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Focus Groups of Alaska Native Adolescent Tobacco Users: Preferences for Tobacco Cessation Interventions and Barriers to Participation

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Abstract

Tobacco cessation interventions developed for Alaska Native adolescents do not exist. This study employed focus group methodology to explore preferences for tobacco cessation interventions and barriers to participation among 49 Alaska Natives (61% female) with a mean age of 14.6 ($SD = 1.6$) who resided in western Alaska. Using content analysis, themes from the 12 focus groups were found to be consistent across village, gender, and age groups. Program location or site (e.g., away from the village, hunting, fishing), a group-based format, and inclusion of medication and personal stories were reported to be important attributes of cessation programs. Motivators to quit tobacco were the perceived adverse health effects of tobacco, improved self-image and appearance, and the potential to be a future role model as a non-tobacco user for family and friends. Parents were perceived as potentially supportive to the adolescent in quitting tobacco. The findings will be used to develop tobacco cessation programs for Alaska Native youth.

Keywords

tobacco use; tobacco cessation; intervention; adolescents; Alaska Native; focus groups

The prevalence of cigarette smoking among youth ages 12 to 17 in the United States is currently highest among American Indians and Alaska Natives (28%), compared with Whites (16%), Hawaiians or other Pacific Islanders (11%), and Blacks (7%) (Carabello, Yee, Gfroerer, Pechacek, & Henson, 2006). Among 665 Alaska Natives 11 to 18 years of age residing on the Yukon-Kuskokwim (Y-K) Delta of western Alaska, 31% were current tobacco users (Angstman et al., in press). Yet tobacco cessation interventions developed for this population do not exist (Hodge, 2001; Sussman, Sun, & Dent, 2006). The first step recommended toward developing effective, culturally tailored interventions that are

acceptable to Alaska Native youth is to assess their needs in stopping tobacco use and preferences for tobacco cessation interventions (Dent, Lichtman, & Sussman, 2001).

Approximately 94% of the Y-K Delta population of 25,000 is Alaska Native—primarily Yup'ik or Cupik ethnicity. Unique to the Alaska Native people of this region is the use of a homemade form of smokeless tobacco (ST) known as iqmik, a mixture of tobacco leaves and fungus ash (Renner, Enoch, et al., 2005). However, iqmik and other tobacco products are not used for religious or ceremonial reasons (Blanchette, Renner, Held, Enoch, & Angstman, 2002). More than half of Y-K Delta women use iqmik or other forms of tobacco during pregnancy (Renner, Patten, Day, Hurt, & Lanier, 2005). Iqmik is thought to be safer to use during pregnancy than other forms of tobacco (Renner, Enoch, et al., 2005; Renner et al., 2004). Among Y-K Delta youth (Angstman et al., in press), we observed the rates of current ST use (iqmik or commercial brands) to be 12% for 6- to 10-year-olds, 26% for 11- to 14-year-olds, and 44% for 15- to 18-year-olds. In contrast to national data (Centers for Disease Control and Prevention, 2003), the rates of ST use were significantly higher for *females* than for males in all age groups.

Building on our successful partnership and collaboration, this study employed focus group methodology to assess (a) the acceptability and preferences for tobacco cessation interventions and study recruitment methods and (b) the barriers and information and support needs in stopping tobacco use among Alaska Native adolescents residing in western Alaska.

METHOD

This study was approved by the Mayo Clinic Institutional Review Board (IRB), the Alaska Area IRB, the Yukon-Kuskokwim Health Corporation (YKHC) Human Studies Committee, the YKHC Board of Directors, and the Alaska Native Tribal Health Consortium Board of Directors.

Study Design

We chose to use focus groups as the target methodology for this study. The use of focus groups was consistent with the research objectives of our study and allowed us to gain insights into community norms (i.e., shared meanings) and personal influences related to tobacco use and preferences for quitting tobacco. Another major consideration was that focus groups and talking circles are an acceptable means of gathering and disseminating information and for sharing of personal stories in this community (Hodge, Pasqua, Marquez, & Geishirt-Cantrell, 2002). Focus groups also allow researchers to capture the process of interactions among participants or group dynamics, including nonverbal interactions (Krueger, 1994).

