NIH Public Access

Author Manuscript

Asian Am Pac Isl J Health. Author manuscript; available in PMC 2006 October 20.

Published in final edited form as:

Asian Am Pac Isl J Health. 2000 ; 8(1): 46–57.

Tobacco Use by Chinese-American Men: An Exploratory Study of the Factors Associated with Cigarette Use and Smoking Cessation

Shin-Ping Tu, M.D., M.P.H.

Department of Internal Medicine, University of Washington, Seattle, WA

Mary Walsh, B.S. and **Ben Tseng, Ph.D.**

Cancer Prevention Research Program, Fred Hutchinson Cancer Research Center and the Department of Health Services, University of Washington, Seattle, WA.

Beti Thompson, Ph.D.

Abstract

Purpose—There is little information on cigarette use and smoking cessation in Asian Pacific Islanders. This study explored factors associated with tobacco use in the largest Asian American ethnic group – Chinese American men.

Methods—Chinese American men age 17 or older, recruited by convenience sampling, were interviewed by a male trilingual and bicultural interviewer. Open-ended, semi-structured interviews were coded using PRECEDE framework under two categories: cigarette use and smoking cessation.

Findings—Smoking, favorably perceived and valued, plays an important role in Chinese society. Lack of appropriate information and some beliefs pose challenges to effective tobacco control. Participants expressed willingness to adhere to no smoking rules and regulation. Attitudes and perceptions in the U.S. towards cigarette smoking, which differ from those in China, reinforce attitudes more favorable to smoking cessation.

Conclusions—Themes elicited challenge mainstream smoking cessation approaches for Chinese American men. Further exploration of these results are needed to develop effective tobacco control in this and possibly other Asian American populations.

INTRODUCTION

The relationship between cigarette smoking and lung cancer has been well documented[1]. Although national surveys suggest a low prevalence of cigarette smoking in the Asian American and Pacific Islander (AAPI) population overall (13.9%), these statistics are misleading[2–3]. First, by focusing on aggregated data, the severity of the tobacco problem among AAPI men is obscured by the low prevalence of tobacco use in AAPI women (4.3% to 9.7%)[2–4]. National surveys have consistently estimated the prevalence of cigarette smoking among Asian American and Pacific Islander men to be above 20 percent. Second, selection bias from telephone surveys conducted in English exclude recent immigrants who are not proficient in English, yet who represent a significant proportion of the AAPI population. Studies conducted in native languages demonstrate that smoking prevalence is higher among persons with limited English-language proficiency and more recent immigrants[3,5–8]. Third, by aggregating data by ethnicity, variations in smoking rates among AAPI ethnic groups are obscured[9].

Address correspondence to: Shin-Ping Tu, M.D., M.P.H., Division of General Internal Medicine, Harborview Medical Center, Box 359780, 325 Ninth Avenue, Seattle, WA 98104, tel: (206) 731-4845, fax: (206) 732-8247, e-mail: shinping@u.washmgton.edu..

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript
NIH-PA Author Manuscript
NIH-PA Author Manuscript

Smoking in the AAPI population has been little studied[10]. While cultural values, norms, expectancies and attitudes are recognized to differ among various racial and ethnic groups[9], little information is available in the literature about individual and interpersonal factors associated with tobacco use among AAPIs. Data on AAPIs are limited. From 1988 to 1992, the Surveillance Epidemiology and End Result (SEER) program collected data on several ethnic AAPI groups (Chinese, Filipino, Hawaiian, Japanese, Korean and Vietnamese). Based on the SEER registry, lung cancer ranked as the most common malignancy among AAPI men, the leading cause of cancer mortality in these populations. The age-adjusted incidence of lung cancer ranges from 52.1 to 89.0 per 100,000 population depending on the ethnic group[11].

Asian American and Pacific Islanders are the fastest growing minority group in the United States in percentage terms[12]. The Census Bureau projects that by the year 2050, AAPIs will reach 41 million or 10.7% of the U.S. population[13]. AAPIs are highly heterogeneous, with persons from at least 28 Asian countries and 25 Pacific Island cultures[14].

Research on the white United States population has demonstrated the importance of psychosocial factors on tobacco use[15]. Culture and values affect smoking[16–17]. In 1998, the report from the Surgeon General of the United States concluded that rigorous surveillance and prevention research are needed to improve the understanding of racial/ethnic smoking patterns and identify strategic tobacco control opportunities[9]. The goal of this study was to elicit essential information of tobacco related beliefs and practices which may be culturally dictated by Chinese Americans, the largest AAPI ethnic group in the United States.

