Smoking Is the Least of Our Problems: Focus Group Findings from Native Hawaiian Youth

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Native Hawaiian youth have higher smoking rates than other Hawaiʻi youth, a discrepancy that continues into adulthood. To inform the development of tobacco-related interventions for Native Hawaiian youth, we explored intervention preferences with adolescents (ages 14–19) in a predominantly Native Hawaiian community in a rural area in Honolulu County. Five focus groups involved 26 adolescents identified by guidance counselors and teachers as current/former smokers. Data were transcribed and analyzed by the research team. Honest and candid discussion revealed that smoking was a small part of youth concerns. While not embraced, smoking and alcohol use were both preferable to using marijuana and ice (crystal methamphetamine), which were perceived as more dangerous to health and leading to family and community disintegration. Findings are discussed in the context of an ecological model that recognizes that complex problems need to be addressed on multiple fronts.

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Hūlili: Multidisciplinary Research on Hawaiian Well-Being Vol.5 (2008)
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Cigarettes remain the most frequently used substance on a daily basis by high school students nationally (Johnston, O'Malley, Bachman, & Schulenberg, 2005). Adolescents become addicted to tobacco products faster than adults because, developmentally, their brains are more sensitive to nicotine (Zickler, 2005). Adolescents often misperceive smoking as being responsible for fewer combined deaths than from gunshots and automobile accidents, and being safer than using drugs and alcohol (Jamieson & Romer, 2001). Early initiation and regular use of cigarettes and alcohol are important predictors of substance use problems in young adulthood (Riala, Hakko, Isohanni, Jarvelin, & Rasanen, 2004). Although in the past 3 decades, adolescent smoking in the United States has declined, in 2005 about 25% of high school seniors nationally report having smoked in the past 30 days (Johnston et al., 2005).

Native Hawaiians (hereinafter Hawaiians) are the indigenous people of Hawai'i, comprising about 22% of the state's population. Other major ethnic groups include Caucasians (21%), Japanese (22%), and Filipinos (16%; Office of Hawaiian Affairs [OHA], 2002). With Western contact and colonization, Hawaiians have sustained devastating loss of their population from infectious diseases, loss of land and sovereignty rights, and the disintegration of their cultural and healing systems (Andrade et al., 2006). These types of historical legacies contribute to ongoing intergenerational trauma, unresolved grief, and historical trauma response often linked to self-destructive behaviors such as suicide, substance abuse, depression, anxiety, and anger (Brave Heart, 2003; Brave Heart & DeBruyn, 1998), behaviors which are high for Hawaiian youth (Andrade et al., 2006; Else, Andrade, & Nahulu, 2007; Goebert, Nishimura, & Hishinuma, 2005; Makini et al., 1996, 2001; Yuen et al., 1996; Yuen, Nahulu, Hishinuma, & Miyamoto, 2000). Cultural loss has resulted in socioeconomic losses that persist to present day for Hawaiians, who have the lowest mean family income that support larger households and the highest percentage of individuals living below poverty (one in six Hawaiians) of the major ethnic groups in Hawai'i (Kana'iaupuni, Malone, & Ishibashi, 2005).

Hawaiian adolescents initiate smoking earlier than other adolescents and have higher rates of monthly (30-day) and lifetime cigarette use at 6th, 8th, 10th, and 12th grades when compared with state averages and rates for Asian, Black, and Hispanic youth (Pearson, 2003). The monthly (30-day) rate for Hawai'i high school students was higher for Hawaiians (17.4%) when compared with the state average (14.3%; Pearson, 2003). Cigarette use in Hawai'i youth has been linked with poor

school performance (Hishinuma et al., 2006), poor emotional health, suicide attempt, Hawaiian culture, and low socioeconomic status (Else, Hishinuma, Goebert, Nishimura, & Baker, 2008).