A series of 12 focus groups were conducted from November 2003 to April 2004, with 4 focus groups conducted in each of three villages, constructed to include participants of the same gender and age (11 to 14 and 15 to 18 years). The number of focus groups was chosen to ensure adequate coverage of the major subsets of interest based on gender and age, and groups were conducted in different villages to capture community-specific needs and tobacco use. Furthermore, more than one group was conducted per subset to increase reliability of the resulting data (Krueger, 1994). The groups were selected to be homogenous with respect to gender and age to promote ease of interaction among participants (Heary & Hennessy, 2002).

We estimated a total sample size of 60 participants, with a projected average of 5 per focus group. Recruitment of 60 participants was deemed to be feasible within the 1-year study

period based on our previous focus group work conducted in western Alaska. However, the actual focus group size ranged from 2 to 6, with an average of 4 participants. Because of limited resources, we were not able to conduct additional focus groups and recruitment was stopped.

Participants

Adolescents were recruited through school personnel, through word-of-mouth referrals, and in person. Study staff arrived in the respective village 1 to 2 days before the focus groups commenced. They gave a presentation to the community on tobacco use, which included results of our prior study on focus groups of Alaska Native adults (Renner et al., 2004). Discussed were the implications of the previous project for the community and why the adolescent focus groups were being conducted. Educational presentations on the health effects of tobacco use were also conducted in the classrooms, where a brief description of, and eligibility criteria for, the study were described.

Potential participants were screened in person using a brief four-item interview that assessed the study inclusion criteria. Alaska Natives were eligible if they (a) were 11 to 18 years of age, (b) were current tobacco users, defined as any tobacco use (iqmik, commercial ST, and/or cigarettes) in the past 30-day period, (c) provided written informed consent or assent (if younger than age 18), and (d) provided written parental or guardian consent if younger than the age of 18. We considered including only adolescents who were established tobacco users (use of a tobacco product at least 100 times and current use) but decided to allow for any amount of previous use because we are also interested in designing interventions that will help adolescents circumvent the process of becoming a regular tobacco user. Adolescent volunteers were eligible irrespective of their level of motivation to stop tobacco to enhance generalization of the findings. Of the 53 adolescents screened, 4 did not show on the day of the scheduled focus group because of lack of interest or inability to participate. Thus, this report is based on a total of 49 adolescents.

Study Setting

The focus groups were conducted in three Yup'ik villages on the coast of western Alaska with populations ranging from 750 to 1,000 and were held at the village school. Most of the residents of these villages live subsistence lifestyles, hunting and fishing and gathering berries and plants, and receive some monetary assistance from the federal and state governments. The 58 villages throughout western Alaska are accessible only by boat, airplane, or snowmobile. The majority of Alaska Natives residing in this region receive their health care through the village-based clinic managed and operated by the YKHC, located in Bethel, Alaska (population 5,000), with tertiary care provided at the Alaska Native Medical Center in Anchorage. Bethel is the regional hub for the 58 villages composing western Alaska.

Procedure

Prior to the focus group, a research staff member met with each adolescent individually to assess sociodemographics, tobacco use, and stage of change (precontemplation—not thinking about stopping tobacco use, contemplation—thinking about stopping within the next 6 months, or preparation—thinking about stopping in the next 30 days; Pallonen, 1998).

The duration of each focus group was approximately 90 minutes and included one 5- to 10-minute break. All participants were provided with a gift certificate of \$25 to their local store for their participation, and beverages and snacks were provided.

A trained Alaska Native facilitator (C.E.) with bilingual (English and Yup'ik) expertise moderated all of the focus groups. The facilitator had extensive clinical experience in tobacco dependence treatment and with conducting focus groups in a prior study (Renner et al., 2004).

There were a total of 7 trained observers, and at least 1 to 2 observers were present for each of the focus groups. An Alaska Native media communications expert with bilingual expertise (C.N.) audiotaped and videotaped all of the focus groups and served as an observer. The observers recorded their observations using a structured form that followed the topics in the moderator guide.