METHODS

Research participants were Chinese-American men living in the Seattle, Washington, area who were aged 17 or over and who were current or past smokers. A qualitative approach described by Sensky was used to minimize the potential limitation of ethnocentricity - the interpretation of one culture using the norms of another-the researcher's own[18–19]. Sampling was based on convenience and participants were recruited between September, 1996 and March, 1997 by a male trilingual and bicultural Chinese interpreter. Participation was voluntary and all research participants signed consent forms that were in English and Chinese. All procedures and forms were reviewed and approved by the Human Subjects' Review Committee at the Fred Hutchinson Cancer Research Center in Seattle, Washington.

A meeting of male and female community group leaders was convened to obtain initial input and suggestions for questions to be included in the semi-structured interviews. This meeting was conducted in Mandarin and was audio taped and translated into English and transcribed. Individual interviews were then conducted in an open-ended, semi-structured format. Thirty-four men were interviewed. The interviews were conducted in Mandarin or Cantonese, at a time and location that was convenient for the participant and lasted about an hour each. The interviews were audio-taped, translated into English, transcribed, and then edited by the interviewer. Interview transcripts were then analyzed and coded for major and recurrent themes.

Interview Analysis

The PRECEDE conceptual framework was utilized for categorizing major themes. According to this framework, major determinants of behavior can be classified into Predisposing, Reinforcing, and Enabling factors. PRECEDE assumes that behavior is largely determined by culture and that individual variables affecting behavior may differ depending on the population subgroup to which an individual belongs[20].

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

Predisposing factors are factors antecedent to the behavior that provide the rationale or motivation for the behavior. Knowledge, attitudes, beliefs and values are all predisposing factors; thus, cultural values may predispose one to smoke or quit depending on which beliefs are most important.

Reinforcing factors provide positive or negative reinforcement for the behavior and may include social and peer support, physical benefits and tangible as well as imagined rewards.

Enabling factors allow a behavior to be realized, such as availability of cigarettes making it easier to smoke. Such factors include personal skills and resources as well as community resources.

Major themes from all interviews were grouped into two categories: Cigarette Use and Smoking Cessation. Predisposing, Reinforcing, and Enabling factors under these two categories were then coded and analyzed.

Validation of Coding

There were two coders (ST, MW) for all the transcripts, and an additional third coder (BT) for selected transcripts. Coders independently coded and analyzed transcripts for content and then compared their findings for correlation. Validity of the findings was assessed through meetings between the coders where discrepancies were discussed and resolved.

RESULTS

Group Demographics

Thirty-four participants were interviewed. Two potential participants refused to be interviewed. The mean age of the participants was 45.1 years and ranged from 17 to 83. Fifty-one percent of the interviews were conducted in Mandarin; the remainder in Cantonese. Table 1 shows that most respondents were born in Mainland China, were fairly well educated and were not married. Two-thirds were self-reported current smokers. The average number of years in the United States was 8.6 years.

I. MAJOR RECURRING THEMES - CIGARETTE USE

Table 2 summarizes the major themes that emerged regarding cigarette use.

A. Predisposing Factors

Over 70% of the participants acknowledged dependency on cigarettes. Some knowledge of the negative effects of cigarettes was common among the participants; such as, “I felt sick when I had one or two packs of cigarettes a day …. I felt something was wrong with my stomach, “or “If I smoked too much when I exercised I had breathing problems…. Sometimes I had pain in my throat, … lungs, … heart.”

Lack of adequate information in Chinese and sometimes contradictory information promoted disbelief in the negative health effects of cigarettes as demonstrated by one interview:

…I have not thoroughly considered that problem because there are examples which show that smoking has negative impact on personal health, but there are also some examples which show that smoking does not have impact on personal health. I mean a smoker lived a long, long time. Therefore, you cannot say or you cannot completely believe that problem is caused by smoking. Because in this world too many factors may cause the problem. I think smoking may not be the only reason.

