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Commentary
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Commentary

Tobacco-Related Disparities Viewed Through the Lens of Intersectionality

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Abstract

Despite remarkable progress, tobacco control efforts are not equitably distributed, and tobacco-related disparities continue to contribute to significant health disparities. Our premise in this commentary is that Intersectionality can serve as a productive analytical framework for examining tobacco-related disparities across and within multiple marginalized populations. Intersectionality is a theoretical framework for understanding the multiple interlocking societal systems that bestow privilege and oppression and is increasingly being to the study of health inequities. We present a model and describe how tobacco-related disparities can be understood via critical elements of Intersectionality. We conclude that the application of Intersectionality to understanding tobacco-related disparities has potential to stimulate meaningful discussion and lead to new and innovative multilevel and cross-cutting interventions to eliminate tobacco-related disparities and foster culturally safe environment in which all people can thrive.

Implications: This commentary describes how Intersectionality can serve as a productive analytic framework for examining the development and maintenance of tobacco-related disparities across and within many marginalized groups.

Despite remarkable successes, tobacco control efforts are not equitably distributed and tobacco-related disparities contribute to significant health disparities in many marginalized groups across the world.[1] Tobacco-related disparities include unequal tobacco control protections, higher prevalence of tobacco product initiation and use, lower rates of quitting, poorer responses to standard evidence-based treatments, less access to treatments, variation in health care providers' tobacco treatment delivery, and increased burden of tobacco-related disease.[1,2] Our premise in this commentary is that Intersectionality can serve as a productive analytical framework for examining the development and maintenance of tobacco-related disparities across and within multiple marginalized populations. Intersectionality is a theoretical framework for understanding the multiple interlocking societal systems that bestow privilege and oppression and is increasingly being to the study of health inequities.[3,4] Please note: Throughout this commentary, the term "tobacco use" refers to commercial, not traditional, tobacco use.

Marginalized populations are typically described by social identifiers that are visible and relatively static such as race; or by experiences such as a mental or physical illness.[5] Social identities associated with well-known tobacco-related disparities are depicted in Figure 1.[1] However, people are holistic and dynamic, therefore, focusing on one identity in isolation and devoid of context can be shortsighted, inaccurately reflect reality, and lead to faulty assumptions. For instance, the overall difference in the prevalence of smoking cigarettes between Black and White people in the United States is negligible (14.9% vs. 15.5%),[1] but Black people are substantially overrepresented in lower socioeconomic status (SES) groups in the

