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“It’s Not a Life or Death Thing”: A Grounded Theory Study of Smoking Decisions among Chinese Americans

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Abstract

Smoking results in a high mortality rate for Chinese Americans. Little is known, however, about the decisions members of this group make that lead to these unhealthy behaviors. Examining smoking decisions could help us understand these choices as well as develop effective prevention strategies. This grounded theory study was conducted to understand Chinese Americans’ smoking decisions. Fifty-four individual interviews and three focus groups were conducted with Chinese Americans of different smoking statuses. The findings describe five smoking decisions including the trajectory of these behaviors. Optimistic bias is identified as one of the main reasons that regular smokers decide not to quit. Some Chinese Americans decide to smoke in order to protect themselves from secondhand smoke because of the perception that secondhand smoke is more dangerous than active smoking. Finally, many Chinese Americans change their smoking behaviors after immigration, with their social environment after immigration playing a key role.

Keywords

Smoking, Decision-Making, Chinese Americans, Grounded Theory, Optimistic Bias, Immigration

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“It’s Not a Life or Death Thing”: A Grounded Theory Study of Smoking Decisions among Chinese Americans

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Smoking results in a high mortality rate for Chinese Americans. Little is known, however, about the decisions members of this group make that lead to these unhealthy behaviors. Examining smoking decisions could help us understand these choices as well as develop effective prevention strategies. This grounded theory study was conducted to understand Chinese Americans’ smoking decisions. Fifty-four individual interviews and three focus groups were conducted with Chinese Americans of different smoking statuses. The findings describe five smoking decisions including the trajectory of these behaviors. Optimistic bias is identified as one of the main reasons that regular smokers decide not to quit. Some Chinese Americans decide to smoke in order to protect themselves from secondhand smoke because of the perception that secondhand smoke is more dangerous than active smoking. Finally, many Chinese Americans change their smoking behaviors after immigration, with their social environment after immigration playing a key role. Keywords: Smoking, Decision-Making, Chinese Americans, Grounded Theory, Optimistic Bias, Immigration

Cigarette smoking is a significant global health issue that has been considered a priority for the world health community (WHO, 2008). Cigarette smoking is the leading cause of preventable death resulting in over 5 million deaths each year worldwide (WHO, 2008) including 480,000 deaths in the U.S. alone (U.S. Department of Health and Human Services, 2014). Tobacco increases mortality from cancer, cardiovascular and heart diseases (Gandini et al., 2008; He et al., 2008), however, Chinese Americans continue to smoke despite reductions in smoking among American populations (U.S. Department of Health and Human Services, 2014; Gomez et al., 2013; McCracken et al., 2007). This study explores the smoking decision-making processes of Chinese Americans who continue to risk severe health problems for themselves and others around them to maintain their smoking behaviors. Understanding smoking decisions could help us better understand these choices as well as develop effective prevention and treatment strategies (Chang, Song, & Lee, 2008).

Previous research identified a variety of factors that influence Chinese Americans’ smoking behavior including low education level (Yu, Chen, Kim, & Abdulrahim, 2002), low language proficiency (Fu, Ma, Tu, Siu, & Metlay, 2003), lack of adequate knowledge about smoking consequences (Hu et al., 2006) and early warning signs and symptoms of cancer (Yu et al., 2002), positive social smoking norms (Tu, Walsh, Tseng, & Thompson, 2000), perceived benefits of smoking (FitzGerald, Poureslami, & Shum, 2015), acculturation (Sussman & Truong, 2010), and depression (Tsoh, Lam, Delucchi, & Hall, 2003). These factors provide a context in which Chinese Americans make smoking decisions. However, to date, little is known about the decision process, itself. We know, for example, that lack of knowledge about smoking harm is one of the main reasons that Chinese Americans smoke (Hu et al., 2006). However, we do not know if Chinese Americans use inaccurate information or just lack basic information in making smoking decisions. In other words, how these identified factors (e.g., lack of knowledge) play out in Chinese Americans’ smoking decisions remain unknown. The

aim of the study is to describe Chinese Americans' smoking decision processes and identify factors that influence these decisions.

Literature Review

Smoking Disparities and Chinese Americans

The past 50 years have witnessed aggressive tobacco control programs in the U.S. that resulted in great changes of the social acceptability of smoking (U.S. Department of Health and Human Services, 2014) and, ultimately, in decreased smoking prevalence (CDC, 2011). However, this success has not been uniformly shared by all segments of the population. Smoking remains a problem particularly among Asian Americans (Maxwell, Crespi, Alano, Sudan, & Bastani, 2012; Ma, Tan, Fang, Toubbeh, & Shive, 2005), with its prevalence exceeding 50% in some Asian communities (Averbach, Lam, Lam, Sharfstein, Cohen, & Koh, 2002). Like all racial groups, considerable within-group variation in smoking prevalence exists among Asian Americans. The observed high level of heterogeneity of smoking prevalence rates (Maxwell et al., 2012; Weiss, Garbanati, Tanjasiri, Xie, & Palmer, 2006) leads to the recommendation to target smoking interventions by country of origin (Baluja, Park, & Myers, 2003). This study focuses on smoking among Chinese Americans, the largest Asian group in the U.S., constituting 23% of the Asian American population (U.S. Census Bureau, 2010). The term "Chinese American" refers to anyone who is of Chinese origin. In most demographic research, this includes both immigrants and their descendants from Mainland China, Hong Kong, Macau, Taiwan, as well as overseas Chinese who have immigrated from Southeast Asia and South America. Since the initial wave of Chinese immigrants arrived in the 19th century in response to the need for labor to build railroads and in response to the gold rush, their numbers have continued to grow, reaching 4 million in 2010 (U.S. Census, 2010).

One health disparity that has been largely ignored of this group is the high mortality rate that Chinese Americans face as a result of cigarette smoking (Gomez et al., 2013). Research on Chinese Americans living in different regions in the U.S. indicates that current smoking rate among Chinese Americans ranges from 10% to 24% (Ma, Shive, Tan, & Toubbeh, 2002; Maxwell et al., 2012; Shelley, Fahs, Yerneni, Qu, & Burton, 2006; Tang, Shimizu, & Chen, 2005; Yu, Chen, Kim, & Abdulrahim, 2002). Most Chinese American current smokers are also regular smokers who have smoked for 10 years or more and have no intention to quit (Yu et al., 2002). Perhaps as a result, Chinese Americans have a high rate of lung cancer (McCracken et al., 2007). Chinese American women, in particular, despite a low smoking prevalence rate compared to men (Maxwell et al., 2012), have the highest lung cancer incidence rate and the highest lung cancer mortality rate among Asian American groups (McCracken et al., 2007), which might be caused by high secondhand smoke exposure at home and at work sites (Ma, Shive, Tan, & Toubbeh, 2005; Shelley et al., 2006).