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

Another respondent commented:

…Regarding smoking, I have the impression that a long time ago I heard that smoking had a negative impact on human life but I also had another thought. I know some people die of smoking but also people die for other reasons. Anyway, people will die no matter whether they smoke or not. I can also tell you one of my relatives never smoked but the doctor told him he had lung cancer. I just wonder why. He never smoked but he had lung cancer. My relative is OK now but not in good shape. Therefore, I believe that smoking does not cause lung cancer.

The association of smoking with physical symptoms was expressed by 20 participants. Therefore, if no symptoms were present, or there were no abnormal check ups or radiographic changes, participants believed that they had no physical abnormalities related to smoking and that quitting was not necessary.

Based upon the concept of *yin* and *yang*, the idea of balance was also raised in different contexts. Some discussion referred to the ability of exercise to balance the negative effects of cigarettes, as follows: "I do believe that smoking may affect a person's health, but I also think exercise probably can balance the disadvantages from smoking," and "…smoking more or less has an influence on your physical energy. Smoking has become my habit, but I exercised much when I was in college."

Smoking in moderation was not considered harmful, and reference to the fact that a little wine is even good was raised in support of this belief. Others emphasized that quitting abruptly would imbalance the body and lead to physical problems:

"A little wine, I believe, is good for your body. If you drink too much, it will damage your body. Smoking is just like drinking. Don't smoke too much."

"Some people who have been smoking 15 or 18 years, if they quit right away, they probably will get cancer. I smoked only three or four years. I don't think I will get cancer so quickly."

"After quitting smoking, cancer cells explode inside the lungs. It is better to quit smoking gradually. The body cannot resist the explosion of cancer cells right after quitting smoking immediately."

B. Reinforcing Factors

Attitudes towards smoking in this group were generally favorable. Respondents noted that in Chinese society, smoking was culturally appropriate. In fact, the act of offering a cigarette was described as an important social exchange. The appropriate etiquette was to accept an offer of cigarettes, because to refuse would be impolite and disrespectful: "In China, smoking is indispensable to social life. It seems that the most important thing is the first meeting between males is a cigarette. Cigarette plays a role of courtesy or politeness between people." Other respondents said, "If you did not accept a cigarette from the other person, it might be considered as impolite behavior," and "If you refuse to accept a cigarette from the other person, you are not polite."

Almost one-third of those interviewed identified smoking expensive cigarettes as representing social status or wealth: "Smoking has a certain value …. means you could afford to smoke …. smoking is a way to raise your social status."

Smoking was therefore perceived as a means to success: in business, studies or playing *mahjong* (a popular gambling game). Participants described smoking as "fun," "relaxing," "pleasurable." Smoking was referred to as a "leisure activity" for some and also served to relieve boredom: "If they play *mahjong* and they don't smoke, the chance for them to lose is

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

pretty high because smoking can keep up one's *jing shen* (energy) to play *mahjong*. If a person smokes, he will not lose money in playing *mahjong*. Others added, "I also know the reason why I smoke…. because I often feel bored," "Without smoking, there is no fun in my life," and "If you are exhausted and you smoke, you will feel relaxed."

Overall, social support for smoking is firmly established. Over half of those interviewed described smoking as a social activity, being part of the "circle" and not being an outsider: "If you stay in a small circle and everybody smokes, then you will smoke. You don't want people to say you are an alien, you know. You won't feel yourself a stranger; you just want to be a part of the circle." A different participant said, "Later I went back to smoking because I stayed with my friends. Even if you did not smoke but they smoked in front of you, you would have a feeling of being left out."

Several subjects saw smoking as a social entree with the significance of cigarettes in society and work intertwined. As a first exchange, the offer of cigarettes serves to break the ice in social and business encounters. Smoking with one's superiors was also noted as important for the job. In addition cigarettes, along with alcohol, are valued business "gifts" and, in certain, circumstances, expected gifts.

…In China, the first thing at the first meeting between travelers and political officers, between subordinates and their superiors, or between friends is to offer a cigarette to the other party. It seems that the most important thing at the first meeting between males is the cigarette. Cigarette plays a role of courtesy or politeness between people or, you know, at different social activities. If you take cigarette out of your pocket and you smoke by yourself, it seems that you look down on other people. You know, this is my personal experience. I told you before I was a truck driver. Whenever I dealt with police officer, the first thing was to give the officer a cigarette, then you start your conversation.