Discrepancies in smoking rates for Hawaiians continue into adulthood, where smoking prevalence rates have historically been higher than other groups in Hawai'i (Dachs et al., 2008; Hawai'i State Department of Health, 2004; Kaholokula, Braun, Kana'iaupuni, Grandinetti, & Chang, 2006). To illustrate, a study combining adult data from 19 studies in Hawai'i between 1975 and 2001 found that despite a small decline in smoking prevalence, ethnic differences in rates persisted with Hawaiians highest, Caucasians intermediate, and Japanese having the lowest levels of smoking (Maskarinec et al., 2005). Data from the 2007 Behavioral Risk Factor Surveillance System for Hawai'i show that 24.3% of Hawaiians are current smokers (Hawai'i State Department of Health, 2008) compared with national rates for Whites (21.9%), Blacks (23%), Hispanics (15.2%), American Indians/Alaska Natives (32.4%), and Asians (10.4%; Centers for Disease Control and Prevention, 2006). Although smoking prevalence is high for Hawaiian adults, 44% of Native Hawaiian smokers reported that they would like to quit smoking, and 45% have already tried to quit but have found it difficult (Ichiho, 2001). In 2007, 'Imi Hale–Native Hawaiian Cancer Network received a grant from the American Legacy Foundation to implement a tobacco-cessation protocol across the five Native Hawaiian Health Care Systems. Preliminary demographic data showed that Native Hawaiian smokers who were ready to quit had been regular smokers by age 18 and had lower socioeconomic status of 12th grade education or less, were not currently employed, and had a household income of $20,000 or less (L. Santos, personal communication, July 28, 2008). Prevalence of diseases affected by smoking (e.g., cancer, cardiovascular disease, stroke, hypertension, pulmonary disorders, and childhood asthma) are high in Hawaiians (OHA, 2002).

Cessation studies are critical given the large number of adolescents who smoke (Prokhorov, Hudmon, & Stancic, 2003). Some teen smoking-cessation interventions have been tested, including programs based on nicotine replacement, stages of change, motivational interviewing, and behavioral management (Grimshaw & Stanton, 2006). However, preferences for smoking prevention and cessation programs among Hawaiian youth have not been examined. As a first step in the development and testing of culturally appropriate programming for Hawaiian teens, we examined youth perspectives on health, smoking, and cessation interventions.

Materials and Methods

Design

Focus groups were held to engage small teen groups to discuss tobacco use and cessation (Morgan & Kreuger, 1998). This method fits well with Hawaiian preferences for group learning and face-to-face meetings that give individuals an opportunity to meet researchers and gauge their intent and sincerity (Braun, Mokuau, Hunt, Ka'ano'i, & Gotay, 2002; Pukui, Haertig, & Lee, 1979).

Participants

We conducted focus groups in one high school, chosen because it was located in a predominantly Hawaiian community in a rural area in Honolulu County where researchers had an established and collaborative relationship with the high school and community. With principal approval of the project, high school counselors and teachers helped identify Hawaiian teens, current or former smokers, who would be willing to openly discuss cigarette use. School enrollment is approximately 1,000 students, 80% of which are Asian and/or Pacific Islander. In all, 26 students (23 Native Hawaiian and 3 non-Hawaiian) participated in five focus groups.

Procedure

This project was approved by Institutional Review Boards of the University of Hawai'i and the Native Hawaiian Health Care Systems (the membership of which is 85% Hawaiian). Parents/guardians were notified of the study via a letter sent home with students. They were required to give written consent for their child's participation, and students gave active, written assent prior to their participation.

Five focus groups were conducted in a 2-week period in May 2005 in a private room in the school, each session lasting approximately 1 hour. Two researchers, a Hawaiian female and a Japanese/Caucasian male, cofacilitated the groups. Three research associates (a Samoan female, Japanese/Filipino female, and Caucasian female) served as recorders. The facilitators and recorders ranged in age from 24 to 35 years. Researchers were trained in conducting focus group facilitation and data coding (e.g., finding common themes and agreement among coders) by the 'Imi Hale–Native Hawaiian Cancer Network (Braun, Tsark, Santos, Aitaoto, & Chong, 2006).

