old living in the housing developments. The lay health educators had two main tasks: to promote viewing of the televised program and to elicit participation in the local smoking cessation classes that were part of the intervention (*10*).

More than 600 residents, who were canvassed door-to-door in the housing developments, expressed interest in a smoking cessation program, and more than 200 preregistered. However, maintaining continuous participation in the smoking cessation classes was problematic, and the number of actual participants was less than half that of those who preregistered.

We examined data from our baseline sample of residents in housing developments not selected for the intervention with data from a sample of the general population of female smokers in the Chicago metropolitan statistical area matched by age and divided into two groups, one black and one white. Based on this analysis, those in the public housing sample had less interest in quitting or desire to quit and were less likely to have made plans to quit compared with other black or white female smokers in the general population study. Moreover, when we analyzed in detail the responses of women in the housing developments, it was evident that they did not share with other black women or with white women the same understandings about the relationship between smoking and risk of disease, especially cancer, and did not see how risks made smoking less desirable. On the other hand, it was unclear from the results exactly what value smoking held for these women (*11*).

How can this analysis and the results of the original study be employed to design a more effective program for women residents of public housing? To address this task, we used qualitative methods to help us understand the role of smoking in the lives of these women and how best to deliver a cessation program relevant to these women.

Method

Marketing researchers commonly use focus groups to provide data about how people think, speak, act, and feel with respect to products, services, and marketing communications (*12–14*). Focus groups are used to identify issues important to respondents in language that the respondents use. Often, focus groups raise important issues that researchers had anticipated; in other situations, the results expand the data and generate new insights and hypotheses about motivations, needs, symbols, behavior, and meanings.

Recently, preventive health researchers have been using focus groups to develop new interventions (*15–17*). Schechter and coworkers (*18*), for example, used focus groups to develop mammography promotion messages. They were used in Eckert's research (*19*) to provide feedback on a smoking cessation program among black adults.

We conducted eight focus groups with black women residents from three Chicago public housing developments that were not among the intervention sites for the original study. These women had sociodemographic characteristics similar to those of the women in the intervention sites.

Specifically, our survey data revealed that 42 percent of the women in public housing had not completed high school, 66 percent were single parents, and all had annual household incomes of less than $13,000. By age 17, 68 percent had initiated smoking. Just over half (51 percent) smoked more than 10 cigarettes daily, and 96 percent smoked mentholated cigarettes. No or weak desire to quit smoking was reported by 54 percent (*11*).

Each group session had six to eight participants and lasted about 2 hours. Discussion focused on participants' daily activities, stresses and pleasures, social environment, beliefs about smoking and health, and smoking and health behavior. The discussions followed a structured format to identify perceived benefits of smoking, barriers to cessation, and receptivity to various cessation approaches.

To ensure reliability of the findings, we used three different moderators (two black and one white), multiple observers, and immediate postsession debriefings. Observers wrote summaries of each session. In addition, audiotapes and videotapes were made of each session, and transcripts of the audiotapes were prepared and compared against each videotape for accuracy and completeness. Finally, all themes which emerged in the summaries were cross-checked against the tapes and transcripts for counter evidence.

Findings

Our synthesis of the sessions revealed a consistent theme of distinct barriers to smoking cessation that related to life circumstances and social environments of the women. Their environments as viewed through comments in the focus groups were highly stressful. Smoking seemed to provide them with relief and comfort.

Barriers to smoking cessation. Our synthesis of the content of the group discussions indicated seven barriers to the participants' cessation: (*a*) the problems of managing their lives in a highly stressful environment, (*b*) their isolation and the limited support systems within these environments, (*c*) the availability of smoking as an attainable pleasure in a milieu with very limited resources for pleasure, (*d*) perceived minimal health risks of smoking, (*e*) the commonality of smoking, (*f*) the scarce-to-nonexistent information about how to stop smoking, and (*g*) the belief that all they need is determination to quit on their own.

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All of these barriers followed from social isolation and lack of support. In fact, we observed that these women were most motivated to quit when they were doing well, that is, working, attending school, and receiving positive support. When their lives left them little support or made them feel less valued, they wanted to smoke. These general feelings, however, can best be described when organized around the barriers.