Smoking also was referred to as a rite of passage. It was perceived as a characteristic of being a man. Nearly half of the participants thought smoking stimulated thinking and concentration and increased energy: "After I graduated from high school…I worked and I smoked to show people that I was a man." Other men responded, "If a person smokes, that means he's grown up and he is mature and he can be admitted into society," "Some scholars and philosophers are heavy smokers, so I have a feeling that smoking might play a certain function on their thinking," and "I like to analyze problems when I smoke. Most of the time I could find a new way while I was smoking because I like to think when I smoke."

Nearly two-thirds of the participants noted the impact of social referents on persistent cigarette use. The majority identified friends who smoked and peer pressure as an important factor; a few others pointed to their observation that some doctors and nurses also smoked: "When you want to see a doctor, you have to put a carton of cigarettes on his or her desk. The doctors smoked heavily." One respondent even commented, "When I was in Hong Kong, my family doctor also smoked-and he always said, 'Oh, I try to cut down. I try to smoke less.'"

This contradiction, magnified by the incomplete medical advice seemed to provide ineffective reasons to quit smoking. In fact, nearly one-third of the participants questioned the effectiveness of quitting smoking when they said, "My doctor suggested that I cut down smoking or even quit smoking, but I don't know why. My doctor did not tell me the reason. Smoking does not have any impact on my health," and "I believe people who have lung cancer might be caused by smoking for a long, long time…. like more than 30 years," and also, "Everybody knows that smoking may cause lung cancer but Deng Xiao Ping smoked for a long time. He was a chain smoker and he had a long life. Many famous men are also chain smokers but they don't have particular problems."

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

Eleven percent of smokers complained of the complicated language, content or concepts about smoking presented to them by their doctors: "I don't know how to say that because, you know, my educational background does not allow me to absorb much knowledge related to medicine." Another respondent commented, "Yes, I know smoking does have some impact on lungs, but my lungs seemed OK. I do not speak English. I often read Chinese newspaper which talks about the impact of smoking, but because of my language barrier, I could not understand more about the impact of smoking on personal health.

Another 11 percent never discussed smoking with their doctors. The lack of physician advice was affirmed by participants in the focus group.

The majority had friends who smoked, and for those who attempted to quit, the process was described as painful, physically and psychologically. It also led to a sense of loss and loneliness. Smoking is a friend–a loss if you give it up. Survey participants stated, "You will have a feeling of loss or loneliness if you suddenly quit smoking … The hardest thing to quit smoking is to fight with yourself," and "My friends tried to quit smoking but they did not make it because they were not able to adapt to their feeling of uneasiness or discomfort. They are kind of addicted to smoking, so it is very uncomfortable for them to quit smoking … when I don't smoke for a short time I feel there's something missing."

In summary, factors contributing to cigarette use were: lack of appropriate, relevant information about the health hazards of smoking; lack of symptoms or physical abnormalities associated with smoking; favorable attitudes and perceptions about cigarette smoking; the concept that moderate cigarette consumption is not harmful; lack of stress management skills; and importance of social referents (e.g., peers and family).

C. Enabling Factors

Thirty-eight percent of those interviewed lacked skills to handle stress and irritability. They felt that smoking soothes and relieves stress. Some said, "I did not smoke for fun. I smoked to relieve the pressure from my working," and "When I smoked I could relieve the pressure which I suffered from my job and also to help relax from my nervousness."

Several also explained that to prevent exposing their families, they would simply smoke outside of the house, such as, "All of them want me to quit smoking, especially my mother. I'm afraid of smoking at home. I have to go outside to smoke even in the wintertime."

II. MAJOR RECURRING THEMES - SMOKING CESSATION

In addition to information on cigarette use, the interviews also provided an opportunity for participants, both current and past smokers, to share their views and experiences on various aspects of quitting cigarettes. We also classified these themes based on the PRECEDE framework. Table 3 summarizes these themes.

A. Predisposing Factors

Two-thirds of the participants indicated that personal willingness or determination was key to quitting: "I just told myself, 'you have to stop smoking now.' I just did it with my willingness or I can say determination." Another responded, "I am addicted to smoking but I believe a person's willingness can control a person's behavior. Maybe I have not thought about quitting smoking. I think it's a question of persistence. If you persist to quit smoking, then I believe you can make it. If you don't persist, then you just want to maintain the current situation."

