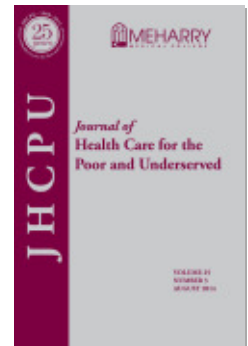# Urban, Low-income, African American Light Smokers: Perceptions of Cessation Counseling

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Urban, Low-income, African American Light Smokers: Perceptions of Cessation Counseling

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Abstract: Nine focus groups (*N* = 57), which included a demographic survey, were conducted to evaluate urban, low-income, African American light smokers' experiences of cessation counseling. Chi-squared and independent t-tests were run to analyze survey data. Participants with a self-reported co-morbidity were more likely than participants without a co-morbidity to have been asked about quitting, and advised to quit. Fewer than half of all participants reported recommendations to use cessation pharmacotherapy, try a quit smoking program, or have a follow-up. Qualitative analysis revealed three focus group themes: (1) health provider as information source; (2) unsatisfactory counseling; and (3) mistrust of physician-prescribed pharmacotherapy. Participants expressed frustration regarding receiving inadequate counseling for smoking cessation since they viewed health providers as the most trusted source for health information. Findings demonstrate the need for further study of cessation counseling among urban, low-income, African American light smokers, particularly those with co-morbidities.

Key words: 5 A cessation counseling, low-income African Americans, light smokers, perceptions.

Tobacco use remains the leading cause of preventable morbidity and mortality in the United States and is responsible for more than 400,000 deaths and more than 30% of all cancer deaths.[1] Although recent studies suggest a decline in overall smoking prevalence among adults in the United States, prevalence rates for certain segments of the population, such as urban African Americans, remain high.[2] Further, the prevalence of light smoking (10 or fewer cigarettes per day [CPD]) is growing in the United States, and among light smokers the proportion of racial ethnic minorities, such as African Americans, is higher.[3] Despite smoking fewer CPD, African Americans experience disproportionately high cancer mortality rates and tobacco-related co-morbid medical conditions compared with other racial/ethnic groups.[4]

Tobacco-related health disparities are associated, in part, with disparities in smoking cessation among African American light smokers.[5–7] Cohen and colleagues[8] reported that in general light smokers were more likely than regular smokers to report that they

want to quit,[9] and that they were planning to quit in the next 30 days, that it would be easy for them to quit, and that advice from a physician would help them quit. While African American light smokers are more likely to attempt to quit smoking than Whites, the success rate is lower for African Americans.[10] A greater number of quit attempts suggests an interest in quitting smoking but possibly a gap in access to or effectiveness of cessation resources for African American light smokers.

Research continues to demonstrate that African American smokers, light and heavy smokers (more than 10 CPD), are less likely than White smokers to receive physicians' advice to quit.[11-13] Within a group of African American smokers (N = 245) across demographic characteristics and CPD, 42% reported that no advice to quit had been offered; men were less likely than women to receive advice to use quit-smoking products.[14] The study concluded that compared with Whites, African Americans receive suboptimal advice to quit. A comparison of the 2000 and 2005 National Health Interview Surveys found that during that time the percentage of African American smokers who were advised to quit increased by only 5.5 points (from 49.9% to 55.4%).[15-16]

Research indicates that African American smokers have lower rates of trust of cessation pharmacotherapy and recommendations to use quit smoking medications than White and Asian smokers.[17-18] Investigators have also found that generally African Americans have limited trust in their physicians.[19-20,21] These findings are confounded by sociodemographic characteristics.[22] Some studies show that African Americans are more likely than Whites and Hispanics to trust information from physicians.[22] Low-income, older African Americans are more trusting of their physicians, a finding similar to older White patients.[20] Trust affects African American light smokers' engagement with cessation intervention resources.