Managing in a highly stressful environment. A consistent theme among the women in the focus groups was that smoking helps them to manage the overwhelming pressures in their lives and to stay calm. In this context, they believed smoking offered strength for coping with the harsh realities of their life situations in communities that presented immediate and constant dangers to them and their families. These communities were unclean, had substandard housing, and offered few resources. Life there was plagued by violence and crime, often related to drug use. Although all smokers tend to emphasize the stress-management utilities of smoking as reasons for not quitting, the magnitude and nature of stressors in these communities gave stress a unique dimension. For example, one participant described vividly the extreme stress encountered daily in trying to get her daughter onto the school bus:

> My daughter use to have to get on the [school] bus. She had to walk down the stairs, stepping over the dope fiends and the junkies. And one day she walked downstairs, this guy was laying in the hallway with a needle in his neck scaring her. She ran out to the bus, she fell down, she missed the bus, she missed a couple of days of school. I got to hear from the school [about her absence] you know it's bad.

Smoking was believed to bring some control when the women faced so many situations over which they had minimal control. Another partici-

pant related the lack of control about the very basic issues of survival as she described an encounter with the bureaucracy at the local welfare office and her response:

> To top it off, Public Aid mess me up. [She was sent to the wrong office.] . . . I got there late, and asked the gentleman, "Are you going to call my name back now?" He said, "You have to wait." So they put down "no show," then they sent me a letter decreasing me for 3 months. Three months! . . . I smoked a lot on that day, do you hear me?

It was clear from watching the members of the group that "lighting up" was a natural, normatively accepted response to situations of this type. They smoked to control their reactions to uncontrollable events.

Isolation and limited support systems. The structure of these communities promoted isolation. All were located in racially and economically segregated areas of the city. Some of these women lived in housing developments considered the poorest communities in the nation. One housing complex was almost at the city limits, near a dump site. Most of the high-rise buildings had poorly functioning elevators and unsafe stairways, which limited movement outside of the home except for necessary activities. General fear for personal safety enhanced the physical and social isolation. Women in the groups believed that development of relationships and contacts beyond the immediate family were risky. Opportunities to establish close friendship networks were limited by the suspicion that relationships with persons outside the household might create additional problems in their lives. A recurring comment was that attempts to have relationships outside of their immediate families brought what was frequently described as confusion into their lives. A participant who lived in a high-rise development described why she limited outside contact to her family: "I'm not visiting too much—I'm a house person. There's too much going on down there in the streets."

Families were the most trusted source of support. For these women, family seemed focused on children, sisters, and mothers. But still, many of the participants described intense loneliness. One woman, age 23, who smoked three packs of cigarettes per day, had this vivid description of her isolation:

> I might be depressed or whatever and I don't have anybody to talk to and my baby . . . he'll be in his playpen. I'll just talk to him and tell him a bit of my problems. He'll just look at me, like mama I know what you are going through or, you know . . . I just sit out there and pour all my problems out to my baby and sometimes I feel better.

One element frequently missing in the lives of many of these women seemed to be the support that can come from a male partner. A stable relationship with a partner—whether or not he is the spouse—means one can share problems, receive emotional support, and in some cases, can rely on someone to defend one's safety. But merely having a partner was not enough to reduce the overwhelming stress caused by these women's environments.

Smoking as an attainable pleasure. Lack of financial resources and physical and social isolation limited access to sources of pleasure. Many prefered to forego material pleasures for themselves to provide the basic needs for their families. One participant described her pleasure with smoking in this context:

> I have a lot of pressure on me. [She works, takes care of an aging mother, has children, and tries to keep the house together.] . . . I don't have time for me . . . so the only time I have is when I take a cigarette out of the pack and fire it. Cause that's the quickest thing you can do, you know, something that you want to do for yourself.

These women perceived smoking as a legal, harmless pleasure, attainable for a relatively small investment. The perceived alternatives were drugs, alcohol abuse, or losing self-control. As one participant remarked,

> I'm going to have to stop smoking because I really can't afford it but I've got to do something . . . I'd rather smoke than go there and shoot some drugs or smoke a pipe or something like that.

Perceived minimal health risks of smoking. Although these women tended to agree about the negative effects of smoking on the health of their children, they seemed less convinced about the harmful health effects of cigarette smoking on themselves or other adults. They felt that cigarette

smoking, in general, was not good, but they expressed doubts about a specific link, for example, between cancer and smoking. Few mentioned cancer as a health concern for themselves or their families.

Furthermore, they believed that the cancer that they have seen among their family members and other acquaintances was due to many other causes than smoking. In fact, they were adamant that medical scientists do not know the cause of cancer. Balshem (*20*) has recently described similar findings among a white working-class population. The women in Balshem's focus groups also expressed such fatalistic beliefs as "everything causes cancer" and "once it occurs, there is little that medical practitioners can do to control its course."