The focus groups were conducted in the context of an exploratory model (Becker et al., 1992) used in prior needs assessments with ethnic minorities. This framework aids in collecting qualitative information about the experiences, opinions, preferences, and attitudes of the target group and helps to develop hypotheses, although they are not necessarily generalizable. The facilitator used a structured moderator guide. Participants were encouraged, but not required, to respond to each question. The facilitator encouraged participants to expand on responses as appropriate and encouraged group discussion.

The facilitator introduced herself and then instructed the participants on confidentiality. Prior to introducing the major topics, participants were asked to describe tobacco use for themselves, their family, and their village members. All of the major topics described below were then addressed in each of the focus groups. These topics were based on social cognitive theory (Bandura, 2004) and prior research assessing the needs of teen tobacco users (Dent et al., 2001; Pingree et al., 2004).

Motives for Quitting—The perceived benefits and disadvantages of using tobacco, self-image related to tobacco use, and motives for stopping tobacco were discussed.

Barriers to Quitting—Participants were asked to focus on their most recent attempt at stopping tobacco or on a time when they had seriously thought about stopping. They were asked to recall reasons why they wanted to quit or would in the future want to quit and reasons for continuing their tobacco use (e.g., what makes it hard to quit).

Role of Family Members and Others in Quitting—Questions addressed the role of family member modeling of tobacco use, potential support from family members when quitting, whether or not parental consent was perceived as a barrier to participation in a cessation intervention, and strategies that would be helpful in quitting when most, if not all, family and village members use tobacco. Participants were asked about supportive behaviors from family members and friends that would help them to quit smoking.

Preferences for Tobacco Cessation Interventions—Preferences for type of intervention (behavioral, pharmacological, education, social support, personal stories, talking circles) modality of treatment (individual, group, face-to-face, telephone counseling), setting (schools, village clinic, churches or other social gatherings), treatment provider, and the perceived value of providing incentives with respect to study retention were discussed. Moreover, we assessed the perceived feasibility and acceptability of various methods of collecting outcome data. The facilitator first used an open-ended format, then listed potential program elements and asked for feedback on what adolescents believed would be successful and acceptable.

Preferences for Study Recruitment and Retention Methods—Participant feedback on potential study recruitment materials (e.g., flyers, media advertisements) and methods (e.g., in-person, media approaches) and retention strategies was elicited.

Qualitative Analysis

We chose content analysis because it was appropriate to our methods of participant sampling and data collection (i.e., focus groups). Data analysis was facilitated by debriefing among the study team following each focus group, in which the moderator and observers discussed emerging themes in the data. Focus group discussions were transcribed verbatim, resulting in a written script for each focus group. In one of the villages, both the facilitator and participants spoke in both Yup'ik and English. An Alaska Native observer (C.N.) translated the responses that were in Yup'ik to English. Study data consisted of participant statements reflecting expressed attitudes and preferences and context units—observations of behavior and various forms of nonverbal communication (e.g., affect of responses, prolonged silences).

We employed standard methods for the content analysis (Knodel, 1993). First, a set of content codes was developed corresponding to the items included on the moderator guide. Second, the study data were coded by marking on the transcripts where the material corresponding to the codes started and ended. Third, an overview grid was constructed for the five major topic areas. Fourth, the coded data were grouped using the cut and paste technique according to the topic areas. Study data consisting of context units were also grouped as appropriate under each of the five topic areas. A fifth step in the analysis was the construction of thematic units based on each of the five major topic areas. Thematic units are explanatory sets of statements and behavioral observations consistent within and across the focus groups. This more global interpretative step involved searching for patterns within and between major topic areas to draw meaningful conclusions. For each topic area, two of the investigators interpreted the grid and produced a summary outlining the major conceptual categories or themes. Also determined was whether the views expressed were consistent across the participants' age and gender and across the three villages.