Smoking Decisions

Smoking is a health-related decision that may cause serious and widely known health problems while providing certain rewards (e.g., fun). Depending on their present smoking status (i.e., never smoker, current smoker, and former smoker), people make decisions about whether to initiate, maintain or quit smoking, and/or whether to stay away from secondhand smoke. For those who quit, decisions are made about relapse, as well.

Accordingly, smoking interventions target these different types of smoking decisions, such as preventing smoking initiation (Elek, Wagstaff, & Hecht, 2006), reducing the amount of smoking (Cantrell, Hung, Fahs, & Shelley, 2008), promoting smoking cessation (Zhu,

Wong, Tang, Shi, & Chen, 2007), and fostering a smoke-free environment (Shelly et al., 2006). Regardless of the targeted behavioral change, all interventions are built on understanding how people make such decisions and attempt to alter these factors in order to enact behavior change. This qualitative grounded theory study was conducted to explore Chinese Americans' smoking decisions.

Methods

Grounded theory is "a qualitative research method that uses a systematic set of procedures to develop an inductively derived grounded theory about a phenomenon" (Strauss & Corbin, 1990, p. 2). It begins with an area of study (i.e., smoking decision of Chinese Americans) and attempts to discover what is relevant. Conducting a grounded theory study gives individuals a chance to articulate their thoughts, allowing for social constructions to emerge through analyses. Moreover, grounded theory allows the study to explore and understand Chinese American's smoking decisions from their own perspective. A local perspective can help better understand the people and the culture than applying a theory that is not developed for the group (Airhihenbuwa, 2006), especially given that theories developed based on one ethnic group might not work the same with a different population (Kim, 2002). Using a grounded theory approach is particularly appropriate when relatively less is known about a phenomenon, such as smoking decisions of Chinese Americans, allowing culturally unique findings to emerge.

Data were collected through both individual interviews and focus groups. Individual interviews are capable of collecting rich, detailed data and offer flexibility, which is appropriate for probing individualized experiences of smoking decision-making processes. Meanwhile, focus groups provide interaction data that helps unveil participants' similarities and differences and give rich information about a range of perspectives and experiences (Freeman, 2006). Thus, individual interviews were conducted first to gather personal accounts of smoking decisions. Next, focus groups were organized by gender and smoking status to cross-validate the findings (Morgan, 1997) and to obtain more comprehensive data (Lambert & Loiselle, 2008) by examining possible (dis)similar opinions and beliefs. The study procedure was approved by the Institutional Review Board of Protection of Human Subjects at Pennsylvania State University.

Participants

A purposive sample of 72 adult Chinese Americans living in Atlanta, Georgia was recruited to participate in this study. The researcher utilized various recruitment methods, including fliers, face-to-face communication, and electronic messages. A snowball sampling method (Atkinson & Flint, 2001) was used at the end of each interview. The researcher asked participants if they had friends or acquaintances to refer. Potential participants were instructed to contact the researcher either by phone or via email to answer a set of screening questions about their age, gender, and smoking status and then to schedule a time for the interview.

Participants were selected based on their age (must have been at least 18 years old), gender (to include both genders) and smoking status (i.e., never, current or former smoker). The goal was to include individuals of different smoking statuses and both genders in order to obtain a comprehensive description of all different types of smoking decisions and decision-making processes. All recruitment methods yielded some responses, although snowball sampling recruited the largest number of participants, representing a wide range of socioeconomic and professional status (e.g., business owner, doctor, lawyer, banker, restaurant worker, university professor, student, truck driver, househusband and housewife). The sample

was skewed toward highly educated people, 85% having at least an associate college degree. Fourteen participants were between the age of 18-25 (20%), 26 were between the age of 26-35 (36%), 16 were between the age of 36-50 (22%), and 16 were 50 or older (22%). All participants but one were foreign-born with some migrating to the U.S. as young as four years old. Their length of stay in the U.S. ranged from three months to more than 35 years.

Procedure

The data collection consisted of two parts: individual interviews and focus groups.

Individual Interviews. Fifty-four Chinese Americans participated in the individual interviews. Among these were 18 never smokers (9 women, 9 men), 19 former smokers (6 women, 13 men), and 17 current smokers (8 women, 9 men). Following the funnel approach (Morgan, 1997), interviews with the broad question “what do you think of when I say ‘smoking’?” and then moved to more structured questions about specific smoking decisions. Based on the smoking statuses, interview questions differed. Never smokers were asked about their decision not to smoke and their perceptions of smoking and secondhand smoke. Current smokers were asked about their smoking decisions and intention to quit. Former smokers were asked about their quitting decisions.

The researcher conducted all individual interviews. The researcher greeted the participants upon their arrival at the interview location and had a brief casual conversation to create a comfortable environment. Before starting the interview, the researcher asked the participants which language they would like to use for the interview and all but four preferred Chinese. The researcher then explained the study’s purpose and procedures and asked participants’ permission to record the interview. Verbal consent for participation was obtained and recorded. In addition to the audio recordings, the researcher also recorded field notes during the interviews. Member checking was performed throughout the interviews by asking participants if the researcher’s understandings of their experiences or opinions were correct. This continued at the end with a short debriefing session when the researcher summarized the key points of the conversation and asked the participants for correction, confirmation, or additional comments. After the interview each participant received \$25.

Since grounded theory research requires concurrent process of data collection and analysis (Lazenbatt & Elliott, 2005), at the end of each day of field work throughout the one-month data collection period, the researcher casually chatted with a community leader and sometimes a few community members to discuss and debrief the interviews of the day. The researcher also listened through the interview recordings, reviewed field notes, and wrote research memos summarizing the interviews, researcher’s impressions and thoughts, and the conversation with the community leader/members. When necessary, interview questions were revised and new questions added to check the emergent preliminary findings with new participants. For example, in addition to the question “What do you think of secondhand smoke?”, a new question was added for later participants, “Some people say that secondhand smoke is more harmful than smoking, what do you think?” This process also led to purposive selection of new participants to ensure that the findings were theoretically complete (Lazenbatt & Elliott, 2005). Individual interviews stopped when saturation was reached.