Surprisingly, even the actual presence of more urgent health problems that smoking aggravates did not deter these women. Several women had chronic pulmonary disease (asthma, emphysema), heart disease, or kidney disease, but they continued to smoke apparently unaware or unaccepting of a possible relationship between smoking and these health problems. Where they perceived possible environmental effects, they attributed them to hazards in their environments. These attributions had a basis in reality, since some lived in housing developments near waste dump sites, and all lived in areas highly polluted with dust and dirt. They emphasized this situation through their description of their constant need to clean dirt from surfaces in their homes.

Commonality of smoking. Another barrier to cessation was the commonality of smoking in these women's social environments. A consistent theme throughout the groups was the belief that most adults smoke. These women believed that more than 75 percent of adults in their communities smoked cigarettes. They thought that the rate in the general population was the same.

When informed that smoking is decreasing and that less than 30 percent of the general adult population smokes, many of these women expressed disbelief. They seemed not to see smoking in the same negative context that it increasingly appears elsewhere. The actual prevalence within their own social groups made it difficult to avoid smokers or smoking situations and made their perceptions accurate for their effective environment.

Scarce information about how to stop smoking. Electronic media were a major source of health information often cited by the women with whom we spoke. This observation is consistent with our 1987 baseline data and has been reported by others working with similar groups (*21,22*). When asked if they knew where they could go or methods they could use to help them stop smoking, nearly all reported no knowledge about such resources. The consensus was that the only way to quit smoking was to do it on their own, "cold turkey."

'. . . cessation cannot be the single focus or even the primary focus. To increase the likelihood of success, smoking cessation should be part of a program that has other meaningful purposes . . .'

Another theme emerging from this discussion was that their sources of health information—electronic media—provided little guidance about smoking cessation. Although there were frequent references to smoking-related issues on television, the reports did not offer advice about or direction for smoking cessation except for the infrequent programs such as those offered in this study.

After tracking media references for 2 years, we found very little in any of the media about cessation. In our continuing work, we have found that these women may be told often by their health care providers to quit, but these recommendations do not include clear guidance on how to quit. Hence, there is minimal concrete direction to assist them.

Determination to quit without help. Because of a lack of specific guidance and information about the cessation process and because of social isolation, there was little awareness of the process and of the fact that many smokers relapse and have to make several attempts before successfully quitting smoking. The lack of exposure to those who have tried to quit reinforced the beliefs that only self-determination leads to smoking cessation and that those who quit must exert Herculean efforts. Pervasive smoking in the environment, the absence of social support, and the likely absence of specific constructive assistance should these women want to quit reinforced their perceptions about the high cost of trying. Besides, their reality was always to be self-reliant; to be dependent or in need of supportive help suggested vulnerability to their

environment. Apparently, this ethos extended to many areas of their lives.

The operative belief was that a woman must be in control of herself to stop smoking, much as she needed control to survive at all. Impersonal sources of support in which she had little control were not compatible with this belief structure. For example, one woman recounted her failure to stop smoking. She was among those who had seen a quit-smoking manual at one of the local discount stores. When asked if she thought a manual would work, she replied,

> No, if you haven't got the will power, it's not going to work. You are just spending your money on nothing. I look at it as if they are taking my money. Because I'm not going to go along with the program [because she does not want to quit smoking] . . . if you really want to stop smoking you don't need a manual.

Others echoed from around the room, "It would not work because they don't want to quit."

Social support. Smoking cessation in the face of all of these barriers requires help and perseverance, but the help must come from known and trusted sources if it is to be accepted. Traditional smoking cessation programs and the support from them seemed not to be effective even when motivation to quit is present.

Given these observations, it was surprising to observe during these sessions a consistent pattern of spontaneous formation of group support among the women as they discussed their experiences and frustration with everyday living. Most of these women did not know each other before the group sessions, yet they were remarkably accepting of each other and openly shared experiences and the accompanying sorrow, worry, and concerns. These exchanges generated supportive and empathic understanding that obviously reflected common experience and resulted in warm, nonjudgmental, and accepting interaction. As they shared personal sorrows, disappointments, joys (especially about their children), and hopes during the limited session time, each woman was accepted as having worth, human dignity, and full membership in the group.

Some examples illustrate the empathic atmosphere that emerged in each group. One young woman had just been released from the county correctional facility and shared her fear and sadness about what led to her arrest and the possibility of further incarceration:

> I was scared because I never had a record before. I was never in trouble. And I've been going to court since last year. They were getting ready to give me 6 years, and they were going to send me to Dwight [a State women's correctional facility].

She related that her incarceration followed a drug offense in which she had been both a user and pusher. Her comments revealed a trust in the members of the group, who had just discussed their fears of and anger about pushers in their communities. The trust was well founded: when she confessed to being one of those whom they had just castigated, the response was nonjudgmental, warm, and filled with expressions of relief that she did not have to be incarcerated longer.

