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Short Communication

Targeting cessation: Understanding barriers and motivations to quitting among urban adult daily tobacco smokers☆

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HIGHLIGHTS

- Examines barriers and motivations to quit smoking in high prevalence urban sample.
- The smoking rate in the sample was almost double the national average.
- Intrapersonal, financial, social support, and social influence concerns are key.
- Gender, race, education, and age differences exist in barriers and motivations.
- Findings can be used to tailor cessation programs to particular groups.

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ABSTRACT

Introduction: Many people continue to smoke tobacco products despite known negative health consequences, including increased risk of chronic disease and death. Disparities exist in rates of smoking and chronic disease, underscoring the importance of understanding the barriers and motivations to smoking cessation among vulnerable populations, such as socioeconomically disadvantaged people of color.
Methods: This study uses data from a cross-sectional randomized household survey conducted in six low-income neighborhoods in New Haven, Connecticut, USA ($N = 1205$). The objectives were to examine barriers and motivations to quitting smoking among daily tobacco smokers (31.6% of respondents) and sociodemographic differences in endorsement of barriers and motivations.
Results: The two most common barriers to quitting were perceiving it to be too difficult and not wanting to quit. Financial costs, social support, and social influence were themes endorsed highly across both barriers and motivations to quitting. Sociodemographic differences were found, such as women and Black participants being more likely to be interested in a free quitline or quit website; women and Latinos being more likely to be afraid of gaining weight; and women, participants with less education, and older participants being more likely to be concerned about the cost of cessation products.
Conclusions: Understanding barriers and motivations to quitting among disadvantaged populations is crucial. Financial issues, social support, and social norms should be targeted in promoting cessation among disadvantaged, urban populations. Programs, interventions, and policies can also use research about specific barriers and motivations for sociodemographic sub-groups to be tailored, targeted, and more effective.

1. Introduction

Smoking tobacco products increases risk of chronic diseases and is responsible for over 440,000 deaths a year in the U.S. (King, Dube, Kaufmann, Shaw, & Pechacek, 2011). Yet, in 2010 approximately 19% of people in the U.S. smoked cigarettes, including 15% daily (King et al., 2011). While rates of smoking have decreased in the U.S. overall (up until 2007), disparities exist, with persistently higher rates in inner-city, disadvantaged communities, and among lower socioeconomic status individuals (based on income and education; Pleis, Ward, & Lucas, 2010). Smoking disparities contribute to health

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disparities, such as in chronic disease rates (Reid, Hammond, Boudreau, Fong, & Siahpush, 2010). High smoking and low quitting rates among disadvantaged populations (e.g., young, low-income, Black Americans) are concerning (Stillman et al., 2007). Prevalence of smoking in Black Americans and those living below the poverty line, for example, did not decline from 2005 to 2010 although it did for other groups in the U.S. (King et al., 2011). Research and interventions are not sufficiently addressing unique factors driving smoking and quitting among disadvantaged communities, where high rates of tobacco use continue and social norms may support smoking (Stillman et al., 2007).

Research on barriers and motivations to quitting helps inform more successful cessation interventions. In a study of socioeconomically diverse, mostly White adult smokers in Tennessee, the most commonly reported motivation to quitting was to improve their health, and common reported worries about quitting were stress and weight gain, highlighting the importance of intrapersonal (self-oriented) motivations and barriers (Guirguis et al., 2010). In a study of young, urban, Black Americans in Baltimore, Maryland, environmental factors were key barriers to quitting, including perceptions that everyone smokes, easy access to buying cigarettes in one's neighborhood, and exposure to cigarette marketing, highlighting the influence of social context and norms in high-prevalence areas (Smith et al., 2009; Stillman et al., 2007). Women are more likely than men to worry about gaining weight and not having effective social support as barriers to quitting, highlighting the importance of support (Rahmanian, Diaz, & Wewers, 2011; Torchalla, Okoli, Hemsing, & Greaves, 2011). In a study of smokers in Louisiana, men were more likely than women, and Black participants more likely than White participants, to believe smokers should quit on their own without a program, highlighting challenges to gaining interest in cessation programs (Copeland et al., 2010).

