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Self-stigma, Stress, and Smoking among African American and American Indian Female Smokers: An Exploratory Qualitative Study

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Abstract

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Keywords

Adjustment (Psychology); Affect; African Americans – Tobacco use; American Indian; Indians of North America – Tobacco use; Self-perception; Smoking; Stress (Psychology); Tobacco; Women – Tobacco use

Cover Page Footnote

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ABSTRACT

Research suggests that negative emotions and difficulty coping with stressful events might impede women's ability to quit smoking. This study uses qualitative methods to explore interrelationships between smoking behavior and negative emotions among a sample of racial/ethnic minority female smokers with the aims of theory-building and hypothesis generation. Data were derived from a larger study involving sixteen focus groups with current and former smokers from ethnic minority communities. The present study consisted of three focus groups of female African American and American Indian smokers (N = 16). Data was analyzed following standard methods for in vivo coding of qualitative data. Consistent with prior research, participants reported using smoking as a tool to cope with stress and negative emotions. Deprivation from smoking was associated with negative states such as anger, irritability, and distress. However, continued smoking was also a source of negative emotion, as women felt shame, guilt and low self-esteem over their inability to quit, which was perceived by some as indicative of weakness. These negative self-perceptions are consistent with stigmatized views of smokers held by the public. Women also expressed feelings of defiance about their smoking despite pressure to quit and identified external factors which contributed to their inability to quit. The negative emotions, self-stigma and shame experienced by low income American Indian and African American women smokers may contribute to continued smoking and disrupt quit attempts. Additional research is needed in order to develop effective tobacco cessation interventions for this group.

Key words: Smoking, tobacco, women, affect, African American, American Indian

There has been growing attention to the contribution of psychosocial stress and negative affect to women's smoking and quitting behaviors. Women are more likely than men to experience negative affect and affective disorders (Kessler et al., 2005), which are related to smoking dependence and inversely related to successful quitting (Glassman et al., 1990; Paperwalla, Levin, Weiner, & Saravay, 2004). Moreover, the association between affective disorders and smoking, nicotine withdrawal, and smoking cessation relapse is greater for women than for men (Husky, Mazure, Paliwal, & McKee, 2008; McKee, Maciejewski, Falba, & Mazure, 2003; Weinberger, Maciejewski, McKee, Reutenauer, & Mazure, 2009). Likewise, stress has been shown to have a greater effect on continued smoking and failure to quit among women than men (McKee, et al., 2003) and women are more likely than men to report smoking to cope with negative affect and stress (Livson & Leino, 1988). Additionally, women have been shown to experience greater negative affect due to tobacco withdrawal as well as a greater desire to smoke to alleviate such negative affect, compared with men (Leventhal et al., 2007).

Psychological stress and negative affect are likely to play a particularly critical role in smoking among low income women and women from certain racial/ethnic minority groups, such as African American and American Indian women, who have been shown to have greater difficulty quitting smoking and demonstrate a lower response to traditional smoking cessation programs than higher income and white women (CDC, 2002; King, Borrelli, Black, Pinto, & Marcus, 1997; Lawrence, Graber, Mills, Meissner, & Warnecke, 2003; Prevention, 2005). It has been theorized that individual in low income environments experience high levels of chronic stress, which reduces their capacity to effectively cope with additional stressors, and makes them more vulnerable to negative emotions, cognitions, and unhealthy coping behaviors such as smoking (Gallo & Matthews, 2003; Hatch & Dohrenwend, 2007). Members of ethnic minority groups also are more likely than their white counterparts to experience discrimination, harassment, or negative treatment based their ethnic status, which has been associated with higher rates of negative affect and affective disorders (Whitbeck, McMorris, Hoyt, Stubben, & Lafromboise, 2002; Williams & Mohammed, 2008; Williams, Neighbors, & Jackson, 2003) as well as greater rates of smoking (Guthrie, Young, Williams, Boyd, & Kintner, 2002; Landrine & Klonoff, 2000).