In another group, a woman said that she always felt left out, as if she could not do anything right. She had once prepared a Tupperware party and no one came. She felt rejected by people in general, and she did not know if group sessions (for smoking cessation) would work for her. At that point, a member of the session who had been purposely reticent and almost hostile in her interactions with the group said, "Well, you are accepted here." Others agreed. The apparent need and desire these women have to share their experiences in an empathic but neutral setting may provide a basis for interventions that might include smoking cessation as a component.

Applying support to smoking cessation. Others who have studied groups with black women have reported the value of organizing the groups for social support (*8,9*). Participants in our focus groups expressed enthusiasm about forming groups that might help them to stop smoking. They immediately took ownership of the idea, providing several valuable suggestions: (*a*) groups should be multipurpose, allowing for other important needs to be met; (*b*) they do not need a professional leader, since the direction of the discussion should come from them; (*c*) organizers should be former smokers; and (*d*) most of all, they wanted the group to be a mechanism for them to give and receive emotional and social assistance.

The group appeared to be seen as a potential means of reducing the loneliness and isolation experienced in their communities. These groups were perceived as a neutral and safe environment,

not unlike that found in therapy groups; the group was also seen as a potential social encounter, as recreation. The women saw these groups as providing an opportunity for release from family obligations, such as the constant care of their children. Finally, the group was seen as a way to learn about life concerns from family- and household-related tasks to job training. In each group, there was considerable discussion about their desire and strong need for employment. If the support serves as a means of self-enhancement and esteem building, factors which they often associated with periods when they had stopped smoking, it may lead to cessation.

The possibility of smoking cessation occurring within groups that are formed to provide social support is promising. These groups may offer the help needed to attempt behavioral change. These participants mentioned a variety of locales and sites, some within their communities, in such places as community centers and their homes. Churches, which are often mentioned by health professionals as promising places, were not mentioned as a first choice. The strong spirituality that seemed to influence many aspects of their lives did not always translate into church affiliation or attendance. Others were interested in getting away from their communities, going even to places where people smoked to aid in building resistance. What seemed most important was the composition of the group. They wanted to be among other women to learn, share feelings, and offer and receive social and emotional support.

Conclusions

Our findings are based on a qualitative approach, and hence, the limitations in interpreting this type of study data apply. Despite the methodological constraints, there are a number of relevant implications for public health programs for these populations. We observed that for women in our groups, smoking was associated with relief from the heavy burden of stress in their lives. It helped them to cope with a hostile environment and the extraordinarily difficult life situations that accentuated their lack of social support. Furthermore, it was an attainable and acceptable pleasure that had enormous value for them. These women did not see cancer as a health threat associated with smoking. Moreover, they did not see other health problems as urgent enough to motivate a change in their smoking behavior. On the other hand, smoking appeared to be intimately tied to their life experiences, and when they felt productive and supported, they appeared more likely to consider smoking cessation.

Within these groups, the women demonstrated a natural reservoir of support for one another. They shared common backgrounds as black women engaged in continuing life struggles. There was a readiness to share their common life experiences, and the sharing revealed mutual empathy and nonjudgmental support. The group context addressed many of the barriers described previously. The social isolation was lessened by the presence of sympathetic peers with limited claims on the others in the group.

If smoking cessation interventions could be introduced into such a context, the potential for support, so important in the quitting process, would be great, since there would be an environment where cessation was accepted and the experiences of relapse, slips, and so on could be shared and not judged. The challenge is to develop health promotion programs that use the participants' strengths and put the programs in the context of methods that the participants perceive as useful and acceptable.

The fact that the women enthusiastically embraced the idea of support groups and immediately wanted to assume program ownership by shaping its format gave evidence of their interest. Their responses also suggest that the need for self-reliance can be met if the women are active participants in program development and implementation as partners with the health professionals. Our experience and that of others (*7*), however, suggests that attendance and participation are problematic when the program competes with the everyday concerns of living.

How then might the effort differ? Although this paper cannot offer specific answers, it does offer insights important to the development of innovative strategies by health administrators and providers. First, these women clearly indicated that smoking cessation cannot be the single focus or even the primary focus. To increase the likelihood of success, smoking cessation should be part of a program that has other meaningful purposes for these women. Cessation is most likely to occur in the context of programs that have some perceived relationship to improving the lives of these women. Relevance to them will focus on issues that differ from those usually associated with health promotion. These women did not see a clear relationship between smoking and major illness, even when they had an illness. Future research with black smokers

should consider these barriers, and their relevance for other groups should be determined.

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