To assess the quality of the data analysis, for purposes of triangulation (Lincoln & Guba, 1985), an expert in nicotine dependence and focus group methodology and who had prior experience working within the communities of western Alaska independently coded the data. This individual independently evaluated the focus group information using the videotapes, moderator and observer notes, and transcripts and formulated a summary of the themes. There was 100% consensus or concordance with regard to the major themes as assessed by these independent analyses.

RESULTS

Participants

Between 15 and 17 teens participated at each of the three villages. The total number of teens who participated in each of the four groups was as follows: (a) females ages 11 to 14 years ($n = 16$), (b) females ages 15 to 18 years ($n = 14$), (c) males ages 11 to 14 years ($n = 8$), and (d) males ages 15 to 18 years ($n = 11$). Overall, their mean age was 14.6 ± 1.6 ; of participants, 48 were Yupik and 1 was Aleut. During the previous 30-day period, 24 (49%) used iqmik, 10 (20%) used Copenhagen, and 34 (69%) smoked cigarettes. With respect to stage of change to stop tobacco use, 8 (17%) were in precontemplation, 7 (15%) were in contemplation, and 33 (69%) were in preparation. Most (88%) had made at least one prior quit attempt. The proportion of adolescents who reported that one or more other household member smoked cigarettes or used ST was 76% and 78%, respectively.

Focus Group Themes

The results were highly consistent across the three villages, for males and females, and for the two age groups. Therefore, the results were summarized according to the major themes expressed across all of the 12 focus groups. Table 1 highlights the major themes.

Adolescents reported many family members and relatives (over several generations) have used tobacco. Use of tobacco begins during the childhood years. Some teens mentioned they started using tobacco from watching family and friends. Moreover, they reported quitting behaviors at a very early age. Examples are “I started chewing at 5, and tried stopping when I was 9” and “I quit chew when I was 12 and then started smoking.”

Motives for Quitting—Several participants mentioned one motive to stop tobacco use was to avoid tobacco-related disease and adverse health effects: cancers of the throat and lip, lung cancer, asthma, and other respiratory problems (shortness of breath). For example, “My grandpa died of lung cancer before I was born.” Some mentioned that iqmik “burns my lips” or “peels the skin off my mouth” or that they tried to stop before because their “mouth was hurting.” Cigarette smokers were concerned about improving their energy level for running, sports, and hunting because they were easily fatigued.

Another frequently mentioned benefit to quitting tobacco use was improved self-esteem: “Your self-image will be normal if you stop [smoking].” Participants felt embarrassed or were self-conscious when using iqmik outside of western Alaska (e.g., in Anchorage), where iqmik is not used. They reported iqmik “stinks,” “tastes weird,” and is “gross.” Adolescents were concerned about appearance-related consequences of continued tobacco use, such as yellow, black, or missing teeth; bad breath; or facial disfigurement from oral or esophageal cancers. Related to this, it was important for adolescents to successfully quit smoking to be a role model for younger family members and to reduce others’ exposure to secondhand smoke: “I’m not seen as a role model. . . . [I] feel guilty.” Adolescents mentioned that individuals should quit chewing iqmik for their children and/or for their parents, “I care for my family.” They also reported financial implications as a reason to stop their tobacco use (e.g., they could save money for a new snow machine if they quit).

Barriers to Quitting—A major barrier to quitting was the cravings adolescents perceived they would experience, especially if they saw others in their village using tobacco. They recognized that addiction to tobacco makes it hard to stop, and they continued tobacco use to avoid cravings and negative mood-related withdrawal symptoms. Regarding iqmik, one participant mentioned that he currently “chews angry” and that if he stopped he would not know what to do with the feelings he had. Another teen stated, “If we don’t use [iqmik], we are stressed, or mad . . . restless.” Tobacco relieves boredom, and it gives them a “boost.”

Other barriers were the high prevalence and acceptance of tobacco use in the villages (“Iqmik—it’s just everyday life”), the lack of encouragement by peers and other community members to stop iqmik use (“Everywhere you turn you see it here in the village. . . . I don’t think we can [stop]”) and the lack of effective resources in the villages available to help teens quit.