Clinical treatment guidelines recommend brief cessation counseling as part of standard clinical health care for all patients who smoke.[23] This type of cessation counseling provides an opportunity to intervene with light smokers.[24] Brief cessation counseling may be effectively structured around the *5 As counseling sequence*:[23] (1) Ask—Systematically identify all tobacco users at every visit; (2) Advise—Strongly urge all tobacco users to quit; (3) Assess—Determine willingness to make a quit attempt; (4/5) Assist/Arrange aid to help the patient quit. Researchers have found evidence that the longer the 5 A intervention lasts, the more likely it is that the patient will abstain from smoking, but even an intervention lasting fewer than three minutes can be effective. To enhance 5 A counseling and promote abstinence, when the patient utilizes nicotine replacement therapies or other cessation pharmacotherapy, a follow-up visit is recommended. Moreover, since relapse is a concern, arranging for follow-up (e.g., office visit, telephone) is critical, especially within one week of the patient's quitting.[24] The evidence-based practices recommended for clinical treatment of smoking vary greatly.

The implementation of 5 A counseling differs among physicians with implications for quitting smoking.[25-27] For instance, simple advice to quit increases the likelihood of abstinence; more intensive advice slightly increases the likelihood of cessation; and additional counseling during follow-up visits may also slightly increase abstinence rates.[25] Physician's inquiring about tobacco use at every visit[28] and/or integrating counseling into visits for tobacco-related illness[29] results in increased opportunities for use of 5 As and the likelihood of increased cessation rates. Other research suggests physicians con-

sider how smokers will react to cessation counseling as well as how they see themselves as smokers prior to counseling.[26] These differing perspectives underscore a need for more research regarding the use of 5 A counseling among urban, low-income, African American light smokers low who desire to quit but whom have a hard time doing so. There is also a lack of knowledge about health provider-patient cessation counseling within this specific group, a group that suffers disproportionately from tobacco-related disease and illness.

The objective of the current study was to evaluate self-report data of cessation counseling experiences and perceptions from a sample of light smokers who are defined as urban, low-income, African American smokers.[4] These data are from a larger qualitative project within an economically deprived, inner-city community exploring socioeconomic- and environmental-based determinants affecting motivation and personal health promotion behavior among African American smokers.

Methods

Participants. The institutional review board of a large Midwestern university approved this study. The study and analysis were conducted between 2009–2011. Nine focus groups ranging from three to 12 participants (N = 57; 50.9%, male) were conducted at a local church within a predominately African American, inner-city, Midwestern neighborhood. This location was chosen due to its proximity to the chosen sample, credibility of the church within the neighborhood, accessibility to public transportation, and being within walking distance for many participants. An African American, professional recruiter, was hired to recruit and screen participants. Participant inclusion criteria included self-identifying as African American, being on public health assistance, residing in an inner-city environment, being between the ages of 25–65 (M = 43, SD = 10.57), not having a college or trade degree, having smoked 100 cigarettes in lifetime, and currently smoking cigarettes every day or some days (M = 9.33 CPD, SD = 4.79).

Focus groups. The two-hour, audio-taped focus groups were conducted using a semi-structured moderator guide (see Box 1 for interview questions, or *schedule*).[30] Focus groups were conducted with three objectives: 1) to understand how group-based perceptions of class identity (i.e., working class) and neighborhood characteristics are interpenetrated; 2) how they influence motivation and behavior to enhance individual health and wellness among smokers; and 3) how what is found might inform development and delivery of smoking cessation interventions. African Americans served as the moderator and assistant moderator for all focus groups. The participants completed informed consent and a demographic survey. Participants received a $25 gift card. Food and snacks were also provided.

Demographic surveys. Participants were asked to report personal characteristics, smoking-related characteristics, treatments used in quit attempt, and health provider involvement. Each measure is described in more detail as follows.

Participant characteristics. Personal characteristics included individual age, sex, highest level of education completed, employment status, marital status, household size, household monthly income, health status, and psychological and/or physical co-morbidities. Drawing upon prior research within a similar population of light smok-

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Box 1.