In this paper, we present a subset of focus group results pertaining to stress, negative emotions, and smoking behavior among a sample of urban African American and American Indian smokers. American Indians have the highest rates of smoking and mortality rates from smoking-related illnesses (Davis, Helgerson, & Waller, 1992; Doshi & Jiles, 2006) and American Indian women experience greater rates of anxiety disorders and depression compared to women from all other ethnic groups (Duran et al., 2004). Although African American women smoke at lower rates than white women (16% versus 25%) (CDC, 2008), it is also the case that these racial differences are due to lower rates of smoking among African American teenagers and young adults, which converged or reversed during the 1930s and 1940s, due to greater cessation among whites (Pampel, 2008). Moreover, although African American women generally experience lower levels of affective disorders than their white counterparts after controlling for sociodemographic factors (Dunlop, Song, Lyons, Manheim, & Chang, 2003), there is some evidence that the effect of depression and stress on smoking may be stronger among African American women (Ludman et al., 2002). In addition, African American women are more likely to be lower income, which is associated with higher rates of smoking, lower rates of quitting, and higher levels of affective disorders and life stressors (Barbeau, Krieger, & Soobader, 2004; Dunlop, et al., 2003; Hatch & Dohrenwend, 2007). For these reasons, an understanding of the interrelationships among negative affect, stress, and smoking among American Indian and African American women is of great public health importance.

METHODS

This study uses a subsample of data from a larger study, the Perspectives of Ethnic Minority Smokers (POEMS) project, involving 16 focus groups of current and former male and female smokers (N = 95) from the Minneapolis/St. Paul metropolitan area who self-identified as African American, American Indian, Vietnamese American (male only), and Hmong. Groups were homogenous with respect to ethnicity, gender, and smoking status (Morgan, 1993). This analysis uses data from three focus groups of women who were currently smoking (N = 16). Two groups consisted of African American women (N = 10) and one group consisted of American Indian women (N = 6). We did not include the remaining group of female smokers, who were comprised of women who identified as Hmong, because no one in this group mentioned issues related to motherhood.

Participants in the POEMS project were recruited for participation through community organizations. Potential participants were told the purpose of the focus groups was to explore people's reasons for smoking cigarettes and to learn how to help those who are interested in quitting. The moderators followed a 10-item discussion guide that focused on smoking, smoking cessation, and help with quitting smoking. Each session was audiotaped and lasted about 90 minutes. Focus groups were stratified by race/ethnicity, gender, and smoking status (current versus former). Detailed methods for the conduct of these focus groups have previously been described (D. Burgess et al., 2007; Fu et al., 2007). This study was approved by the Institutional Review Board at the University of Minnesota and the Minneapolis Veterans Affairs Medical Center.

For the first stage of analysis, typed transcriptions of each audiotape were prepared and checked for accuracy. Following standard methods for in vivo coding of qualitative data (Patton, 2002), three reviewers independently reviewed the typed transcriptions and identified for indigenous themes and content coded similar statements into major thematic categories, using the qualitative data analysis software program ATLAS.ti (ATLAS.ti, 2004). Discrepancies were resolved by consensus in collaboration with members of the research team. In the second stage, members of the research team identified larger patterns that emerged from the data and drew linkages among individual themes, resulting in the identification of key findings and the generation of several hypotheses, discussed below (Knodel, 1993; Renner et al., 2004; Webb & Kevern, 2001)

RESULTS

A range of themes emerged from the overall analysis. In this paper we identified four major themes pertaining to stress, smoking, and negative cognitions related to smoking behavior.

1. Smoking as a tool to cope with stress and negative emotions

An overriding theme was the use of smoking as a tool to cope with the myriad stressors faced by members of their communities.

> You've got a kid who's going down to juvenile center every other week, you got a daughter trying to stop her from getting pregnant, the man has run off, come on now. So this woman is sitting here by herself trying to make all these things work, you want a cigarette. And it's like you really don't have the real health lifestyle individually that you should have because more is put on you than what should be. There's too much on a Black woman in general… And so she doesn't have the heart or the real feelings to say somebody care about me really because everybody is sucking her dry a lot… So they're just like stuck and if they don't break away from that environmental stuck they go down and cigarettes and you get the blood pressure thing, you got the diabetic stuff, you got the drug stuff because that's a part of black culture. –African American female smoker

A major source of stress for these women was associated with childcare. One African American woman said that her children are "… constantly coming up to me and 'ma, when are you going to quit smoking? When you going to quit smoking?' [and I think] 'When you are grown and out of my house.'" Likewise, an American Indian woman explained that when she smokes, she does not hear "mom, mom, mom" and another African American woman described how smoking kept her calm in the face of her children's demands.

> It just keeps me balanced. Instead of lashing out at my kids, I could smoke a cigarette and calm down for twenty minutes and be able to talk to them rationally instead of just yelling at them and getting upset and then talking to them. It's my, it's like a safety net so to speak…"

In addition to children, other sources of stress that triggered smoking were pressure from jobs, boredom, the death of parents, and breakups or divorces from spouses.