The negative health effects from cigarette use were discussed by nearly half of the participants. As with current use, the belief that problems from smoking are manifested by physical

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

symptoms and clinical findings was expressed by over half of the subjects. About one-third of the participants associated physical symptoms such as cough and excessive sputum production with smoking. Eleven percent indicated that they would contemplate quitting if they developed major symptoms. While one said, “Generally speaking if a person does not have a health problem, he won’t try to quit smoking,” another commented, “If I find out part of my body has abnormal symptom and the symptom is related to smoking, then I would consider (quitting),” and yet another added, “Probably a major impact on my health, if that impact is tremendous, then I will quit smoking.”

Knowledge regarding the benefits from quitting ranged from improved physical appearance (weight gain, improved complexion, whiter teeth, absence of cigarette smell) to improvements in mood, energy, and better overall health. One man remarked, I feel much better. I believe I am in good shape now. I gained weight after I quit smoking.” Another said, “My face color is turning into red. I also gained weight,” and yet another rejoiced, “After I quit smoking I felt much better and I am full of energy.” Some respondents commented, “You know, when you smoke and open your mouth, a strong smell comes out which might disgust your friends or co-workers. When I smoked I did not notice that people tried to stay far away from me,” and “After I stopped smoking, I had more free time and I felt more relaxed and in high spirits.”

B. Reinforcing Factors

A significant reinforcing factor for stopping smoking is the social environment. Over half of those interviewed emphasized the usefulness of rules and policies designating non-smoking areas, from public areas to work and school settings, as significant reinforcements for not smoking. They noted the differences between smoke-free public settings in the U.S. as opposed to the absence of such smoke-free environments in their native countries. Participants observed, “Before in Hong Kong, people could smoke inside their office; therefore, I smoked more. But here, smoking is absolutely not allowed inside the office. Actually, the quantity of smoking has been reduced,” and “There are “No Smoking” signs in your surroundings and you cannot smoke.”

Participants described their discomfort in smoking in an environment where such behaviors are not accepted. They also expressed their willingness to obey rules and laws. Almost one-half talked about the benefits of family rules for not smoking.

The support of family and friends for quitting was identified in over one-third of the interviews. Various family members were identified. The importance of the mother was most frequently mentioned; this was followed by the influence of an older male member of the family. The frequency of discussion regarding the wife and children were equal. In addition to family support, peers were also recognized as important in reinforcing a person to quit. Specific recommendations from doctors to quit smoking were perceived to be influential for some of the participants: “Some of my friends smoke one or more packs of cigarettes a day, but they all quit smoking after the doctor told them they might have lung problems.” One remarked, “My friends saw the doctor because of their smoking. They also believed that smoking was an enjoyment…. but after receiving advice from the doctor, they quit smoking.”

Smoking by women was perceived negatively by nearly a quarter of the participants. Although smoking by men was acceptable, their role as head of the household implied that they were responsible for the well being of the family. Family was greatly valued and about 40% of the participants expressed family as a significant reason to stop smoking. While one participant said, “After my parents came to live with me, I did not want them to say that you should not smoke. Therefore, I decided to quit smoking.” Another commented, “Since my children did not like my smoking, I thought I should quit smoking.”

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

C. Enabling Factors

Enabling factors to quit cigarette use were the different perceptions and values toward cigarette smoking in the U.S. These themes were brought up by nearly half of those interviewed. For example: “I also found in this country so many public places prohibited people from smoking and that caused inconvenience for me to smoke if I wanted to smoke,” and “ In this country they don’t use cigarettes as a tool to socialize because when you ask people if they like to smoke, they might just say, ‘No, I don’t smoke,’ and that will embarrass you.”

Specific skills utilized by the subjects to stop smoking included the avoidance of smokers. Only eight resorted to replacing cigarettes with a variety of things (water, candy, tea, medicine). Distraction was also cited as a tool to assist with quitting.

Reducing smoking cues in the media and increasing non-smoking cues was noted by five as an approach to motivate Chinese-American men to quit smoking: “You know, some advertisements describe smoking as a good thing, or kind of smart or cool behavior. They have to reduce the advertisements.” Another participant recommended, “Explain to kids that smoking does not stand for a good image and for being grown up. You should explain … what is the real meaning of being grown up. You cannot use an image to say that you are an adult.”

Among various motivators, cost was a factor raised by nearly a quarter of those interviewed. Smoking was described as “wasteful” like “burning money.”