INTERVIEW SCHEDULE

1. What are your thoughts about taking care of your health?
2. Who has taught you what about taking care of your health in your community? (e.g., Media, Family, Friends, Church, Neighbors, Culture, Health Care System).
3. Why do you think you are more or less healthy than other groups of people?
4. How does your community (where you live) influence your health behavior?
5. Please tell me what group of people smoke more and why?
6. Why do you believe you smoke?
7. How much does smoking define who you are?
8. As a current smoker, how do you see your health in the future?
9. How would your health change if you quit smoking?
10. How is possible for a lifetime smoker to feel very confident that he or she can quit smoking?
11. What can help motivate a lifetime smoker to think about/attempt to quit who has no desire to stop smoking?
12. What can help a lifetime smoker who wants to quit/is trying to quit to be successful?

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ers,[29] demographic items queried smoking-related characteristics, including asking participants to report the number of times they had tried to quit smoking for at least 24 hours in the last year, how confident they were of their ability to quit and continue not to smoke using a 11-point scale, and how important quitting and continuing not to smoke was for them using a 11-point scale.

Type of treatment. Type of treatment to aid in previous quit attempt was assessed with 10 *yes* or *no* items: gum, patch, spray, inhaler, prescribed medication, clinic, helpline, one-on-one counseling, online services, or quit program.[29] There was an "other" option for participants to write in additional cessation aids used. These items were collapsed into three overarching categories: nicotine replacement therapy, prescribed cessation aid, and behavioral counseling.

Health provider involvement. Health provider involvement was measured with five *yes* or *no* items based on the 5 As:[23] asking about tobacco use, advising quitting, recommending a quit smoking product, suggesting a quit smoking program, and offering a follow-up visit. Participants were asked to use a modified four-point scale (*not at all* = 1 to *a lot* = 4) to report how much they trusted information from sources such as physicians, family or friends, community leaders, and media.[21]

Data analysis. All survey data were analyzed using PASW Statistics 18.[31] Descriptive statistics were generated for survey data. Means and standard deviations were used to describe continuous variables. Categorical variables were summarized by percentages. Chi-squared and independent t-tests were run to determine whether physician advice to quit, use of cessation aids, and trust in health information sources varied according to co-morbid condition, sex, and age.

All focus group audio-tapes (Box 1 Interview Schedule) were transcribed verbatim and inductively (i.e., no *a priori* categories or theory used to find meaning) coded using the long table method[30]—by hand with highlighters, paper transcripts, and index cards. To analyze focus group data an iterative process of constant comparison was applied across focus groups to statements made by the participants.[30] Two independent coders identified preliminary domains and major topics after thoroughly reading the transcripts. Once preliminary domains were established, the coders identified possible codes and recurrent themes within domains. Through weekly meetings with the principle investigator, the coders applied a refined list of codes to the content of statements within the transcripts. Any specific comment made by a single speaker was coded only the first time it occurred. If a different participant made the same point, or responded with agreement, the code was applied to that statement as well. Discrepancies were discussed and resolved in meetings with the principle investigator.

Results

Survey findings. Table 1 presents demographic characteristics of the study participants. A little more than half indicated their health in good status (61%). Co-morbidities included asthma, chronic obstructive pulmonary disease, high blood pressure, chronic kidney disease, hepatitis B, arthritis, and depression.

Table 2 presents smoking-related characteristics of the study participants.

A series of independent sample one-tailed t-tests revealed no significant difference between males and females, adults 25–45 and adults 46–65, and smokers with or without respiratory and heart problems for trusting information about quitting provided by physicians. A series of 2X2 chi-squared tests were employed to examine physician advice to quit as a function of co-morbidity. A significantly larger percentage of participants with a co-morbidity (100%) than without a co-morbidity (80.5%) were asked about tobacco use, $\chi^2(1, N = 57) = 3.63$, $p < .05$. In addition, a significantly larger percentage of participants with a co-morbidity (87.5%) than without a co-morbidity (61.5%) were advised to quit smoking, $\chi^2(1, N = 57) = 3.58$, $p < .05$. Although a larger percentage of participants with a co-morbidity (40%) than without a co-morbidity (17.1%) were offered a return visit, this difference fell short of statistical significance, $\chi^2(1, N = 57) = 3.24$, $p = .07$. A series of 2×2 chi-squared tests revealed no significant difference between males and females or adults 25–45 and adults 46–65 for physician advice to quit.