Focus group interviews. Next, three focus group interviews were conducted with 18 Chinese Americans. The first focus group consisted six female never smokers, the second focus group comprised four male never smokers, and the last one included eight male current smokers. These three population categories represented the majority of the Chinese Americans because of the small number of former smokers (Yu et al., 2002) and female smokers (Tang et al., 2005). Focus groups were conducted at a community center. The researcher moderated the female never smoker group discussion. A male bilingual undergraduate student with previous

research experience was hired and trained to moderate the focus groups with male current and never smokers. This arrangement was made because of the potential discomfort with a female researcher moderating the discussion of a group of men where gender may become particularly noticeable for a topic (i.e., smoking) that is a gendered experience in Chinese culture (Tang et al., 2005).

The procedures for the focus groups were similar to individual interviews. After arrival, focus group participants were greeted by the moderator, asked to self-introduce themselves and then freely conversed with each other for about five minutes. The same set of interview questions from the individual interviews was used with additional cross-validating questions asking if focus group participants would agree with the preliminary themes that emerged from individual interviews. All focus groups were conducted in Chinese and audio recorded. After the discussion, focus group moderators created memos recording the observations of the group interaction. Each participant received \$25 for compensation.

Data Analysis

The final data consisted of 2,200 minutes of interview recordings, field notes and research memos. One third of the interviews were transcribed verbatim by two trained transcribers and the rest of the untranscribed audio recordings were analyzed using audio coding (Crichton & Childs, 2005). This decision was made for two reasons. First, Crichton and Childs (2005) suggested that the use of audio data instead of verbatim transcription has several benefits. It not only helps reduce the risk associated with transcriptions, such as misinterpretation, transcription errors, and loss of contextual cues but also helps with capturing the richness of how things are said in addition to what is said (i.e., noting the paralinguistic cues). Second, there are linguistic challenges in managing transcription process, with the potential problem that transcription might not truthfully and objectively represent data (Tilley, 2003). The researcher had a portion of the audio recordings transcribed by trained transcribers first. When checking the transcripts, the researcher noticed that sometimes the meaning of the text was not clear from reading the transcripts but required listening to the paralinguistic cues from the audio. Thus, it was decided that audio coding would be more appropriate. The transcripts were still included in the data analysis. All existing transcripts were checked against their corresponding recordings to ensure accuracy. Additionally, the original recordings were included in the analysis in case transcripts were not clear for meaning interpretation.

NVivo 9 (QSR International, 2010) was used for data analysis because it helps manage and organize large amount of data and enables audio coding. The researcher and a second coder, a Chinese man who lived in Atlanta, conducted the data analysis. The purpose of including a second coder from within the study population was to negotiate the interpretation of the emerging themes and to ensure that data interpretation reflected and resonated with Atlanta Chinese Americans' point of view. The second coder's perspective strengthened the validity of the findings. Since the purpose of including a second coder was to help with data interpretation, inter-coder agreement was not calculated but rather, the two coders discussed their understandings and interpretations of data until they reached agreement on each category. The procedure of data analysis is shown in Figure 1.

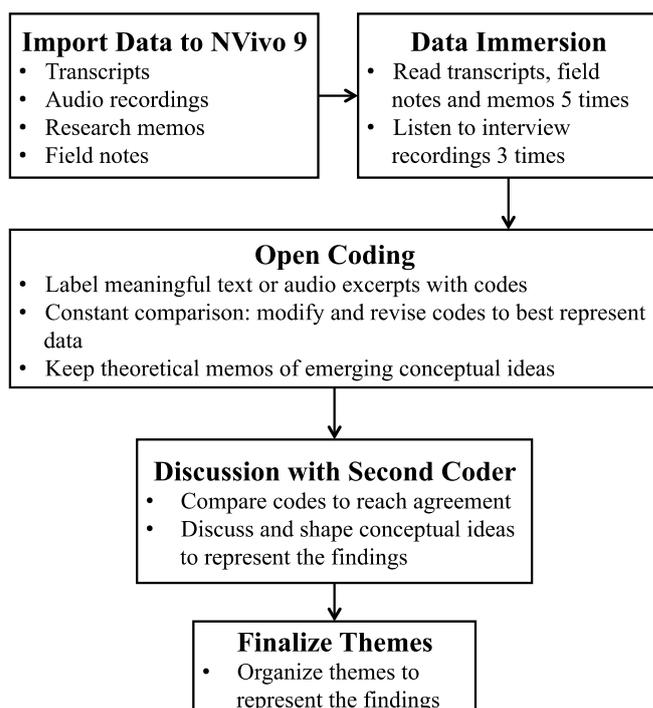


Figure 1. Data Analysis Procedure

Research Rigor

Research rigor was ensured through evaluating whether the study included four essential components of grounded theory: concurrent data collection and constant comparative analysis, theoretical sampling, memoing, and a built-in, on-going checking process to ensure research quality (Elliott & Lazenbatt, 2005; Glaser, 1998). First, back and forth data analysis occurred simultaneously with data collection that the researcher reviewed the completed interviews at the end of each field day and revised interview questions when necessary for the upcoming interviews. Second, to ensure the newly developed theory is theoretically complete, the researcher purposefully selected participants to interview next based on the analysis and emerging findings. Third, the researcher kept memos of emerging preliminary findings throughout the research process to be used as building blocks of the new theory.

Finally, checking to ensure accurate interpretation of data was performed throughout the research in various ways: (1) the researcher checked accuracy of understanding throughout interviews with the participants, (2) the findings from individual interviews were cross-validated in the focus group discussion by asking specifically what the participants thought of the themes emerged from the individual interviews, and (3) various members from the study population were included in the data collection and analysis process, including the community leader and members who had casual conversation with the researcher after each day of field work, the two hired transcribers, and the second coder, all of whom helped check the findings.

