An Exploration of Latino Smokers and the Use of Pharmaceutical Aids

Arnold H. Levinson, PhD, Evelinn A. Borrayo, PhD, Paula Espinoza, PhD, Estevan T. Flores, PhD, Eliseo J. Pérez-Stable, MD

Background: Latino smokers are less likely than white non-Latino smokers to use nicotine replacement therapy (NRT) or bupropion when trying to quit smoking. The current study explored sociocultural and psychosocial factors related to nonuse of smoking-cessation medications among Latino smokers.

Methods: Structured discussions were held with six separate focus groups of current smokers (n = 49) who self-identified as Latino, had attempted to quit in the past 12 months, and were aged 35 to 64 years. Participants were recruited from Latino-serving health clinics, community events, and community organizations. Session recordings were transcribed, and content analysis was used to organize themes into categories.

Results: Six thematic categories emerged across most or all discussion groups: (1) smoking is a weakness rather than an illness, (2) pharmaceuticals are generally avoided, (3) NRT is mistrusted, (4) bupropion is widely rejected, (5) views are mixed regarding ethnic dimensions of smoking and quitting, and (6) misconceptions are common regarding smoking and cessation.

Conclusions: Cognitive reframing strategies should be developed and tested for Latino smokers who decline pharmacologic smoking-cessation assistance for reasons other than well-informed autonomous choice.

Introduction

Latinos in the United States who smoke are less likely than white non-Latino smokers to quit. Nicotine replacement therapy (NRT) and bupropion are standard treatments to help smokers quit. NRT increases cessation efficacy 1.5-fold to twofold, and bupropion increases efficacy twofold. However, Latinos who smoke are relatively unlikely to use pharmaceutical treatments when trying to quit smoking. In a large population sample from Colorado, low Latino use of NRT and bupropion was not explained by differences in income, healthcare access, physician cessation advice, smoking consumption levels, or health status.

An in-depth, qualitative study explored sociocultural attitudes that might influence Colorado Latino smokers to avoid medical treatments for smoking cessation. Specifically, these smokers might avoid cessation medications for any of several reasons: unawareness of efficacy, general reluctance to use medications, mistrust of medical products and personnel, suppression of health concerns, association of mental health stigma with smoking-cessation antidepressants, ambivalence in quit attempts, or devaluation of cessation aids compared to other wants. The findings are the subject of this report.

Methods

Design and Instruments

The study used one-time focused group discussions. The created script explored perceptions of smoking, illness, medications in general, and smoking-cessation medications in particular. The draft was pilot tested with several Latinos (current, former, and never-smokers) external to the study and revised based on their feedback. Core questions are presented in Table 1.
Table 1. Core discussion questions

| Would you say that addicted smoking is an illness, and if not, what would you say it is? ("Addicted smoking" previously defined as ≥10 cigarettes daily and withdrawal symptoms.) |
| When you have a head cold, what do you do about it? ... Do you crawl into bed until you feel better, or do you keep going to work, keep up your normal life? What do you personally feel is the best way to deal with illnesses that let you live a pretty normal life but don’t go away? (Previously defined and exemplified as chronic diabetes, hypertension, etc.) |
| Suppose you decide tomorrow that you’re going to try to quit smoking. How would you go about it? (Probe if necessary to elicit sociocultural views of nicotine replacement therapy.) |
| Does anyone know a person who used a nicotine product to try to quit smoking? (If yes, “What did they say about it?”) |
| (Repeat for bupropion.) |
| So if you decide again to try to quit smoking, would you spend your own money to use one of these cessation products? |
| These cessation products sound medical. Would you go to a doctor or health clinic for help to quit? |

Results

Participants

The sample included 49 middle-aged Latino smokers (26 women, 23 men) with previous quit attempts. All but two were U.S.-born English speakers with Mexican ancestry, and most were Colorado natives; one was Spanish and one was Peruvian. (Nativity and language have reliably represented acculturation in studies of smoking behavior among U.S. Latinos.) Roughly equal numbers of participants were recruited from blue-collar jobs, primary care clinics, and service centers for impoverished individuals; several participants reported alcohol dependence. Education, income, and specific smoking levels were not measured.

Thematic Categories

Most participants perceived smoking as a weakness, not an illness. Consistently across discussion groups, smoking was described as more of a character weakness and/or failure of will than an illness. To one participant, smoking was not an illness because “an illness is something you can treat with medicines.” To another, a “real illness” is heritable across generations, and smoking was seen as not heritable. One participant succinctly summarized the non-illness perspective: “I think that it’s a weakness, because I think we have a choice.”

Most avoid pharmaceutical medicines. “I don’t like to take medicine,” or “I just don’t like to take pills,” were typical comments. Participants were apprehensive about known and undiscovered side effects; some said they would interpret an unpleasant sensation as a signal to stop using a medicine. Many feared becoming dependent on medicinal treatments. Instead, participants said they usually “tough it out” when ill, or they use alternative therapies (e.g., chamomile tea, exercise).