DISCUSSION

In a consensus statement, the Agency for Health Care Policy and Research (AHCPR) acknowledged that there was a paucity of research on smoking cessation interventions tailored to minority populations. The AHCPR affirmed that interventions for a minority group may need to be especially tailored for those groups in order to be effective, and that culturally appropriate models or examples may increase the smoker’s acceptance of treatment[21].

What constitutes a culturally appropriate intervention? Marin proposed a set of criteria for a culturally appropriate community intervention[16]. First, the values of a culture must be used as a foundation or building blocks of the intervention. Personal interactions and other significant values need to be considered as a cultural map in the development of the intervention. Second, a culturally appropriate intervention must also reflect the group’s subjective culture including its attitudes, expectancies, and norms toward a targeted behavior, in this case, cigarette smoking. Thirdly, it is also necessary that the actual strategies that are a part of the intervention fit within the preferred behavioral repertoire of the targeted group. This would include possible channels of intervention, the credibility and perceived usefulness of the strategies among the group’s members, as well as the actual preferences of the members of the targeted group for certain strategies[22].

The paucity of information on the cultural values, norms, expectancies and attitudes of AAPI, hinders the development and assessment of effective tobacco control efforts among these populations[9]. The results from our qualitative study, however, support the existing data on AAPIs. Zane and Sasao noted that multiple stressful life events related to cultural adjustment and the acquisition of specific social skills needed in the United States may contribute to the increased use of cigarettes among recent AAPI immigrants[23]. Some studies have indicated that cigarette smoking is associated with lower levels of acculturation[5]. Among 296 adult Chinese Americans surveyed in 1991 in Oakland, California, 40% of those who smoked reported that they began smoking to be sociable[24].

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

Social attitudes and expectations of the country of origin are also brought to the United States among Chinese Americans[25]. For example, in the interviews described here, participants emphasized the importance of cigarette smoking as a form of etiquette. They perceive cigarette smoking as essential for success in studies, *mahjong*, as well as in business. As noted by Frankel and Mufson, cigarette smoking in China, particularly of certain brands, is associated with affluence and sophistication[26]. The importance of the family in reinforcing smokers to quit was supported in 20 out of 34 interviews.

Although previously not reported in association with cigarette smoking, yet consistent with traditional Chinese health beliefs, the issue of balance and moderation was raised in these exploratory interviews. Based upon the *yin-yang* framework and the deficiency and excess basis of illness, participants reported a belief that the negative health effects of cigarette smoking has been or can be tempered by exercise or through decreasing the amount of cigarettes smoked. Values previously not reported among AAPI men also include the positive perception of weight gain and better complexion[20] among those who quit smoking cigarettes. This belief, also based upon traditional Chinese medicine, uses a person's demeanor and appearance (including complexion) to assess health and illness[27].

Interestingly, our interviews showed the eagerness of the participants to follow rules and regulations. Several participants noted that the regulations on cigarette smoking in the United States are tremendously different from those in their countries of origin. The negative perceptions of smokers in the United States were repeated in these interviews. This result is consistent with the Asian value that the benefit of the aggregate outweighs that of the individual[28–29]. Regardless of negative feelings, the Chinese-American smoker will respect societal rules.

Tobacco cessation interventions based on research of the white population may be both a challenge and inappropriate to pursue among Chinese and possibly other AAPI populations. It is possible that, in this population, for example, setting a quit date and using an initial approach of going "cold turkey" may be culturally inappropriate and less likely to be effective. A gradual decline in cigarette consumption is more consistent with traditional Chinese health beliefs, and the introduction of pharmacotherapy within the construct of "balancing" the body deserves further study for tobacco cessation strategies among Chinese-American men. Our results clearly show that lack of quitting skills and appropriate health information are issues that need to be addressed to promote tobacco cessation among the Chinese-American population.

The strength of this study is the qualitative approach undertaken to explore cultural values and attitudes pertinent to cigarette smoking and cessation among Chinese-American males. By using an ethnographic approach, ethnocentric pre-assumptions common to quantitative survey methods were minimized. However, due to the sampling method, our results may not be able to be generalized to other Chinese-American or AAPI populations.

Using the PRECEDE model, our analysis categorized themes based on the authors' best judgment. For instance, the positive attitudes towards smoking could have been categorized in the Predisposing as well as the Reinforcing categories. Similarly, some other themes overlapped in the PRECEDE categories and made clean classification difficult.