Before each focus group, a survey collected data on age, gender, grade, and tobacco and alcohol use (see the Appendix). Participants were informed that the findings would be presented in aggregate with no one comment attributed directly to a specific student. Focus group questions were open-ended, proceeding from broad to specific. For example, participants were first asked, "What is a healthy teen?" We then asked "Why do teens smoke?" and "If you were to design a program to help teens stop smoking, what would it be like?" We asked follow-up questions about emerging topics, some of which were not directly related to smoking but were relevant to participants. Recorders wrote key concepts on posted paper to assure that members' comments were accurately captured and noted nonverbal behaviors (facial expressions, body language). Participants received a $25 gift certificate from a book/music store.

Audio-recordings and notes were transcribed with statements attributed to the speaker. Three researchers independently read each transcript and collaborated on developing a codebook. Once developed, researchers reread the transcripts, noting which participants supported which topic and highlighting passages that illustrated the topic. There was high agreement among researchers on themes and which individuals supported them. Disagreements were discussed until consensus was reached. Researchers collaborated on consolidating results and selecting the best quotes to illustrate specific themes.

Results

Participants were 13 male and 13 female students with a mean age of 16.6 years (range = 14–19). Most were in their junior year; 23 (88%) were Hawaiian, 1 was Filipino, 1 was Vietnamese, and 1 was mixed non-Hawaiian. Nine participants (34.6%) reported that they "drank too much beer or other alcoholic drink." Despite recruitment by teachers and guidance counselors of only current and former smokers, none of the 26 participants answered "yes" when asked in the survey "Do you smoke cigarettes regularly?" (Table 1). However, 18 (69.2%) reported that family members smoked regularly.

TABLE 1 Demographic information of focus group participants

	Gender				Total (N = 26)	
	Male (n = 13)	%	Female (n = 13)	%	*N*	%
Ethnicity						
Hawaiian/Part Hawaiian	11	84.62	12	92.31	23	88.46
Filipino	0	0.00	1	7.69	1	3.85
Mixed non-Hawaiian	1	7.69	0	0.00	1	3.85
Vietnamese	1	7.69	0	0.00	1	3.85
Mean age (in years)	16.77		16.38		16.58	
Parental education						
Less than high school	0	0.00	1	7.69	1	3.85
High school diploma	5	38.46	9	69.23	14	53.85
Some college	4	30.77	1	7.69	5	19.23
College graduate	4	30.77	2	15.38	6	23.08
Cigarette and alcohol questions						
Regular cigarette smoker	0	0.00	0	0.00	0	0.00
Family members who smoke regularly	9	69.23	9	69.23	18	69.23
Drank too much beer or other alcoholic drink	3	23.08	6	46.15	9	34.62

Perceptions of a Healthy Teen

Youth were first asked a broad question: "What is a healthy teen?" Answers covered multiple domains, from personal behaviors to family and peer influences, school environment, and neighborhood and community realities. Healthy teens were perceived as being active, eating a balanced diet, being physically and emotionally balanced, able to deal effectively with peer pressure, and having goals for their future. Participants agreed that a healthy teen did not smoke cigarettes, drink alcohol, or do drugs (specifically marijuana and crystal methamphetamine [ice]). Youth reported that teen health was influenced by the following factors: family members, who could be either good or bad role models; the school, which could provide (or not) a secure environment and an expectation of respect; teachers, who could be supportive (or not) of student health; and their community. Youth reported the school's inability to always enforce policies against smoking and drug sales on campus.

General Reasons for Using Cigarettes, Alcohol, and Other Substances

When asked about healthy teens, all groups noted that healthy teens did not smoke cigarettes. Peer pressure, experimentation, wanting to belong to a clique, poor role modeling from family and friends, and image (e.g., being cool) were given as reasons why teens smoked.