Results

Chinese Americans of both genders and different smoking statuses were interviewed to understand their smoking decision-making processes. The results start with describing the categories of smokers. It turns to describing the types of smoking decisions and the reasons for

each decision-making. Finally, it explains in detail immigration experience, an emergent factor that influenced Chinese Americans’ smoking decision changes.

Categories of Smokers

Analyses started by attempting to separate and describe different types of smoking decisions. The study initially adopted the CDC (2011) definition of smoking statuses (i.e., never, current, and former smoker) for recruitment purpose. However, more than half (52%) of “never smokers” by the CDC definition (i.e., never having smoked 100 cigarettes) had experimented smoking at some point of their life and their smoking decisions were quite different from truly never smokers. As a result, the smoking decision of these “experimenters” was separated out from never smokers who literally never tried smoking.

In addition, analyses revealed that not all smoking was alike. Respondents clearly separated “social smoking” and “real smoking” (i.e., regular smoking) and their corresponding decision process differed. Five smoker categories were hence identified, include 6 never smokers, 10 experimenters, 7 social smokers, 15 regular smokers, and 16 former smokers.

Once the categories of smokers were established, analysis turned to the decision process, itself. Various smoking decisions were made by the five types of smokers. These decisions seemed to follow a trajectory that starting with never smokers deciding to experiment or not. Experimenters who continued smoking became either social smokers or regular smokers depending on their smoking occasions. Regular smokers also faced the decision to quit or not to quit. Once they quit smoking, they became former smokers who decided to stay abstinent, relapse, or smoke socially to become social smokers. The trajectory of smoking decision-making processes is shown in figure 2.

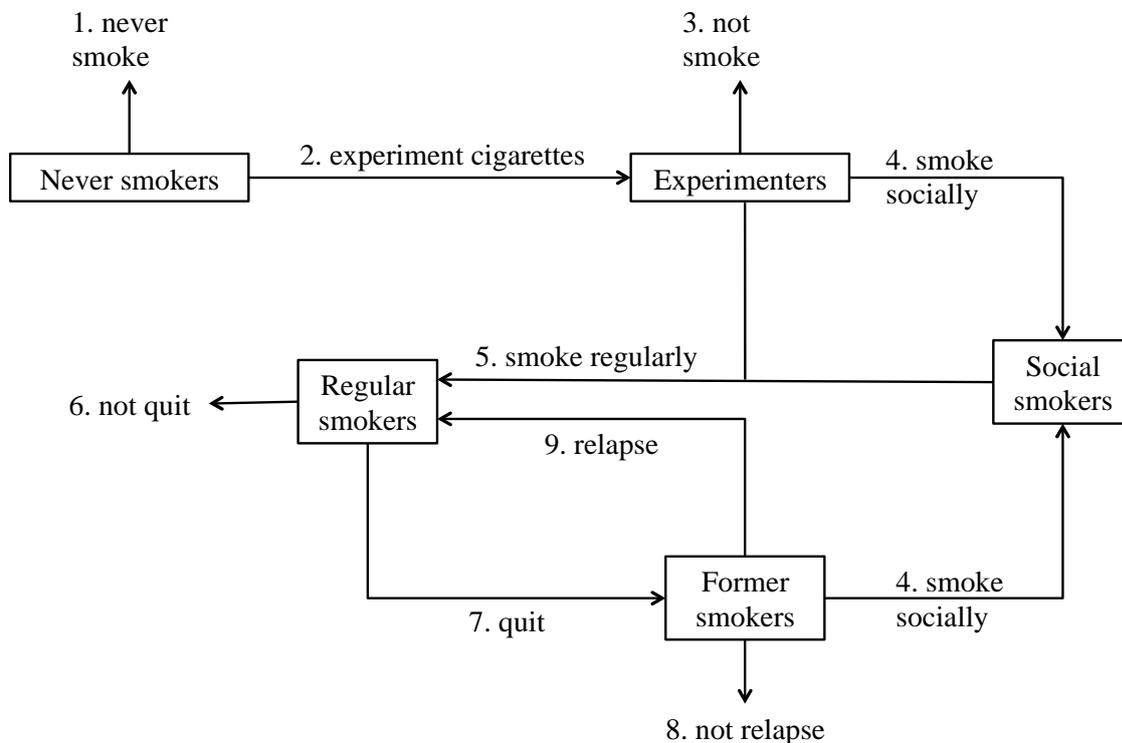


Figure 2. Trajectory of Chinese Americans’ Smoking Decisions

Table 1. Description of Smoking Decisions

Types of Decisions	Self-reasons	Interpersonal Reasons	Environmental Reasons
1. Never smoke	“Having asthma” “Never thought of smoking”	Lack of social exposure: “None of family member smokes,” “Few friends smoke” Anti-smoking norms: “only bad people smoke,” “women should not smoke”	
2. Experiment cigarettes	Curiosity Stress Wanting to be like adults Romantic relationship problems	Asked by others To fit in social circle To avoid <i>gehe</i> (estrangement)	Available: cigarettes at home
3. Not smoke after experimentation	Unpleasant experimentation experience: “felt dizzy,” “did not like taste” No benefit: “did not relieve stress”	Anti-smoking norms	“cannot afford”
4. Smoke socially after experimentation or quitting	“Enjoy the social atmosphere” “Have fun” No severe health consequence Avoid secondhand smoke	“Didn’t want others to be left out” “Establish a common identity by doing the same thing as others”	
5. Smoke regularly after experimentation	Like the taste Benefits Addiction “Habit”	“Everyone smokes” Help with socialization	Excuse to take work break
6. Not quit	Enjoy smoking Addiction Negative consequences of quitting Benefits outweigh costs Optimistic bias Gambling	“Everyone smokes”	
7. Quit	Health problems Personal life change (e.g., having baby)	Children/spouse ask to quit Household ban of smoking	Social environment change (e.g., after immigration)
8. Not relapse	Health problems	No social needs of smoking	
9. Relapse	Addiction	Hanging out with smokers	

Table 1 describes the nine smoking-related decisions made by Chinese Americans of various smoking statuses and their reported reasons for such decision-making. These decisions are about cigarettes experimentation, smoking socially, smoking regularly, continuing smoking and not quitting, deciding to quit, and finally, relapsing or not after quitting. Four of the more complex decisions – smoking socially, smoking regularly, smoking and not quitting, and quitting - are described in detail respectively.