Role of Family Members and Others in Quitting—Teens thought their parents would be generally positive about their attempts to quit, irrespective of parental tobacco use. Examples are “I would tell them I want to quit, my family would be proud of me and say congratulations!” “They would help me and encourage me,” “They would be happy I quit, they would let me stay home,” and “They would keep me from activities where smoking occurs.” However, the need to obtain parental permission or consent was not perceived as

barrier to the teens' enrollment in a research study because most of the parents knew the teens used tobacco.

Adolescents did not perceive tobacco cessation to be a high priority in the villages, although there was some hint this may be changing for the better. Participants indicated that assistance from family, friends, and other community members in the form of not using tobacco around them and encouraging and supporting them to quit would be helpful. Family members could also be helpful by keeping tobacco away from them or not buying it for them and creating tobacco-free environments. Furthermore, adolescents thought family members could be most helpful by sending them away from the village for a program.

Reactions to whether friends would be helpful were mixed. Suggestions for friends were to keep them busy (e.g., watch videos or TV or play sports, hunt, or fish), quit tobacco with them, help them to spend time with people who did not use tobacco, listen to them with respect to their struggles with quitting, and not offer tobacco to them or share it with them.

Preferences for Tobacco Cessation Interventions—Medication use was reported as the most acceptable tobacco cessation strategy (i.e., nicotine patches, nicotine gum, and the “smoking pill”). The other most frequently mentioned quit methods were help from family and friends, professional counseling, and personal stories of smokers who had quit and/or experienced the health-related adverse consequences of tobacco. In contrast, showing “gross pictures” and other health aspects of tobacco use were deemed to not be effective strategies with these youth.

The most frequently mentioned locations to hold an intervention were at the schools, at the village community hall, or away from the villages (e.g., Bethel, Anchorage). The intervention sessions could be held at any time except for the summer months. The program should include fun activities (e.g., pool, basketball, games), provide food and beverages, and offer door prizes. Ideas for prizes were toys, bikes, water bottles, T-shirts, pens, tote bags, music CDs, airline tickets, and gift certificates (e.g., for shopping or purchasing gasoline for four-wheelers or snowmobiles).

With respect to the type of behavioral counseling preferred, most participants thought talking circles or a group-based intervention would be most effective. In contrast, telephone counseling would not be effective because “it is better to talk in person.” No preferences were stated for the gender or ethnicity of the counselor or interventionist. Most preferred a bilingual-speaking or English-only-speaking counselor, whereas very few thought the counselor should speak Yup'ik only. They did prefer to speak with an adult or older person who was more experienced and knowledgeable. Participants suggested that elders in the community—or from other villages—would be most credible as a resource to help them not use tobacco.

Preferences for Study Recruitment and Retention Methods—To engage adolescents in a tobacco cessation intervention, the best ways to let them know about the program were primarily by television or radio commercials or in person (word of mouth). Other potential recruitment methods were flyers and posters. For example, one teen suggested having an Alaska Native who had successfully quit tobacco interviewed for a television commercial.

The program should be advertised as a tobacco-free fun event to which all villages are invited or a group event away from the village (e.g., “Meet for a retreat or seminar away!” and “If you want to stop using tobacco, come and join us”). Participants also thought recruitment advertisements should include tobacco “survivors.” In addition, the

advertisements should offer assistance in quitting (e.g., “Do you want to quit?” and “We can help you stop for free”).

When asked what would keep them interested in a program, teens liked the idea of having prizes or “door prizes” at each session or monetary incentives. Ideas for prizes were a trip away from the village, T-shirts, cookies or other food, bags, mugs, hats, or tickets to an event. Other ideas were providing encouragement and praise and individual feedback on the benefits of quitting.

To obtain biochemical verification of smoking outcome (e.g., saliva sample), the teens preferred an in-person assessment because they were “not sure who handles it” or “what is done with it” if a sample were collected through the mail. If the researchers were to require only self-reported outcome information, teens preferred an in-person or telephone-based assessment, but many also indicated contacting them by mail would be acceptable.