This study is a first step in addressing the continuum of tobacco cessation efforts as well as the psychosocial issues influenced by norms, attitudes, and behaviors of this ethnic minority group. The findings from this qualitative study confirm that culture and values affect smoking among Chinese American men. Some of these factors differ from the general U.S. population and will need to be further explored and verified in order to effectively promote tobacco control in the Chinese and other AAPI populations.

Acknowledgements

This research was supported in part by an American Cancer Society Development Award for Primary Care Physicians and a grant from the National Cancer Institute (NCI 5-P01-34847).

LITERATURE CITED

1. Centers for Disease Control. Cigarette smoking-attributable mortality and years of potential life lost: United States, 1990. MMWR 1993;42:645–9. [PubMed: 8350857]
2. Centers for Disease Control and Prevention. Cigarette smoking among adults - United States, 1995. MMWR 1997;46:1217–20. [PubMed: 9427212]
3. Jenkins CNH, McPhee SJ, Bird JA, Bonilla N-TH. Cancer risks and prevention practices among Vietnamese refugees. West J Med 1990;153(1):34–9. [PubMed: 2389574]
4. Centers for Disease Control. Prevalence of selected risk factors for chronic disease by educational level in racial/ethnic populations - United States, 1991–1992. MMWR 1994;43:894–9. [PubMed: 7969013]
5. McPhee SJ, Jenkins CNH, Wong C, Fordham D, Lai KQ, Bird JA, Moskowitz JM. Smoking cessation intervention among Vietnamese Americans: a controlled trial. Tobacco Control 1995;4(Suppl 1):16S–24S.
6. Jenkins CNH, McPhee SJ, Le A, Pham GQ, Ha N-T, Stewart S. The effectiveness of a media-led intervention to reduce smoking among Vietnamese-American men. Am J Publ Health 1997;87(6):1031–4.
7. Centers for Disease Control. Cigarette smoking among Chinese, Vietnamese, and Hispanics California, 1989–1991. MMWR 1992;41(20):362–7. [PubMed: 1584194]
8. Chen MS Jr, Guthrie R, Moeschberger M, Wewers ME, Anderson J, Kuun P, et al. Lessons learned and baseline data from initiating smoking cessation research with Southeast Asian adults. Asian Am Pacific Isl J Health 1993;1(2):194–214.
9. US Department of Health and Human Services. Tobacco Use Among US Racial/Ethnic Minority Groups - African Americans, American Indians and Alaska Natives, Asian-Americans and Pacific Islanders, and Hispanics: A Report of the Surgeon General. Atlanta, Georgia: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 1998.
10. Coultas D, Gong H, Grad R, Handler A, McCurdy S, Player R, et al. Respiratory diseases in minorities of the United States. Am J Respir Crit Care Med 1994;149:S93–131. [PubMed: 8118656]
11. Miller BA, Kolonel LN, Bernstein L, Young Jr. SL, Swanson, GM, West D, et al. (eds). In: Racial/Ethnic Patterns of Cancer in the United States 1988–1992. US Department of Health and Human Services, Public Health Service, National Institutes of Health. National Cancer Institute, Division of Cancer Prevention and Control. NIH Pub No 96–4104. Bethesda MD, 1996b.
12. Chen A. Demographic Characteristics of Asian and Pacific Islander Americans: Health Implications. Asian Am Pacific Isl J Health 1996;4(1–3):40–9.
13. U.S. Bureau of the Census. Washington (DC): US Government Printing Office; 1992. Current Population Reports. Population projections of the United States, by age, sex, race, and Hispanic origin: 1992 to 2050; p. 25-1092.
14. Lin-Fu J. Asian and Pacific Islanders: An overview of demographic characteristics and health care issues. Asian Am Pacific Isl J Health 1993;1:21–36.
15. Ajzen 1, Fishbein M. The prediction of behavior from attitudinal and normative variables. J Exp Soc Psych 1970;6(4):466–87.
16. Marin BV, Marin G, Perez-Stable EJ, Otero-Sabogal R, Sabogal F. Cultural differences in attitudes toward smoking: developing messages using the theory of reasoned action. J Applied Soc Psych 1990b;20(6):478–93.
17. Vander Martin RV, Cummings Sr, Coates RJ. Ethnicity and smoking: differences in white, black, Hispanic, and Asian medical patients who smoke. Am J Prev Med 1990;6(4):194–9. [PubMed: 2223166]
18. Eyton J, Neuwirth G. Cross-cultural validity: Ethnocentrism in health studies with special reference to the Vietnamese. Soc Sci Med 1984;18(5):447–53. [PubMed: 6729523]

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

19. Sensky T. Eliciting lay beliefs across cultures: Principles and methodology. Brit J Cancer 1996;74 (Suppl XXIX):563–5.