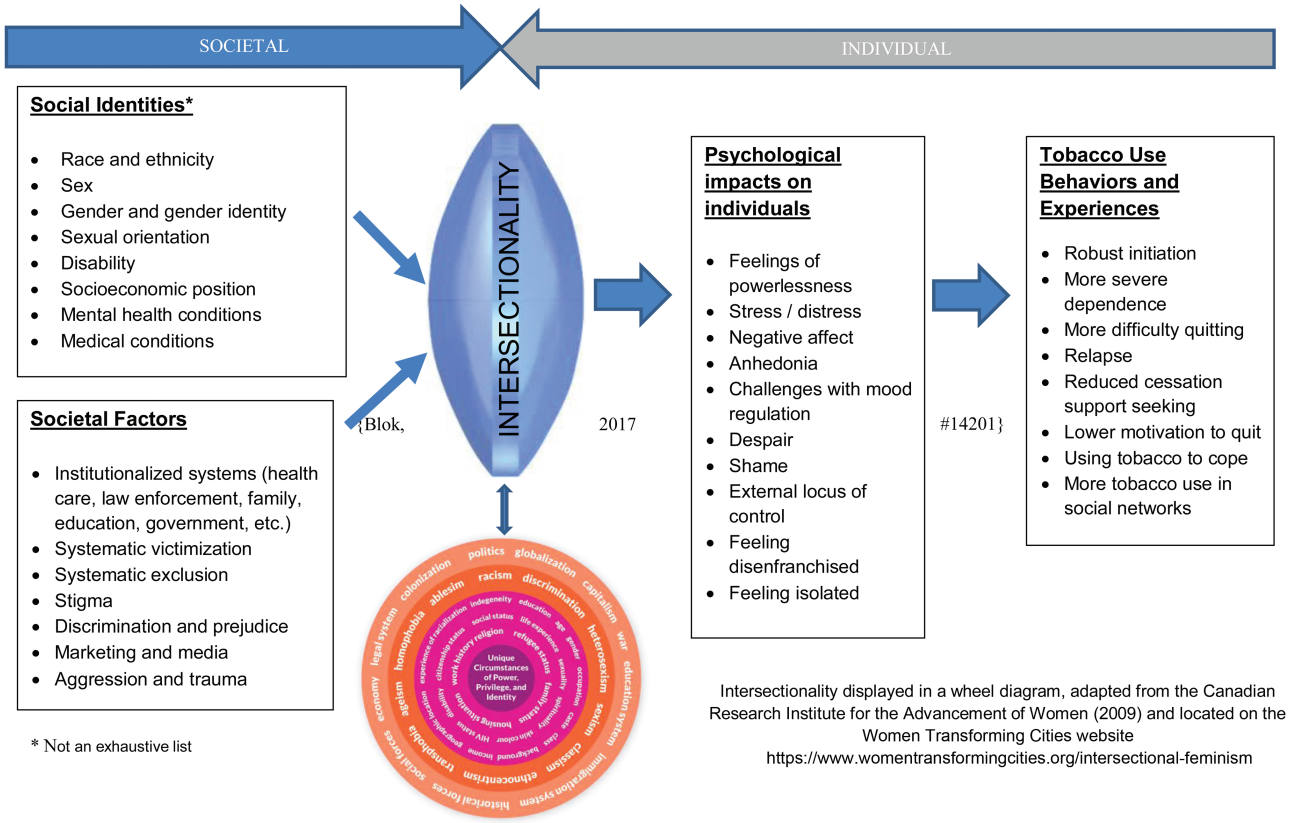

Figure 1. Viewing tobacco-related disparities through the lens of intersectionality. Intersectionality highlights the asymmetrical life opportunities associated with structural inequalities.

United States[6] and lower SES groups smoke at nearly three times the prevalence rates of more affluent groups.[1] Cigarette smoking prevalence rates are higher among Black men (20.9%) than among Black women (13.3%)[7] and contribute to 20%–48% of the gap in Black–White life expectancy at age 50 for men, but not women.[8] Similarly, while the impact of mental health conditions on smoking cessation is similar between men and women; women, sexual minorities, and veterans are more likely to suffer from depression, anxiety disorders, and trauma.[9,10] Childhood adversity interacts with stressful events and significantly affects smoking cessation among women but not men.[11] Many individuals who have serious mental health conditions and/or physical and intellectual disabilities are also of lower SES.[12] Focusing on just one identity ignores the distinct multilevel experiences that can impact tobacco use and cessation.

Social identity is inextricably linked to institutionalized systems of oppression that are significant sources of marginalization in health care, industry, law enforcement, family, employment, education, and government.[13] Marginalization operates through systemic exclusion in practice and policy, the value and curation of knowledge and history, stigma, discrimination, prejudice, negative characterizations, dehumanization, trauma, and aggression.[5,14] The tobacco industry directly and indirectly exploits these mechanisms by targeting marginalized groups with messaging that equates tobacco use with freedom, power, and social acceptance.[15] Among Indigenous peoples in particular, the industry continues to exploit Indigenous values, culture, and stereotypes (see D'Silva et al. for a review of industry documents[15]) and undermine Indigenous self-determination.[16,17] Marginalized groups and communities are often systematically excluded from tobacco control protections (ie, prohibiting the sale of loose cigarettes, enforcing smoke-free policies in the places where they live and work).[18,19] When members of marginalized groups disproportionately die of tobacco-related diseases, society often attributes these tragedies to personal responsibility, ignorance, or other negative characterizations, when the core of the problem is undoubtedly unequal access to power.[13,14]

The concepts and principles of Intersectionality highlight the asymmetrical power structures and subsequent life opportunities associated with different social identities. Social identities are viewed as dynamic, unequal social relationships among groups of people, not innate personal characteristics, and importantly, the relationships, not the characteristics, act as social determinants.[5,20] Intersectionality also assumes that viewing one social identity as primary denies its interaction with other identities as well as the context and access to power. We propose that Intersectionality might be a unifying approach to productively analyze and integrate existing tobacco disparity conceptualizations, models, and research in terms of multiple systems of oppression including racism, sexism, heterosexism, ableism, and classism. We also propose that these systems of oppression can repeatedly and unremittingly impact the psychological well-being of individuals[21] and may lead to vulnerabilities for a reliance on tobacco use and development of nicotine dependence.