Exceptions usually involved serious chronic or potentially fatal illnesses. “I think if you have a medical condition and need medication to keep it under control, like diabetes, high blood pressure, cholesterol, whatever it may be, I think it’s a good idea to take medication,” said one participant. Another said, “I went into a diabetic coma last Tuesday and was hospitalized, and was very close to dying. So I think I will take my medication.”

Most said NRT is unpleasant, does not work, or merely trades one addiction for another. Most respondents were aware of NRT from personal or hearsay experiences. Many had tried the patch, gum, lozenge, straw, or inhaler, often only briefly before rejecting it because of discomfort. Among more than 60 distinct mentions of NRT, most comments involved reports of unpleasant or worrisome side effects, ineffectiveness, or wariness of “trading addictions.” A few examples follow: “The patches got him nervous, and they made me sleepy.”

Procedures

A convenience sample of English-speaking Latino smokers was recruited in 2004, using a flyer that described the purpose of the study (“to learn what smoking means and how smokers try to quit”) and provided a partial list of eligibility criteria (Hispanic or Latino/a, currently smoking ten or more cigarettes daily), incentive information (light supper and $35 cash), and the availability of transportation and child care. Some eligibility criteria (aged 35 to 64, quit attempt in the previous 12 months) were withheld to protect against false presentation of eligibility. Flyers were posted and distributed at Latino community organizations, Latino-serving health clinics, and Latino-oriented events. Respondents were screened, and eligible participants were scheduled for a focused group session.

Six sessions were planned and implemented, each attended by an average of eight participants (range, 6 to 13). Sessions lasted 90 to 120 minutes. Before starting, each participant provided written informed consent using the form approved by the University of Colorado at Denver’s human subjects review board. Discussions were facilitated in English and were tape-recorded. Data were transcribed verbatim.

Analysis

Transcripts were organized using software for qualitative analysis (ATLAS.ti, Berlin, Germany). Content analysis techniques were used to code transcripts, identify emergent themes, and organize themes into categories. Six categories were developed, each of which was exhaustive (every instance was assigned to a category) and exclusive (every instance was assigned to only one category). The first author conducted the initial analysis, and other authors reviewed the transcripts, codes, themes, and categories. Agreement was reached on the final theme categories. Analysis was initiated in 2004 and completed in 2005.
They say it’s an antidepressant . . . and I don’t take
stigma attached to mental health problems.

The fear of unknown, and hearing all those side
effects, which I have heard of, would keep me away
from even trying the product.

Many knew about bupropion, but most rejected it.
Reasons for avoidance included a connotation of men-
tal illness, fear of side effects, general aversion to
medicine, or belief that willpower alone controls suc-
sessful cessation. Although discussions occasionally elicited longing for a “magic pill” to help with quitting,
aversion to bupropion seemed stronger than aversion
to NRT precisely because bupropion is a pill and thus
represents a more intensive pharmaceutical interven-
tion with greater risks. Also, several participants had
tried bupropion and declared it a failure. A few exam-
pies follow:

“I tried the patch, that didn’t work, then the doctor put
me on Wellbutrin® [bupropion] and that didn’t
help.”

“Also tried the Wellbutrin® and that didn’t do nothing
for me.”

“I don’t even want to try it at all, because I wouldn’t
even know what the effect it’s gonna have to my
system, my body.”

“I’ve heard about it, and I’ve also listened to the side
effects: nausea, diarrhea, I could go on, ten more:
high blood pressure, dizziness, don’t do it while
you’re driving, or if you’re at work.”

“The fear of unknown, and hearing all those side
effects, which I have heard of, would keep me away
from even trying the product.”

Concerns were also raised about bupropion as a
treatment for depression, prompting concerns about
stigma attached to mental health problems.

“They say it’s an antidepressant . . . and I don’t take
antidepressants, so I don’t take Zyban®
[bupropion].”

“That word [antidepressant]. Sounds like you’re
messed up in the head . . . I don’t think I’m a
depressed person . . . It’s labeling you as a—as a
what?—as a depressant. That scares a person. That’s
scary.”

In contrast, one participant reported a secondhand
“success” story, and a few expressed cautious interest in
trying bupropion.

“It would depend. I’d have to look more into it, I’d
need way more information, being that I know I saw
the commercial and you could have these side
effects.”

“Well, I knew a coworker that tried the Zyban® and
she’s no longer smoking. And she smoked for 45
years or something like that. So I think I would try
that.”

Views were mixed about whether smoking and quit-
ting have an ethnic dimension. Some participants
declared that smoking was a universal problem. Said one:
“Your a smoker. That labels you, as a smoker, whether
you’re white, brown, red . . .” Said another: “It seems
like we’re talking about the whole population in gen-
eral, not just the Hispanic people.” Some acknowl-
edged that financial barriers disproportionately affect
Latino smokers and may limit access to cessation pro-
grams and methods.