Deciding to Smoke Socially

As shown in Figure 2, all types of smoking started with the decision to experiment cigarettes. Many people did not continue smoking because the experimentation experience was unpleasant. Yet, some experimenters continued smoking socially and became social smokers, that is, they smoked only around smoking friends or business partners and never smoked alone. Some of the social smokers did not consider themselves as smokers, but self-identified as a “non-smoker” (if they never smoked by themselves) or “former smoker” (if they had quit smoking and only smoked occasionally with friends).

One thing to note is that social smoking could be a transitional phase in the process of becoming a regular smoker by either experimenters or former smokers, or it could be a terminal smoking decision. Most social smokers stated that they would never smoke regularly. They seemed to have sophisticated thoughts about smoking consequences and made a deliberate decision to only smoke socially. They acknowledged that they did not want to smoke regularly because of health concerns and consciously tried to control their smoking, but were willing to take a small risk by smoking socially. One social smoker compared social smoking to unhealthy food, “it’s like having French fries, it’s not good for your health, but it won’t kill you if you do it only occasionally.”

Among the main reasons for social smoking decisions as shown in Table 1, the reason of smoking socially in order to avoid secondhand smoke was particularly interesting. A few social smokers reported that, because “secondhand smoke is more poisonous than smoking myself,” they smoked to “protect” themselves from secondhand smoke. For example, one self-identified male “former smoker” said that even though he had “quit smoking,” the only occasion he would still have a cigarette occasionally was when he was hanging out with a group of smoking friends in order to protect himself from secondhand smoke. One female smoker also told the story about one nonsmoking friend in her friend circle who liked to join the smokers during smoking breaks. She and other smoking friends often told the nonsmoking friend, “you should smoke too when you are with us, secondhand smoke is worse than you smoke yourself.”

The perception that secondhand smoke leads to more severe health consequences than active smoking seemed to be quite prevalent among Chinese Americans. Participants reported frequently reading or hearing from Chinese media (e.g., news reports) that nonsmokers who are exposed to secondhand smoke have higher health risks than smokers and are “more likely to die from lung cancer.” Although some participants did question the validity of this information, this perception was reported as the reason for smoking initiation or social smoking for a number of participants.

Becoming a Regular Smoker

Fifteen participants smoked regularly (i.e., regular smokers) after experimentation. In contrast to social smoking, regular smoking was not an deliberative decision, but rather a result of a gradual process that ended up becoming a “habit” many consider as “a part of life.” The gradual process usually extended over a long period of time, initiated by experimental smoking,

and accelerated to regular use. Unlike experimenters, regular smokers' experimentation did not stop after the first experience. Some simply enjoyed the experience and continued smoking. Others, however, did not like the cigarette taste, but continued to smoke because of strong social reasons (e.g., co-workers smoked regularly). They eventually got used to the taste, became addicted and began smoking regularly on their own. Their decision process hence was a transition from experimenting to social smoking and finally to regular smoking. Still others initially stopped smoking after experimentation but became smokers a few years later when "life was stressful" or "bored." They reported using cigarettes to soothe the negative feelings and trying cigarettes the second time, "it did not taste as bad," or "grew up, [I] had better ability to endure." Common to this group were comments such as, "gradually it worked out, [it] became normal," and they became regular smokers.

This gradual, non-deliberate decision-making process to become a regular smoker was demonstrated by the comment typifying many regular smokers that "[I] never thought I would become a smoker." They started with cigarette experimentation thinking that they "could stop anytime [they] want." Unexpectedly, smoking gradually became a "habit." It seemed that, as the researcher noted in a research memo,

Many smokers picked up the "habit" without being aware of it, and when they realized, it was already too late because of nicotine addiction, and the decision was only to be made whether they wanted to quit and/or capable of quitting.

Continue Regular Smoking and Not Quit

Twelve regular smokers reported being aware of smoking consequences but still deciding not to quit. Some of the reasons reported for picking up the regular smoking habit remained as the reasons to continue smoking. These include enjoying smoking, "everyone smokes" and addiction. Although not all regular smokers admitted addiction, those who were trying to quit reported difficulty because of being addicted. One male regular smoker said,

When I wake up in the morning, I want a cigarette. I hit my hand when I reach out for cigarettes, but it doesn't work, I smoke eventually during the day when I am driving. There is no way [to quit], because I'm addicted.

In addition to these reasons, regular smokers reported four other reasons for not quitting: negative consequences of quitting, smoking benefits outweigh costs, optimistic bias, and a mentality of gambling.

Negative consequences of quitting. A number of perceived negative consequences of quitting stopped regular smokers from quitting. Reported negative consequences included death, gaining weight, increased amount of smoking if failed, and psychological consequences, such as bad spirit, feeling bored and lonely as well as stress management issues because of "chemical imbalance." Worry about death from quitting smoking was, perhaps, an extreme case. One female regular smoker said that she was worried because two of her friends died not long after they quit smoking but she was unsure if quitting would actually cause death. She said "It's like they have been smoking, and there was no problem at all, but after quitting, all problems came out, and then, you know, they passed away... It felt strange."

Smoking benefits outweigh costs. In addition to the difficulties and concerns about quitting, another reason regular smokers did not want to quit was based on their evaluation of smoking costs and benefits. They explained that they needed the benefits of smoking, such as stress relief or staying awake, and more importantly, "there was nothing to stop me from smoking" because they had never experienced health problems associated with smoking and

hence did not perceive smoking as a risky behavior. Although some mentioned minor health issues, such as coughing or itching throat, they either attributed these issues to other causes, such as reduced immunity because of stressful life conditions, or did not see them as severe problems that would require quitting “because I’m not dying.” In other words, regular smokers did not want to quit because the perceived costs of smoking did not outweigh the benefits. Many regular smokers had the mentality that severe health problems, such as lung cancer, were not likely to occur to them and they “accept the consequences” of minor health issues, such as breath problem, because “I’m not an athlete, I don’t need to be that healthy” and “it is just small sacrifice” given the benefits. Their view of smoking health consequences is somewhat related to optimistic bias and a mindset of gambling, which are explained next.

Optimistic bias. Optimistic bias, people’s tendency to view the risks of various behaviors as lower for themselves than for others engaging in similar behaviors (Arnett, 2000), is one of the main reasons that regular smokers do not quit smoking (Masiero, Lucchiari, & Pravettoni, 2015). This study identified three types of optimistic bias, including underestimated susceptibility, chronic consequences of smoking, and unrecognized addiction.