Given these stressful circumstances, smoking was seen by some as one of their few sources of pleasure. An African American participant explained, "It's about giving yourself something sometimes" and an American Indian participant explained how, after giving up drugs and alcohol, she did not want to give up smoking too.

2. Negative emotions associated with actual or anticipated deprivation from smoking

Anticipated deprivation as well as actual deprivation from smoking—either due to a deliberate quit attempt or to the inability to obtain cigarettes—was associated with negative emotions and cognitions such as anger, irritability, distress, and fear. For instance, an American Indian participant described how, when she needs a cigarette, she gets desperate and "crabby and I'll even…pick fights for a cigarette." The group discussed people they knew who became difficult and angry when they were trying to quit, although they acknowledged that this was not true of everyone. An American Indian participant said that the idea of quitting was "really scary for me. I don't know what I'd do without my cigarettes."

3. Smoking as sources of self-stigma and negative emotions

Although smoking was seen as a tool for coping with negative moods and stressful situations, women's continued smoking and failure to quit successfully was also a source of guilt and shame. An American Indian woman said, "Sometimes I feel ashamed of my smoking like when my kids' friends are over I'll hide all my cigarettes and my ashtrays or if I'm out in public I don't want to smoke when there's a lot of people walking by and stuff."

Much of the guilt and shame was associated with women's role as mothers. Participants were aware of the harmful effects of second hand smoke on their children, and some were told by their pediatricians how smoking around their children was hurting their children's health. The following comment by an American Indian smoker illustrates the shame she felt in not being able to quit, despite her knowledge that her smoking was hurting her baby and angering her daughter.

> Yeah, until I take my shower and then I can smell it coming right out of my pores and you know it's in my clothes, my daughter would get mad because her hair would smell like smoke and she'll be with me just a brief moment you know and she's like there every physical and stuff that he (the baby) has that the doctor doesn't want smoking around that baby. He can walk down, come over by me or he'll crawl you know. It's like I won't give it up for him like I feel like I don't love him enough to do that for him. But it's like, it feels like I'm a failure and I can't.

Children, who were aware of the health risks of smoking, also pressured their mothers to quit and expressed fears that their mothers might die. An American Indian women explained how her son "… actually makes me promise, I have promised and broken couple of them to quit smoking just because he wants me to be alive… He doesn't want me to die because it's like into their heads these little ones that smoking is so bad it's going to kill you and everything."

Several women saw their inability to quit smoking as indicative of weakness, selfishness, and stupidity—particularly in the light of their own acknowledgment of the many disadvantages and harms of smoking. This theme is illustrated by the following conversation among several African American participants, in which they lamented their continued smoking despite the high price of cigarettes.

> R: there's goes my bills… The things I could have, there goes a bottle of cologne I had, I just bought two packs….Something I could have gave somebody. This is a selfish thing also. This is a very expensive habit. This is a death habit. This is a stinky habit. Why do I do this?...
> R: Why do I have that? It's not very smart.
> R: And I say the same thing, it's nasty, it stinks, it has my clothes stinking. I got a brand new car. I've had my car almost two years and it smells like smoke.
> R: My kids say that, oh your car, it's terrible…
> R: I sat down one time and just kind of added how much money I spend a month, a year on cigarettes… And I wanted to cry.

Later, in the group, a few women discussed how their inability to quit reflected lack of strength.

> R: I think any time you want to do something you really don't have the positive initiative to just say, "Hey, you know my momma's a strong-willed woman." Back in the days I knew when I said stop, it's a done deal… If I'm going to do it, I'm going to do it, if I'm not, I'm not. Nowadays we have all this technology, pleasure, comfort, and dollars. We ain't got to worry about a thing.
> R: Oh yeah, all that comfort from it.
> R: There's too much out there so then you said "I don't think I could do it" because our minds are not as strong as back in day. We don't have the same constitution. We don't have the same stuff going on. It's a different way.
> R: You can't help.
> R: It's a different way of lie.
> R: They can't give you drugs or tell you stop.
> R: Quit smoking.
> R: But see it's a mind thing.

This conversation underscores a shared belief, held among these women, that the ability to quit smoking is internally located, residing in a person's own willpower.

4. Defiance and resistance

Women also expressed feelings of defiance about their smoking despite pressure to quit and identified external factors, including those linked to race and disadvantage, which contributed to their inability to quit. This is illustrated by an American Indian woman who explained why she continued to smoke, despite her children's objections.