In contrast, a few respondents perceived ethnic di-
ensions to smoking and quitting. One woman said
that when she took up smoking as a teenager, she
viewed it as part of the defiance and social justice
orientation of the Chicano political movement: “I
thought that all came together, the strutting, the smok-
ing, as a young Chicana.” Another recounted a discus-
sion with a Chicano political activist who viewed pro-
motion of quitting as one more Anglo dictate of
propriety. A third respondent characterized medical
advice to quit as white because caregivers are white.

Misconceptions about smoking or cessation were
common. Roughly one fourth of participants expressed
a smoking-related knowledge gap. A number of gaps
involved false beliefs about cigarettes, including beliefs
that additives to tobacco cause people to smoke more
than they otherwise would, one cigarette is as harmful
as 20, chemicals in filters are the source of health harm,
harsher cigarettes are more harmful, nicotine is the
source of health harm, attachable filters remove the
health harm, and generic cigarettes are deadlier than
name brands. Several participants did not know that
prolonged use of NRT poses minimal risk. A few were
unaware that NRT and bupropion may be used concur-
rently. Some sample comments follow:

“They say the filters actually kill you . . . I don’t know.”

“[Nicotine] wouldn’t hurt you? Now that’s the part I
don’t know about. What is nicotine, where does it
come from?”

“When you smoke a cigarette, you don’t feel the tar or
whatever that’s coming out of the patch, going into
you.”

“One [cigarette] is as bad as 20 . . . I don’t know if that’s
true or not.”
“When you don’t have as much money, you start getting those generics that kill you.”
“I have little filters, they’re called TarGard, and I use those . . . because it would take the nicotine and the tar away from your cigarette.”

**Discussion**

Among a convenience sample of Colorado Latino smokers, most rejected the idea of medication for smoking cessation, because they feared and disliked medications generally and smoking-cessation medications specifically. NRT and bupropion elicited concerns about known or yet-to-be-discovered side effects, some unpleasant and others dangerous. NRT was often declared not to work, based on personal experience or hearsay. Bupropion was often rejected because of mental health stigma and resistance to using “pills” to treat smoking.

Many participants viewed smoking as a personality weakness more than a dependence, to feel that willpower alone determines success, and to perceive cessation medicines as a crutch or replacement addiction. These barriers might respond to information delivered in clinical settings, telephone counseling quitlines, websites, and public education efforts. The current findings support several initial hypotheses: reluctance to use medications, mistrust of pharmaceuticals, concern about the mental health connotations of antidepressants for smoking cessation, and skepticism of NRT efficacy. The findings did not support hypotheses that Latino smokers might downplay health concerns, feel ambivalent in quit attempts, or choose other discretionary purchases over cessation medications.

Numerous studies have shown that smoking-cessation intervention strategies must be population sensitive, and that tobacco-related attitudes and behaviors are often culture-specific. The current findings might apply to acculturated, English-speaking Latinos of Mexican ancestry. Acculturation seems likely to play a role in smoking cessation and willingness to use pharmacotherapy, but the relationship has not been well studied. Previous research has found acculturation to be an important predictor of smoking-cessation behavior, although Latinos held similar attitudes and beliefs about smoking, independent of acculturation level.

Belief that quitting requires unassisted willpower has been found among other groups including adolescents and Appalachian smokers (Levinson, unpublished data). Overemphasis on unassisted willpower may lead to rejection of medicinal help, even though medicines can reduce dependence motivations that undermine willpower to quit. Cognitive reframing might clarify, for example, that willpower is not dichotomous, that nicotine alone is not harmful while cigarettes are deadly, and that willpower can be strengthened gradually through regular exercise. Use of the Hooked on Nicotine Checklist (HONC) might help patients consider the value of medication and counseling as useful, temporary tools for recovery.

Cognitive-reframing strategies ought to be culturally resonant. Acceptance might be enhanced among Latino smokers if messages resonate with strong cultural values such as familismo (embracing family as central in life), collectivismo (strong sense of social interdependence), simpatia (congeniality orientation), personalismo (preference for personal interactions), and respeto (deference and respect for authority figures).

The current findings have some limitations: They represent qualitative exploration among a convenience sample of highly acculturated, English-speaking Latino participants. Cessation issues may differ significantly among predominantly Spanish-speaking smokers. For instance, less-acculturated Latino smokers tend to be lighter smokers; hence, these smokers and their clinicians may perceive the use of pharmacologic cessation aids as less important.

In conclusion, this exploratory study identified six potential barriers that limit the use of pharmacologic aids among Colorado Latino smokers. The use of medications to treat nicotine dependence and facilitate withdrawal is not an accepted construct among these Latino smokers. Clinicians may need to address this directly, and public health education campaigns may be helpful. Further research is needed to help physicians counsel Latino patients in the use of pharmacologic assistance to quit smoking, and to explore culturally competent ways to integrate clinical support for smoking cessation with telephone and Internet support among Latino smokers.

This research was supported by two grants from the National Cancer Institute: Special Populations Network (award U01CA86106), and Redes En Acción (award U01CA86117).

No financial conflict of interest was reported by the authors of this paper.

**References**