Many regular smokers believed that their susceptibility to severe diseases was low. They often used family history, smoking history, and health constitution to justify their perception. Examples of family members were frequently used. One male current smokers said, “many of my relatives, like my grandpa, my uncle, they had smoked up to 60, 70 years old, and never had any of the diseases their life from smoking.”

Smoking history, such as length and amount was another frequently referred reason for the under-estimation of susceptibility. A few current smokers reflected that they had not smoked long and/or did not smoke heavily, so they rationalized that smoking would not be as bad for them compared to frequent and/or heavy smokers. They drew a clear boundary between themselves and “heavy smokers,” and expressed their concerns for those who “smoke a pack a day” and how highly likely those heavy smokers would have lung cancer. As to themselves, one female regular smoker stated, “I’ve never been a one pack smoker... because I don’t smoke much, it should be alright.” However, when asked for the actual smoking history, some were surprised to realize that they “had smoked long” for 6 years or longer. In other words, they under-estimated their smoking behavior as well as the health consequences.

A third reason for under-estimated susceptibility is health beliefs based on traditional Chinese medicine. Many smokers stated that drinking tea could help clean some of the toxins from cigarettes and because they drink tea regularly, their health risk is low. “Tizhi” (a Chinese medicine term, similar to constitution) is another frequently mentioned concept. Some participants believed that “everyone has different weak points of body” and some are more susceptible to lung problems and some are not. One male regular smoker, who had throat and nose problems, considered these minor health problems as safety vault to fatal diseases: “I’m less susceptible to lung cancer because [I’ve found out that] my weak point is throat and nose.”

In addition to the optimistic bias toward susceptibility, many regular smokers believed that the severe consequences of smoking (e.g., lung cancer) are “chronic” and take a long time to occur, so they did not need to worry. Meanwhile, the “short-term” effects (e.g., coughing), are minor and disappear once one quits. Although they believed that smokers indeed have a higher probability than non-smokers to develop severe health problems, they did not feel the necessity to worry about it because so many other things could happen before such health problems occur. One female regular smoker said,

Like my former classmate, not smoking, not drinking, but had a car accident the other day, and the person is gone [dead]. It’s really hard to say. Suddenly, one day, the person is gone. After one day, this person is gone again. Doing so much for health right now, who knows you will be gone one day when you go out ...

So lung cancer is a very long-term thing... [I could] die from eating too full [before that].

One male regular smoker also said, “The big diseases caused by smoking might take a real long time to show, maybe it will not come out until you are 100 years old, but you probably have died already before that.” Therefore, their perception of smoking was, as another male regular smoker said, “Smoking, you know, is not a life or death thing.”

Other smokers did not want to quit because of the optimistic bias toward addiction. Without perceiving themselves being addicted, they did not feel the need to worry about quitting at the moment. As one female regular smoker stated, “I will quit when I want to...you know, when I have baby...I know I can quit easily, because I am not addicted.” However, when asked about the smoking habits (e.g., smoking occasions), these participants described situations when they had the urge to smoke if had not smoked for a while, a sign of addiction.

Gambling. In contrast to those articulating an overall optimistic bias toward smoking consequences, other current smokers acknowledged their own risks of having fatal diseases because of smoking but decided to continue smoking. These smokers admitted that they were engaged in a “gambling game.” They had started thinking about the health consequences of smoking but were in hopeful thinking that “bad things might not happen,” or “a little longer would be okay.”

Deciding to Quit

Despite of the large number of regular smokers who decided not to quit, another group of Chinese Americans decided to quit and some succeeded. Three interviewed regular smokers were in the process of quitting and 16 former smokers were not engaged in any smoking behavior at the moment (i.e., were not social smoker).

One of the biggest reasons reported for quitting was health problems. For example, severe health conditions (e.g., heart surgery) “forced” two former smokers to quit. Both of them had quit for more than ten years and never relapsed. Others quit because of changes in their personal lives, such as preparing to have a baby and becoming religious, or interpersonal reasons, such as being requested by spouse/children to quit. However, compared to being ill, people who quit because of life changes or interpersonal reasons seemed to be much less confident about remaining abstinent and indicated that they might relapse. For instance, one former smoker reported that he had quit twice. He quit for three years the first time because he became a father. However, when the child grew a little, he picked up smoking again. His second attempt to quit was still going on at the time of the interview. He had stayed abstinent for a year already because he was planning to have the second child but expected to go back to smoking right after the baby was born. Finally, eight former smokers quit because of social environment changes, such as stricter smoking restrictions after coming to the U.S. Three out of the eight expected to relapse when the social environment change again when they return to China. Thus, the immigration experience played an important role in their smoking decisions, which is explained in detail in the next section.

Smoking Decision Change Due to Immigration

As explained above, Chinese Americans make several smoking decisions based on various self, interpersonal and environmental reasons. One of these reasons, immigration, not only contributed to quitting decision but seemed to encompass a couple of other decisions. This section describes how some smoking decisions changed because of the immigration experience.

Many participants changed their smoking behavior after immigration. Eight former smokers quit smoking after they arrived in the U.S. while three regular smokers reduced the amount or frequency of smoking. In contrast, four people started or increased smoking after arrival. Such changes in smoking behavior can be explained by the social environmental changes associated with immigration.

Immigration-related changes were among the main reasons that Chinese Americans reported quitting or reducing smoking. Five aspects of social environment changes influenced these decisions. First, the taste of the cigarettes in the U.S. were “too light” (i.e., contain less nicotine) and some quit because they never got used to the new taste. Second, stricter smoking restrictions in the U.S. helped reduce the rate of smoking and some even quit because, as one female participant reflected, “how much time do you have per day to go out to smoke?” Third, some perceived a negative U.S. cultural norm toward smoking and quit smoking because, “In the U.S., people do not like smoking.” The second and third reasons seemed to relate to certain occupations such as visiting scholars, bankers, business managers, and so forth. Their work environments usually had strict smoking restrictions so that they “rarely saw people smoke” and were concerned about others’ opinions toward their smoking behavior. Fourth, more and more Chinese families implemented household smoking bans and three former smokers reported that they quit smoking because of this. Finally, the social function of smoking, which is an important reason for smoking and barrier for quitting disappeared in the U.S. where smoking is restricted at most social locations (e.g., restaurants). A male former smoker reflected,

I’ve been thinking about quitting for a long time, but never got the chance because I was always with a group of smokers, and it was hard not to smoke. People would laugh at me or try to persuade me to not quit. Since I am now in the U.S., there is no social occasion requiring me to smoke, I took the opportunity to quit.