20. Green, L.; Kreuter, M. In: Health Promotion Planning: An educational and Environmental Approach. Palo Alto: Mayfield; 1991. Health promotion today and a framework for planning.

21. US Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research, Centers for Disease Control and Prevention. Clinical Practice Guideline Number 18: Smoking Cessation. AHCPR Pub. No. 96–0692, April, 1996.

22. Marin G. Defining culturally appropriate interventions: Hispanics as a case study. Am J Comm Psych 1993 April 21;:149–61.

23. Zane N, Sasao T. Research on drug abuse among Asian Pacific Americans. Drugs & Society 1992;6 (3–4):181–209.

24. Lew, R. Tobacco control in the Asian Pacific Islander community: From research to implementation; Paper presented at the 8th World Conference on Tobacco or Health; Buenos Aires. March 30 – April 3, 1992;

25. Tamir, A.; Cachola, S. Hypertension and other cardiovascular risk factors. In: Zane, NWS.; Takeuchi, DT.; Young, KNJ., editors. Confronting Critical Health Issues of Asian and Pacific Islander Americans. Thousand Oaks (CA): Sage Publications; 1994. p. 209-46.

26. Frankel, G.; Mufson, S. Vast China market key to smoking disputes. The Washington Post: 1996 Nov 20; Sect A: 1.

27. Maciocia, G. Churchill Livingstone; New York, NY: The Foundations of Chinese Medicine: A Comprehensive Text for Acupuncturists and Herbalists 1989.

28. Doi, TL. The Anatomy of Dependence. Tokyo: Kodansha International; 1973.

29. Jenkins, CNH.; Kagawa-Singer, M. Health Status. In: Zane, NWS.; Takeuchi, DT.; Young, KNJ., editors. Confronting Critical Health Issues of Asian and Pacific Islander Americans. Thousand Oaks (CA): Sage Publications; 1994. p. 105-47.

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

Table 1

Sociodemographic Characteristics

Characteristic	%
Country of Birth	
Mainland China	41.0
Taiwan	26.0
Hong Kong	21.0
Vietnam	9.0
Korea	3.0
Employment Status	
Employed	35.0
Students	29.0
Retired	21.0
Unemployed	15.0
Marital Status	
Married	44.0
Single	44.0
Divorced	6.0
Widowed	6.0
Educational Level	
K-8	24.0
9–12	44.0
College	26.0
Grad School	6.0
Health Insurance	
Yes	86.0
No	14.0
	Mean (range)
Years in U.S.	8.6 yrs (6 mos. to 24 yrs)
Age Range	44.5 yrs (17 to 83 yrs)

NIH-PA Author Manuscript
NIH-PA Author Manuscript
NIH-PA Author Manuscript

Table 2

Themes of Cigarette Use

	N	%
Predisposing Factors		
Dependence	24	70
Physical	13	38
Psychological	11	32
Inadequacy of knowledge alone	23	68
Lack of symptoms/Abnormal checkup	20	59
Reinforcing Factors		
Social attitude/values:		
Etiquette	10	29
Social status	11	32
Maturity/maleness	11	32
Entree/business	16	47
Perception:		
Stimulates thinking	17	50
Balance (*yin* & *yang*)	12	35
Cues	20	29
Friends smoked	23	68
Rules about smoking at home	15	44
Enabling Factors		
Lacked skills to deal with stress	13	38
Smoking soothes, relaxes	11	32

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

Table 3

Themes of Smoking Cessation

	N	%
Predisposing Factors		
Personal willingness/determination	23	68
Negative health effects of smoking	19	56
Weight gain/better complexion after quitting	9	26
Reinforcing Factors		
Restrictions	25	73
Rules of family/friends	23	68
Enabling Factors		
Cultural differences in U.S.	13	38
Dislike smell of cigarettes	12	35
Smoking not allowed in public places	21	62
Reduced smoking cues in the media	5	15