> My kids hate it and I've never smoked outside my house because I think this is my house, I pay the bills so I can smoke in here but it comes down to do I love my kids enough. I'm doing this in front of them and they're telling me that they hate the smell of it and they run away I'm smoking, you know? It's just stubbornness too. But I love my kids.

Another example of defiance comes from an African American mother who justified her smoking to the moderator: "And you're (referring to the moderator) not going to win because my son has asthma so I don't smoke in the house."

Likewise, in the conversation among African American women (depicted above) in which failure to quit was described as a sign of low self-esteem, one woman dissented, describing herself as high in self-esteem and arguing that she smoked out of addiction rather than out of stress and weakness. Both African American and American Indian women also pointed to external factors that kept them smoking such as triggers in the environment, nicotine that keeps them "craving" cigarettes, and withdrawal symptoms such as sickness, headaches, tremors, mood swings and anger. Along these lines, the discussion of smoking as a means to cope with stress—including stressors associated with motherhood-- can also be seen as a way for the women in these groups to protect themselves from the "spoiled identities" associated with their status as smokers.

DISCUSSION

This exploratory study provides insight and generates hypotheses related to stress, negative emotions and cognitions, and smoking behavior among minority women. Consistent with other studies of female smokers from socially disadvantaged groups, women perceived smoking as a tool that they and other women in their communities relied upon to cope with negative emotions and handle daily stresses, including stresses associated with motherhood (Beech & Scarinci, 2003; MacAskill, Stead, MacKintosh, & Hastings, 2002; Pletsch, Morgan, & Pieper, 2003; Stead, MacAskill, MacKintosh, Reece, & Eadie, 2001). Deprivation of cigarettes, by contrast, led to anger and irritability directed toward others, including their children. Moreover, the prospect of not smoking was scary, as women anticipated the negative consequences of deprivation and the loss of an important coping tool.

However, while smoking was perceived as something that could alleviate negative emotions, it became apparent that smoking was also a source of negative emotions and cognitions. Women viewed themselves as unintelligent, weak, and selfish and felt guilt and shame, due to their inability to quit, particularly given their awareness about the negative consequences of their smoking on themselves and their children. Notably, these negative self-perceptions are consistent with the negative stereotypes of smokers that are becoming increasingly pervasive in U.S. society, and the particular animosity toward mothers who smoke. (D. J. Burgess, Fu, & van Ryn, 2009). Indeed, smoking by mothers contradicts contemporary discourses that state that mothers should place their children first and avoid doing anything potentially harmful, lest they be viewed as "bad mothers" (Farrimond & Joffe, 2006; Irwin, Johnson, & Bottorff, 2005; Oaks, 2000). These findings led us to hypothesize that women in our study may have internalized negative stereotypes of smokers-- a process known as "self-stigmatization" (Crocker, Major, & Steel, 1998).

Although stigmatization is traditionally seen as negative, in the area of tobacco control, aspects of stigma have been viewed as a positive force in the effort to de-normalize and reduce the prevalence of smoking (Bayer & Stuber, 2006). From that perspective, it can be seen as problematic that, in a recent study, African Americans and those with less education perceived less smoker-related

stigma than respondents who were European American or had greater education (Stuber, Galea, & Link, 2008). The lesser stigma might be one reason for the differential in how socially unacceptable smoking is across different groups. One might therefore posit that an increase in the stigma of smoking among African American and American Indian women could lead to more quit attempts and greater success at quitting in these populations.

Nonetheless, this study raises the issue about whether failing to quit smoking might lead to negative emotional and physical consequences as a result of self-stigmatization. Research on a variety of social stigmas (e.g., race/ethnicity, obesity, minority sexual orientation, AIDS, mental illness, chronic bowel disease) has shown that stigmatization is a correlate of chronic stress, resulting in damage to the immune system, inflammatory disorders, cardiovascular disease, as well as mental health disorders (e.g., depression, anxiety, psychological distress), cognitive impairment, and health-related quality of life (Mak, Poon, Pun, & Cheung, 2007; Mays, Cochran, & Barnes, 2007; Taft, Keefer, Leonhard, & Nealon-Woods, 2009; Williams & Mohammed, 2009; Williams, et al., 2003). One might hypothesize, then, that stigmatization could hinder quitting through negative affect and affective disorders that result from stigmatization. Additionally, numerous studies have shown that, for members of stigmatized groups, situations that trigger expectations or concerns that one will be stigmatized, impair performance (Nguyen & Ryan, 2008) and diminish self-regulatory processes (Inzlicht, McKay, & Aronson, 2006) that are a critical part of making changes in one's health behavior, including but not limited to smoking. Among the overweight, stigmatization has been associated with higher BMI and over-eating as a coping response (Puhl & Brownell, 2006; Puhl, Moss-Racusin, & Schwartz), and overweight women who endorsed negative weight-based stereotypes were also more likely to engage in binge eating and to be less successful at weight loss (Puhl, et al., 2007). Taken together, these studies suggest that smoking, like other unhealthy behaviors, may be maintained in part through the effects of stigmatization.