DISCUSSION

This preliminary study is one of the first qualitative assessments of the barriers to stopping tobacco use and preferences for tobacco cessation interventions among Alaska Native adolescents. We learned that program location or site (e.g., away from the village, hunting, fishing), a group-based format, and inclusion of medication and personal stories were consistently reported to be important attributes of cessation programs across the focus groups. Another major finding was the importance of self-image and appearance and perceived adverse health effects of tobacco as motivators to quit tobacco. Adolescents wanted to be future role models as non-tobacco users for their family and friends. Moreover, parents were perceived as potentially supportive. The primary barriers to quitting tobacco use reported by the adolescents were addiction and cravings, the social acceptance of tobacco use, and the lack of resources available to quit. The findings build on our previous qualitative work with Alaska Natives of western Alaska (Renner, Enoch, et al., 2005; Renner et al., 2004) by assessing teen preferences for interventions.

There are several aspects of the findings that are unique to our Alaska Native adolescents. There were distinct cultural influences reported, such as the pervasiveness of early onset of tobacco use, early quitting behaviors, and the high level of sophisticated knowledge about negative health consequences of tobacco use, that are so rarely salient among teens generally. The early quitting behaviors reported by adolescents in the current study warrant investigation in future epidemiology studies. No comparable data exist among adolescents nationally for age of initiation of a quit attempt (J. Pierce, University of California, San Diego, personal communication, 2005). Adolescents’ use of tobacco was directly tied to culture and community at a macro level. Tobacco use was connected to local activities such as hunting and fishing, whereas most studies link teen tobacco use to peers or anticulture.

Another unique cultural aspect is that our adolescents reported their parents knew they used tobacco. In contrast, a barrier in most youth cessation programs is parental consent because the adolescents perceive their parents do not know they use tobacco, and they do not want to inform them (McCormick et al., 1999). Moreover, even typical findings related to self-image and tobacco use were framed within a unique cultural framework. Studies of adolescent smokers indicate that self-image improves with smoking (Quintero & Davis, 2002), and teens report they smoke to “fit in,” “be cool,” and so on (Amos, Gray, Currie, & Elton, 1997). In contrast, our adolescents indicated that they did not feel good about themselves when they used tobacco, primarily *iqmik*, and that quitting would improve their appearance and self-concept.

On the other hand, some findings are consistent with studies of youth tobacco use more generally (e.g., Balch et al., 2004). For example, youth prefer group-based, “fun” recreational activities and quitting with peers. Our adolescents, like others, mentioned addiction and potential for withdrawal and craving symptoms as major barriers to quitting, and the majority had tried unsuccessfully to quit before. Moreover, the adverse health consequences of tobacco use were a substantial motivating factor to quit.

Limitations

Several characteristics of the sample limit the extent to which the findings can be generalized. First, we included participants from only 3 of the 58 villages in the region. Although the population is fairly homogenous, with similar cultural traditions and practices, it is possible that adolescents in the villages chosen for the study differed from teens in other villages. On the other hand, the focus group findings were consistent across village, gender, and age groups, which enhances our confidence in the general concepts and themes found in this study. Second, about two thirds of the participants were in the preparation stage of change to stop tobacco. Although the findings may be limited primarily to those adolescents who are motivated to quit, this is likely the group who will be targeted for interventions.

There are also several methodological limitations of this study. Other qualitative methods, such as use of key informants or individual interviews, could have been useful in this sample of adolescents, instead of or in addition to the focus groups. For example, a disadvantage to focus groups is that not all members equally contribute, as some may be shy or withdrawn. In addition, focus group responses can be affected by the responses of other participants in addition to the moderator. Moreover, other studies (e.g., Dent et al., 2001) asked teens to quantitatively rate their preferences for cessation interventions. Thus, different qualitative and survey methods should be considered for use in future studies.

Another limitation is that we did not assess the quality of the focus group data using methods such as member checking (Lincoln & Guba, 1985), that is, taking the results back to the original participants to obtain feedback on the results and then refining the conclusions as needed. However, limited resources and travel and scheduling constraints precluded this approach.