Another group of Chinese Americans initiated or increased smoking after immigration. Their social environment and stress associated with immigration were prime factors. First, people working in blue-collar professions where the work environment was less “Americanized,” such as Chinese restaurant workers, truck drivers, as a matter of fact, were immersed in a more smoking intense environment compared to that back in China. Participants working in these professions reported that “everyone smokes” in their work environment and it was hard to resist. This is in contrast to the more professional environment described above where nonsmoking norms predominate. Second, stress experienced in adjusting to the new environment after immigration was another reason for smoking. For example, two Chinese students reported that they picked up smoking after they arrived at their new school because they were too bored and lonely without friends or family. As they got adjusted, however, their smoking reduced because no one else smoked in their social circle. In contrast, those who face both occupational hazard and stress seemed to be at higher risk. One truck driver complained that life was so boring and stressful for them that “smoking was the only entertainment” they had. As a result, they picked up smoking and/or “smoked one after one,” and found quitting “impossible.”

Discussion

Misunderstandings about Smoking Consequences

Previous studies (Averbach, et al, 2002; Hu, et al., 2006; Yu, et al., 2002) reported lack of knowledge about smoking consequences (e.g., not knowing that smoking causes heart disease) as one of the main reasons that Chinese Americans smoke and do not quit smoking. However, this was not the case for these participants in the present study who showed ample general knowledge of smoking consequences of both active and passive smoking. All participants knew that smoking was harmful to the lung and the respiratory system, and many of them discussed other problems with heart, liver, and blood pressure. However, despite the ample general knowledge about smoking consequences, misunderstandings exist due to distortions by misconceptions and optimistic bias.

Protection from secondhand smoke. The perception that secondhand smoke is more harmful than active smoking marks a surprising and alarming situation. The intention of health messages focusing on harms of secondhand smoke is to urge nonsmokers to protect themselves by avoiding secondhand smoke situations or telling smokers to stop. However, as shown in the present study, some Chinese Americans initiated smoking in order to protect themselves from the harms of secondhand smoke because of this perception. It is interesting that this group of people only judged and compared the risks of active smoking and secondhand smoking when making the smoking decision, but ignored the fact that if they smoked with smokers, they were exposed to both active and passive smoking (i.e., combined smoking. see Jiang et al., 2015), which posed a higher health risk, such as risk for cervical cancer among women (Jiang et al., 2015).

This finding highlights a possible oversight of health interventions that they often target one particular type of smoking (either active or passive) and combined smoking is rarely discussed. This is reflected in health research as well. Studies often investigate the risk level of either active (e.g., Willi, Bodenmann, Ghali, Faris, & Cornuz, 2007) or passive smoking (e.g., Almirall et al, 2014) or comparison of the two (e.g., Luo et al., 2011). Risk of combined smoking rarely is studied. As a result, public information and knowledge about this matter is lacking. As shown in this study, although some Chinese Americans questioned the validity of this perception, they did not have any information resource to clear their doubt. Health interventions need to be alerted about this problem and programs need to be developed to prevent smoking initiation because of this perception.

This present study was among the first one to explain in detail Chinese Americans' optimistic bias of smoking risks. Three types of optimistic bias, about smoking consequences, amount and history of smoking, and addiction, were identified. These perceptions were quite similar to that found in White Americans (Arnett, 2000) with the exception that Chinese American smokers based their optimistic bias on Chinese traditional medical beliefs. It seems that Chinese Americans integrate their knowledge based on Chinese traditional medicine and the smoking consequences information they derived from Western medicine when making risk judgments and decisions. Thus, an intervention that targets Western medical knowledge (e.g., smoking causes lung cancer) but ignores the traditional medical beliefs (e.g., *tizhi*) may not work effectively with this population group. A culturally grounded message design is probably needed (Hecht & Krieger, 2006). For the present, the findings suggest a grounded theory in which knowledge of smoking health risks is filtered through misconceptions and optimistic bias. At the same time, perceptions of susceptibility appear to exert stronger effects on smoking behaviors than mere knowledge. Next, I discuss different types of factors that influence Chinese Americans' smoking decisions.

Smoking Decision Permanence Relating to the Reasons for Decision

A number of reasons influencing Chinese smoking decisions were identified and can be categorized into self (e.g., personal benefits and health risks), interpersonal (e.g., smoking to fit in social circle and household ban of smoking) and environmental (e.g., smoking restriction in the U.S.) factors. Although many of these reasons are not new, having been described in previous research (Averbach et al., 2002; Hu et al., 2006; Shelley et al., 2006; Yu et al., 2002), an emergent finding was that the permanence of smoking decisions differs based on the original reasons for the decision. Compared to self-reasons, people who altered their smoking behavior based on interpersonal and environmental reasons were more likely to revert to the original behavior. For instance, individuals smoked for stress relieving found smoking more difficult to give up compared to those who smoked because immersed in a smoking environment. Once the social environment is changed, the decision may alter. Similarly, those who quit smoking because of health concerns were less likely to relapse compared to those who quit because asked by spouse or for children. Former smokers may pick up smoking once their children grow up. This finding provides one explanation for high smoking relapse rate, a concern widely shared by smoking cessation programs (Wang & Shen, 2009). This finding, however, does not argue against intervention programs working on interpersonal factors. Evidences have supported that smoking cessation programs utilizing interpersonal factors, e.g., family assisted smoking cessation intervention, are effective in promoting quitting decision for Chinese population (Huang, Jiao, Zhang, Lei, & Zhang, 2015). It is suggested that these programs to reinforce self-reasons for individuals who have quit smoking in order to stabilize their quitting decision and prevent relapse. It appears, then, that while the culturally grounded Chinese misconceptions and optimistic bias guide perceptions of harm, the source of smoke decision guides the decision change process. Finally, we turn to the role of immigration in this process.