Qualitative results. Recurrent focus group themes emerged, including: (a) physician as information source; (b) cessation counseling; and (c) mistrust of physician prescribed pharmacotherapy. There were no significant differences between the perspectives of male and female or young and old smokers in the coding of the following themes.

Health provider as an information source. The majority of participants perceived physicians to be a trusted resource for health information, including quit information. One participant described their reliance on physician advice by saying: "When it comes to health, I leave it up to the doctor to tell me." Another participant reported: "I learned how to take care of my health by going to the doctor and picking up information there."

Unsatisfactory cessation counseling. Few participants reported their physicians' encouragement to quit, offering assistance, or arranging a follow-up visit. In addition,

Table 1.

CHARACTERISTICS OF SMOKERS (MINNEAPOLIS, MN, 2010)

Characteristic	N = 57
Age, year; mean (SD)	43(10.57)
Sex; percent	
Male	50.9%
Female	49.1%
Marital status	
Married and/or Cohabiting	26.3%
Divorced	8.8%
Separated	1.8%
Single	63.2%
Education	
< high school	28.1%
High school graduate and/or GED	40.4%
Some college and/or trade school	31.6%
Employment Status	
Employed	47.4%
Unemployed	52.6%
Household size	2.61(1.66)
Monthly household income level	
< 2,400	80.7%
> 2,400	19.3%
Health status	
Excellent	3.5%
Very good	10.5%
Good	61.4%
Fair	19.3%
Poor	5.3%
Self-reported psychological and/or physical co-morbid condition	
Yes	71.9%
No	28.1%

physicians did not address the underlying reasons for smoking or barriers to staying quit. Participants expressed their unsatisfactory experiences:

> I tried to quit four times this year. I went to my doctor, but the thing of it is I should have had just more of a boost [from the physician], instead of just trying to give me something go home and do it, it should have been like "Are you doing it?" How many did you smoke today, or something, just a little more help.

> Most of the time when I go to the doctor that's the first time they tell you is like do you smoke? You need to quit . . . Well, that's how most of the intake, you know, do

Table 2.

SMOKING-RELATED CHARACTERISTICS

Characteristic	N = 57
Cigarettes per day; mean (SD)	9.33 (4.79)
Minutes from waking to smoking	20.99 (23.49)
Quit attempt in past year; percent	
Yes	70.2%
No	29.8 %
No. of quit smoking attempts for at least 24 hours	3.13 (4.52)
Importance of quitting; (not important=0 to extremely important=10)	6.58 (3.50)
Confidence in quitting; (not confident= 0 to extremely confident=10)	6.18 (3.11)
Trust in health information sources; (not at all = 1 to a lot = 4)	
Physician advice to quit	3.29 (.92)
Family and friends	2.81 (.83)
Media	2.19 (.90)
Community leaders	3.26 (.90)
Health provider involvement	
Asked about tobacco use	86%
Advised quitting	69.1%
Recommended any product to help	47.4%
Suggested that you seek help	35.7%
Helped access quit smoking program	21.4%
Offered a return visit or phone call	23.2%
Treatments used in previous quit attempt	
Nicotine replacement pharmacotherapy	26.4%
Prescribed cessation aid	15.8%
Behavioral counseling	33.3%
Did not use treatment	24.5%

you smoke, you know? So you might not get a counseling session, you know what I mean? But you know, they just want the information that you're smoking.

So it's like for a doctor if I tell him I'm smoking and they don't try to give me a solution, are you interested in quitting? That's like something is not right with that.