Another drawback is that the targeted number of 5 participants per focus group was low compared to the standard focus group size of 6 to 12 (Krueger, 1994). We chose a target group size of 5 because some researchers (Heary & Hennessy, 2002) working with children recommend smaller groups of between 4 and 6 participants. However, because of issues of recruitment and scheduling for focus groups within each village, the actual focus group size ranged from 2 to 6, with an average of 4. This may have limited the total range of experiences among participants simply because the groups were smaller. In addition, we conducted educational presentations on the health effects of tobacco use in the classrooms prior to the focus groups. This approach may have had an impact on the responses of the participants; for example, some adolescents may not have been comfortable discussing the benefits of using tobacco.

Future Directions

This study addresses a community need in that the health and welfare of the children are paramount (Renner et al., 2004). Together with the YKHC Board of Directors, we developed a long-term plan to address this community need. Perhaps most important, this study could serve as the basis for intervention programs for youth in the region. Several approaches have been evaluated for adolescent tobacco cessation that are effective for adult smokers, including nicotine replacement therapy and bupropion, individual and group

counseling, and telephone counseling (Sussman et al., 2006). It was concluded that some intervention is more effective than no intervention and treatments that included cognitive behavioral approaches appear to be promising. Thus, development and testing of innovative approaches for adolescent tobacco use merit further inquiry. For example, no prior research has utilized a group event or program such as a weekend retreat at which peers could quit together and that includes fun activities. Furthermore, no existing programs for youth focus on self-image enhancement as the primary focus of treatment.

Issues that we have considered when designing a program for Alaska Native youth are the reach of the program to teens at each of the 58 health care service villages within the region and its sustainability by community members. A recent initiative in place within the region is to screen all adolescents in the villages for tobacco use during Well Child Assessments (Angstman et al., in press). Adolescents who use tobacco are referred to the YKHC Nicotine Control and Research Program in Bethel, and travel for face-to-face services will be reimbursed. We are currently in the process of building on this Bethel-based initiative by developing a weekend program in Bethel specifically designed for teens of this region. We anticipate the program will include medication in the form of nicotine replacement therapy, storytelling by elders, and self-image enhancement (e.g., serving as a role model for future generations).

Implications for Practice

The U.S. Public Health Service clinical practice guideline on the treatment of tobacco use and dependence (Fiore et al., 2000) recommends that practitioners working with adolescents consider approaches shown to be effective with adults, namely nicotine replacement (considering degree of dependence such as number of cigarettes per day) and counseling in group, individual, or telephone formats. A more efficient method of treatment that may be appealing to youth, if feasible, is to consider a group-based program. In addition, practitioners are encouraged to consider novel approaches to supplement the standard of care when feasible. We recommend that practitioners working with Alaska Native and minority youth consider the unique cultural and social influences for tobacco use and quitting. Another consideration for assessment and treatment is the role of self-image enhancement with respect to tobacco use and/or quitting.

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Table 1**Key Focus Group Findings**

1	Motives for Stopping Tobacco Use
	Avoid tobacco related diseases and adverse health effects
	Improved energy level for running, sports, hunting
	Improved self-esteem
	To be a role model for their parents and other family members, and for their own children
2	Barriers to Quitting
	Addiction and cravings to use tobacco
	Boredom
	Widespread use among peers and other community members
	Effective resources to quit are not available in the villages
3	Role of Family Members in Quitting
	Parents were seen as potentially supportive of the teen's quit attempt, irrespective of parental tobacco use
	Most teens thought their parents knew they used tobacco
	Family, parents, and friends could be supportive by keeping tobacco away from them
4	Preferences for Intervention
	Medications
	Counseling in a group format or talking circles
	Personal stories of smokers who had quit and/or experienced adverse health effects
	Hold program away from the villages
	Include fun recreational activities (e.g., games), food and beverages, and door prizes
5	Recruitment and Retention Methods
	Advertise as a fun event
	Recruit via television or radio commercials, word of mouth, flyers and posters
	Highlight adverse effects of tobacco in recruitment advertisements
	To enhance retention, provide prizes or incentives and encouragement or praise
	Follow-up assessments that are done in-person are preferred