Immigrant Experience, Acculturation and Social Environment

One factor that helps explain Chinese Americans' smoking decision changes after immigrant is acculturation, the process of cultural adaption that occurs when individuals come into contact with a different culture (Lu & Hecht, 2014). The findings suggested that immediate social environments in which Chinese Americans are immersed after immigration play a vital role. These who were exposed in a more "Americanized" environment reduced or quit smoking because of the perceived anti-smoking cultural norms and strict environmental smoking regulations. On the contrary, those who worked in blue-collar professions had limited exposure to American cultural environment and ended up increasing smoking because of the intensified smoking exposure at work places. The role of social environment has been identified in health disparities literature to explain racial/ethnic disparities (Hebert, Sisk, & Howell, 2008). For example, living in higher-enclave and lower-SES neighborhoods increase the risk of liver cancer for both Asian and Hispanic immigrants (Chang, Yang, Alfaro-Velcamp, So, Glaser, & Gomez, 2010). Residence in low-income communities moderates the effect of race on health (Dressler, Oths, & Gravlee, 2005). Neighborhood affluence, on the other hand, is found to help reduce the negative effect of race on health (Cagney, Browning, & Wen, 2005). Acculturation literature also suggests scholars paying attention to the interactional context (e.g., immigrants' SES, the local community immigrants settle) in which acculturation occurs (Schwartz, Unger, Zamboanga, & Szapocznik, 2010). Findings in the present study also highlight the importance of interactional context, but it goes beyond SES and local community with a focus on the social circles and the health behaviors of the people in individuals' social circle. It is possible that immigrants would acculturate to a sub-culture or co-culture because of extended period of

immersion in a particular social environment and learn the (un)healthy behavior of the people they frequently interact with. Interventions working on social network and social environment, particularly in segregated immigrant communities, may be a good way to address this issue. Thus, the final aspect of the grounded theory is the suggestion that the more Americanized the social environment, the less likely Chinese Americans decide to smoke.

The Grounded Theory of Chinese Americans' Smoking Decisions

Chinese Americans' smoking decisions are made under consideration of various self, interpersonal, and environmental reasons. Self-reasons seem to be the most significant, although the three main reasons are embedded within each other and all together influence Chinese Americans' individual smoking decisions. In addition to these, misconceptions about secondhand smoke, optimistic bias, and immigration experience, play important roles in Chinese Americans' smoking decision. Figure 3 depicts Chinese Americans smoking decision-making.

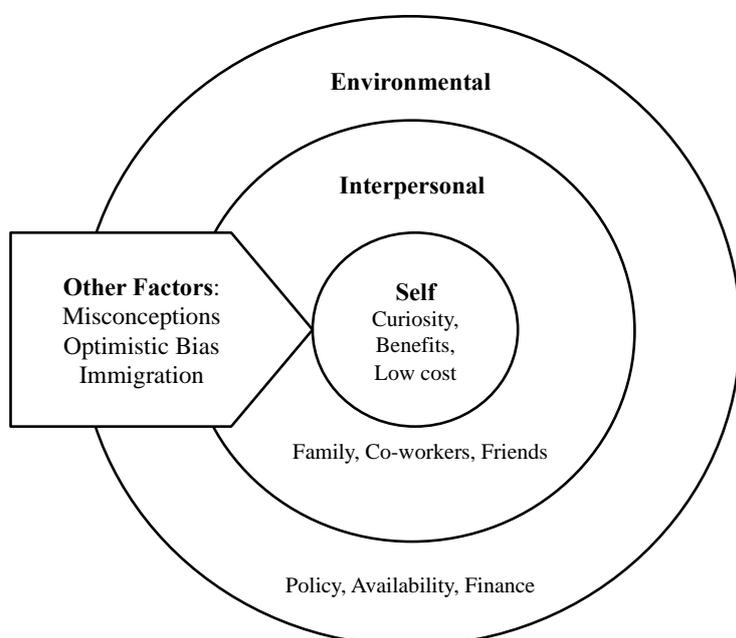


Figure 3. A Model of Chinese Americans' Smoking Decisions under Multiple Influences

Limitations

One study limitation resides in the reliability of self-report data. Participants were asked to reflect retrospectively on their smoking behaviors, which for some older participants dated years ago where memory might be an issue. Furthermore, with increased public knowledge on smoking associated harms and declined public tolerance toward smoking (Cummings & Proctor, 2014), social desirability of answers might pose another challenge in obtaining reliable data. Future research is recommended to use longitudinal designs that follow the smoking behavior of Chinese Americans over time.

Another limitation included the emergent smoker categories. Participant recruitment was guided by a priori CDC definition of never, current, and former smokers. The two categories - experimenters and social smokers - were not intentionally recruited and the findings regarding these two groups, particularly the social smoker group, with a sample size of nine, must be approached with caution. Future research should systematically sample this group to better understand their decision processes.

Finally, the overall high education level of participants may contribute to study bias. However, it is important to note that many of the participants' education credentials were obtained in China before immigration. Some participants with a Bachelor's degree were illiterate in English or even did not speak English at all and were blue collar workers, such as truck drivers or restaurant workers. This mismatch of education level and occupation is not unique to participants in this study but has been noted as a problem for immigrant populations overall (Galarneau & Morissette, 2004). Thus, although education often is used as one indicator of SES, it should be interpreted with caution in the present study.

Implications for Smoking Intervention

Participant segmentation using targeted interventions to address subgroups of Chinese Americans may offer optimal preventive measures. The present study found that individuals' first experimentation with smoking is pivotal in determining whether they decide to smoke or not, suggesting the importance of targeting adolescents and youths who are at the pre-experimentation stage for smoking.

For Chinese American adults, American social environments seem to influence their smoking behavior immediately after immigration. Less exposure to American cultural environments may contribute to increased smoking. Furthermore, many Chinese Americans engage in social smoking and, like "phantom smokers" (Choi, Choi, & Rifon, 2010), do not identify themselves as smokers and consequently, do not perceive smoking consequences are relevant to them. As a result, traditional smoking messages targeting American smokers may not influence Chinese American smokers. Instead, culturally grounded decision making, in which community-based interventions reach people in high risk categories who work and live in culturally segregated communities (e.g., Chinatown) may be beneficial. Additionally, health messages should take into consideration unique cultural beliefs, and reinforce individual reasons for quitting to prevent relapse.

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