The doctor didn't ever encourage me to quit or said that the smoking would aggravate the asthma, you know, and that I needed to stop smoking. The doctor never encouraged that.

Mistrust of physician prescribed pharmacotherapy. When physicians did offer assistance in the form of pharmacotherapy, their motives were questioned. Participants shared their skepticism:

And the doctors—I know for a fact are getting paid to—to not really keep you from stop smoking. I mean they'll—they'll—they'll say, uh, for the Nicorette gum. Well

if you give out 20 of these a month you'll get a paid vacation. So he's just worried about getting that off; he's not really worried about if you wanted to stop smoking. Most doctors, you know.

Most of the doctors that you go to now, they're asking you if you're smoking. They're giving out these lines. They're showing that they want to try to get you to stop smoking, but you know, with doctors, they're doing it for incentives for their sales; it's not really for the care of their patient.

Discussion

The results of this study provide an account of urban, low-income, African American light smokers' experiences and views toward cessation counseling (i.e., 5 As). Participants indicated community leaders as trustworthy resources for health information. However, physicians were rated as the most trustworthy resource. Participants reported relying on their physicians to monitor and keep them informed about all health-related issues, including smoking cessation. Physicians may not adhere to the 5 As counseling steps[27–28] according to participants and those who had smoking-related and other co-morbid medical conditions. "Healthy" and co-morbid light smokers reported not being recommended a cessation medication product, a quit smoking program, or offered a follow-up appointment.

Among participants who averaged three quit attempts there was frustration with physicians' lack of offering assistance and addressing barriers to staying quit. Participants wanted physicians to inquire about reasons for smoking, inability to stay quit, and to encourage them to quit, which are characteristics of a more patient-oriented perspective in 5 A counseling.[25] Participants also wanted to know more about the harms of smoking. Even though physicians were reported as the most trustworthy source of health information, there was a skepticism of physicians prescribing pharmacotherapy. The offer was viewed as more beneficial to the physician (in the form of kickbacks from company) than the patient. All these findings are consistent with other examinations of physician advice to quit in minority populations.[11–13,15,16,18]

The study has several limitations. It is based on self-report data where participants had to recall their experiences, which may diverge from the initial experience. The focus of the larger study was not primarily on cessation counseling but on smokers and personal health promotion. There is significant positive change in the clinical implementation of the 5 A counseling.[15] Compared with the 2005 National Health Interview Study (NHIS)[15] (which had a sample size of 685 African American smokers) the current small sample (N = 57) shows an increase in African Americans receiving advice to quit. This comparison should be observed with caution. First, if there were comparable numbers of participants in the current study, it might show percentages closer to those outlined in the NHIS 2005 study. Second, there were heavy smokers (10–20 CPD) and light smokers sampled across socioeconomic status in the NIHS. Third, the NHIS was sampled from across the United States to be generalizable. The current study has limited generalizability to other racial/ethnic minority groups due to the strict eligibility criteria and small sample size. Further, the absence of a comparison group prevents knowing if the findings are unique to urban, low-

income, African American light smokers. However, these findings do offer important insights into a population disproportionately affected by tobacco-related health disparities.

These findings extend prior research[14,17,18] and focus on a particular group of African Americans with severely limited resources, who are hard to reach, and likely to have multiple unsuccessful quit attempts. This research further identifies opportunities for improving the effectiveness of 5 As counseling among this group of light smokers, which can be useful and a cost-effective intervention in clinical practice.[32,33] In practice however, physicians may not always have time to counsel patients, have limited awareness of quit smoking resources for patient referral, and lack of knowledge of barriers to treatment.[34] Future studies should explore community and/or peer leaders training in implementing 5 As counseling services. Participants' willingness to quit and desire for more quit resources (especially those of African American light smokers with co-morbid conditions) emphasizes a need to develop community-based alternative strategies for 5 A counseling among urban, low-income, African American light smokers.

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