There have been calls for further examination of sociodemographic differences in smoking, and quitting barriers and motivations, to help create interventions tailored for particular groups (McKee, O'Malley, Salovey, Krishnan-Sarin, & Mazure, 2005; Torchalla et al., 2011). Groups with higher smoking rates are least represented in cessation programs and have unique barriers to quitting that need to be better understood to tailor programs and policies and eliminate disparities (Copeland et al., 2010). The current investigation included urban, low-income, mostly Black and Latino adult daily smokers living in New Haven, Connecticut, a sample at increased risk of chronic disease and living in a high smoking prevalence area. Aims were to identify: (1) the most endorsed barriers and motivations to quitting; (2) sociodemographic differences in endorsement of barriers and motivations.

2. Methods

2.1. Procedure

Data are from a health survey conducted in six low-income neighborhoods in New Haven, Connecticut in fall of 2009. The survey contained questions about various health topics, including diet and exercise, tobacco and alcohol use, and chronic disease. Trained interviewers from the community administered the survey in English and Spanish, and collected data via handheld computers. Households were randomly selected from a complete addresses list, and interviewers went door to door. Participants received a $10 grocery store voucher and were entered into a $500 raffle.

2.2. Measures

2.2.1. Sociodemographic characteristics and smoking

Participants reported gender, race/ethnicity, educational attainment, age, and whether they currently smoke tobacco products at all and daily (Duffany et al., 2011; World Health Organization, 2008; see Table 1).

Table 1
Sociodemographic Characteristics of Daily Smokers in Final Analytic Sample ($N = 350$), Community Interventions for Health, New Haven, CT, 2009.

Race, % (n)	
Black	66.0% (231)
Latino	20.9% (73)
White	13.1% (46)
Gender, % (n)	
Female	57.7% (202)
Male	42.3% (148)
Education, % (n)	
H.S. diploma/GED or less	66.3% (232)
Some college or more	33.7% (118)
Age, mean (standard deviation)	39.87 (12.8)
Average number cigarettes smoked per day, mean (standard deviation)	10.15 (7.28)

2.2.2. Barriers and motivations to quitting

Smokers responded Yes or No to seven barriers and seven motivations to quitting (see Table 2). Participants could indicate another barrier and/or motivation. Barriers and motivations were based on the Community Interventions for Health survey (Duffany et al., 2011), capturing themes of intrapersonal, financial, social support, and social influence barriers, as well as financial, social support, social influence, and smoking cessation program (telephone quitline and website) motivations.

2.3. Participants

Surveys were conducted with 1205 adult participants (73% participation; 61% women; aged 18–65). Participants were racially/ethnically diverse (61% Black, 20% Latino, 12% White, 3% Multi-racial, 1% Asian/Pacific Islander, 1% American Indian/ Alaska Native, 1% refused). Fifty-six percent had a High School diploma/GED or less. Tobacco products were smoked sometimes by 35.9%, and daily by 31.6%. Analyses were restricted to Black, Latino, or White participants because of the small numbers for other groups and interest in testing race/ethnicity as a predictor (excluding 83, of which 9 identified as both Black and Latino). Because of interest in gender, education, and age as predictors, analyses included only those who answered those questions (excluding 10). We further restricted the sample to those reporting daily cigarette smoking because of the small number of non-daily smokers or those reporting other tobacco use (excluding 714 non-smokers and 48 non-daily smokers), leaving an analytic sample of 350. Table 1 contains sociodemographic characteristics. Consistent with previous studies and national trends (Pleis et al., 2010), lower educational attainment predicted greater likelihood of daily smoking among the larger sample. There were no other differences between daily smokers and those excluded from analyses because of being non-smokers or non-daily smokers.

3. Results

3.1. Overall endorsement of barriers and motivations

First, we examined percentages of daily smokers endorsing each barrier and motivation (see Table 2). The most endorsed barriers were intrapersonal: “It is too difficult” and “I don't want to quit.” The most endorsed motivations were financial and social support: “Saving the money spent on tobacco products” and “A doctor who would provide support and encouragement.” Across barriers and motivations, items capturing themes of financial concerns (cost of tobacco products, medication and nicotine replacement products), social support (from doctors, friends, and family), and social norms (everyone one knows using tobacco, and not being able to smoke in many places) were highly endorsed. Twenty-six daily smokers listed other barriers, the most common being stress. Forty-five daily smokers listed other motivations, the most common being one's own health, and children/grandchildren.