The psychobiological impact of systems of oppression on individuals can be profound. The ramifications of perceived powerlessness, disenfranchisement, and social isolation are well established and include but are not limited to chronic stress and/or distress, negative affect, learned helplessness, anhedonia, isolation, shame, and an external locus of control.[5] These, in turn, can impact multiple tobacco use behaviors by reducing or overloading the capacity

to cope, challenging mood regulation, reducing motivation, and diminishing confidence in quitting, and perhaps increasing susceptibility and responsiveness to immediate reward.[22] These factors have the capability to potentiate the development of more severe tobacco dependence. Within-group social network influences also have the potential to support sustained tobacco use.[23] These factors are then compounded by limited access to evidence-based treatment for tobacco dependence, exposure to the selling of loose cigarettes, higher tobacco retailer densities, and less protection from tobacco-free policies. These complex interactions are admittedly difficult to disentangle, but must be acknowledged to fully understand the development and maintenance of tobacco-related disparities.[24]

Traditional Euro-western academic conceptualizations of discreet "populations" are commonly essentialist in nature and might limit our clinical and public health approaches and research. These approaches tend to prioritize the impact of one social identity without consideration of the potential cumulative, interactive, and exponential effects of multiple social identities and the systems of privilege and oppression that accompany them. This is in stark contrast to Indigenous worldviews that are holistic and relational, valuing health and well-being more broadly to include the importance of balance.[17] For instance, tobacco treatment protocols, manuals, and materials are commonly adapted for marginalized groups from mainstream approaches and are nearly always geared toward one social dimension (eg, individuals who are women, are pregnant, are White, are Black, are a sexual minority, are gender diverse, or are of lower SES). This has resulted in clinical and research approaches focused on sex and/or gender disparities or racial disparities or socioeconomic disparities with little investigation of how these social identities overlap and interact for individuals in context. This might explain the narrow successes as well as harms that have been perpetuated with these restricted approaches.

We propose that the principles of Intersectionality might be productively applied to improve tobacco-related disparities through innovative research resulting in improved clinical and public health approaches and improved training of public health and health care professionals. Clinical and public health approaches might be improved by supporting a deeper appreciation of context and the personhood of individuals, empathy for the struggle to quit tobacco, and recognition of the unintended consequences of mainstream approaches that assume that our "ask" to quit tobacco is the same "ask" for everyone.

Intersectionality might also guide the development of new transdisciplinary competencies and cultural safety requirements for training a workforce of tobacco treatment and control professionals. The principles of Intersectionality complement recent calls to reduce stigma and implicit bias by using person-first language.[25] These calls have been heralded in many fields (eg, person living with AIDS instead of AIDS patient, person with schizophrenia instead of schizophrenic). Changes in our language can convey a less stigmatizing description of individuals (eg, person who smokes instead of "smoker"). Finally, social determinants are widely accepted as critical to public health and Intersectionality can provide a more in-depth multilevel framework for understanding the impact of interconnected mechanisms of privilege and oppression, for critiquing societal structures, and to identify policy intervention targets for mitigating the impacts of oppression on individuals.

Despite important tobacco control successes in the past two decades, there remain significant discrepancies between tobacco control goals and achievements across the world. These shortcomings are concentrated among marginalized groups. Viewing the problem though the lens of Intersectionality might serve as an integrative analytic framework and a paradigm shift, and increase the rate of progress in the field. This commentary aims to stimulate meaningful discussion about how to apply Intersectionality to understand the development and maintenance of tobacco-related disparities within and across marginalized and priority groups. Such a discussion might lead to new and innovative multilevel and cross-cutting interventions to eliminate tobacco-related disparities and foster an environment for all people to thrive.

We provide a brief description of the authors' social identities to help provide context and understanding of our theoretical and worldviews: All authors identify as white, cisgender, and straight. *Christine E. Sheffer* is a female clinical psychologist, raised Roman Catholic, of Italian descent who smoked cigarettes as a teenager and young adult. *Jill M. Williams* is female Addictions Specialist of European descent. *Deborah O. Erwin* identifies as a married female Medical Anthropologist, born and raised in the American South as a Presbyterian who has never used tobacco. *Phillip H. Smith* identifies as a male, raised Roman Catholic, settler-colonizer of European ancestry, living on land originally inhabited by the Miami tribe in the state of Ohio. He smokes commercial cigars on rare occasions to bond with family and friends. *Ellen Carl* is an agnostic female behavioral researcher, married to a Muslim man of Turkish origin. She has never used tobacco. *Jamie S. Ostroff* is a female Jewish Clinical Health Psychologist of Eastern European descent who never used tobacco.

Supplementary Material

A Contributorship Form detailing each author's specific involvement with this content, as well as any supplementary data, are available online at https://academic.oup.com/ntr.

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Declaration of Interests

None declared.

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