This study also captured expressions of defiance among smokers, which may have been an attempt by participants to resist self-stigmatization and protect their self-image (Crocker, et al., 1998). Specifically, several women in the groups were defiant about their continued smoking, despite pressure to quit from their children and health professionals, and justified their smoking as necessary or acceptable, particularly in light of their responsibilities. This defiance may counteract any benefit that could be gained from stigma if it strengthens smokers' resistance to quitting.

Participants also identified external forces that hindered their ability to quit, such as addiction, cravings, stress and environmental "triggers" as well as "targeted marketing" by the tobacco industry. Attributing negative behaviors to external forces has been shown to be one way in which members of stigmatized groups protect their self-esteem (Crocker & Wolfe, 2001). If women smokers in these focus groups did feel stigmatized as a result of their smoking status, a public identification of external forces that hinder cessation can be seen as a form of impression management—a way to "save face" and restore a "spoiled identity" (Coxhead & Rhodes, 2006; Goffman, 1963).

There are several limitations to this study. First, it is unclear as to the extent to which negative self-views expressed about one's smoking behavior were made salient by the purpose of the focus groups, which was to discuss experiences related to smoking and quitting. Such views may be less likely to be activated in these smokers' communities in which they perceived smoking to be quite common (Fu, et al., 2007). Nonetheless, these negative reactions are likely to reflect how these smokers feel in situations in which they feel pressured to quit (e.g., by their children, by healthcare providers). In addition, the findings may have limited generalizability to other minority communities because participants were not randomly selected from the general population of American Indian and African American, but were recruited through community organizations. It is also important

to stress that these findings are descriptive, given the qualitative nature of focus group analysis, and that the total sample size of this analysis (N = 16) is small. Hence, this study should be viewed as exploratory, as a way of generating hypotheses to be tested more rigorously in future studies. Nonetheless, the in-depth conversation afforded by these three focus groups provides additional insight into the experiences of two under-studied groups of smokers (i.e., disadvantaged African American and American Indian women), and conveys the range of emotional experience that is not always captured by traditional quantitative survey methods.

An additional limitation is that we did we did not collect quantitative information on our interviewees, such as their age and whether they had children. Because issues of motherhood and smoking were not the intended focus of this project, we did not design this study to facilitate exploration of this topic (e.g., we did not create groups based on maternal status, or age of children). Future studies designed to specifically address the role of motherhood, race/ethnicity, and social disadvantage on attitudes and behaviors related to smoking and cessation should use more purposive sampling strategies to examine these issues more systematically.

One hypothesis that flows from this study is whether anti-smoking messages aimed at minority women might be more effective if they were designed to minimize the activation of negative emotions and instead elicit positive emotions and motivation. This might be accomplished by employing a "challenge" format that focuses on the benefits of quitting smoking (e.g., physical and emotional well being) rather than "stigma" format that depicts the smoker as a problem, activates feelings of threat, shame, disgust, and blame toward the smoker; and promotes social exclusion and avoidance of the smoker (Smith, 2007).

This study also points to a dilemma faced by low income, minority women: Many of the factors contributing to their smoking are a function of circumstances outside their control (e.g., targeting by the tobacco industry, financial hardship, physiological effects of nicotine), yet the prevalent health discourse blames the individual smoker for her habit (D. J. Burgess, et al., 2009). It is important that programs help address this "bind" voiced by mothers who feel guilty about smoking around their children but who view smoking as an important tool for coping with difficult circumstances (including the stresses of parenting) (Bottorff, Johnson, Irwin, & Ratner, 2000; Coxhead & Rhodes, 2006; Irwin, et al., 2005; Stead, et al., 2001). This might include helping mothers find alternative strategies to manage negative emotions and nurture themselves during and following quit attempts, such as culturally tailored social support interventions and interventions emphasizing spiritual well-being (Andrews, Felton, Ellen Wewers, Waller, & Tingen, 2007) as well as identifying and reinforcing smaller ways in which women can significantly reduce their children's and their own exposure to cigarette smoke, such as implementing home smoking bans and reducing (rather than completely curtailing) their own smoking behavior.

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