> Some people they get pressured like their friends. They see them smoke and then...they tell them that they should smoke too, but a lot of the times they don't want to, but just to see everybody doing it, they just wanna be part of the group. (Hawaiian male)

There were several known locations on the school campus where youth smoked.

While participants brought up smoking first and without prompting, they did not limit themselves to discussing smoking. Youth saw smoking as one facet of a larger, more dangerous problem—substance abuse in their families and communities that included using alcohol, marijuana, and ice. Alcohol use was related to celebrations and family drinking norms.

> Oh yeah the old man gave me a drink last night...we're gonna go drink there again tonight [said sarcastically]. That's just the base of it...[they're] going to be doing that... by themselves or with friends...peer pressuring them into it. Maybe if [they] have a kid one day, [they say] "oh, my aunty gave a drink...it's okay to give my kid a drink." (Hawaiian male)

Families modeled alcohol use as stress relief and relaxing after work and illustrate how alcohol consumption can be normalized in families and communities.

> My Dad, after work, he'll drink every day and stuff. His body's sore, but then [it] gives him relief...my whole family always drink, yeah? (Hawaiian male)
>
> That's how some people are, they just like to relax...from a hard day's work. (Hawaiian male)

Smoking marijuana was more common than smoking cigarettes for participants.

> [Smoking cigarettes], it's there...but not as big as marijuana. (Hawaiian female)
>
> Yeah, I think it's growing...I see a lot. (Hawaiian female)

Main reasons for marijuana use were peer pressure and liking the "high," and it was perceived as more dangerous than cigarettes in that it impaired functioning and led to loss of initiative.

> Basically, when they're stoned...it's so obvious. People come to class like that. It's...not right...they act so different, because you know they're so good when they're sober. Makes me so disappointed when they're all stoned and they make like they're stupid and give up on themselves. (Hawaiian female)

Additionally, participants believe that parents would rather their child smoke cigarettes than marijuana:

> I think the parents would be more accept[ing] of smoking cigarettes more than smoking marijuana. The kids will start smoking cigarettes then the parents [say], "oh well, I guess its alright to smoke cigarettes." They look at it as just cigarette, as if it's not that bad. (Hawaiian male)

Ice was seen as very different from cigarette, alcohol, or marijuana use. Youth reported that ice was very easy to get, very inexpensive, and scarier than marijuana because it destroyed family and community and increased the user's dangerousness.

> I think ice [is] just gonna break the community down…[it] can break the family apart. It's so cheap. It's so easy to make. It's so accessible…you can tell…the ice areas…ice is just a scary drug…it's just scary. (Hawaiian male)

Youth also clearly saw the impact of parental/family ice use on children. Several teens talked about the increased need for children to assume parental roles for siblings and not trusting parents and others who use ice.

> My friend…her mom does it [ice]…her friends come over to the house and they steal the daughter's money. They steal her stuff so she has to lock all her things in her room. She raises her two little brothers 'cause her mom can't do it. (Hawaiian female)

Participants noted that children of parents who used ice were likely to pick up the habit and talked about ice leading a family to homelessness.

> Their parents do it, and then they end up doing it…I haven't seen these kids for the last two years and they came to school for the week and then…I always see them at the beach…they sleep there now. (Hawaiian female)

Drug use also was seen as destroying pride in one's family and heritage. Several students talked about the transferring of shame associated with drug use and poverty to one's ethnicity.

> There started to be drug influence in certain members of the family and then slowly the family started to break apart. A lot of people are forgetting the…Polynesian culture. Some kids are ashamed of their Polynesian [heritage]…we encounter racism, but you gotta handle it. Some people are ashamed [because] they're Samoan or Māori…but I think some people forget where they came from, forget their culture. (Hawaiian male)

Youth also discussed their perception that family substance abuse has become normalized and that abuse is starting at younger and younger ages.

> In my neighborhood, I see kids 6 years old, lighting up a cigarette walking…down the road like that. I seen their houses…it's a four-bedroom house…[they] got a good 20 people living in there. They're smoking, they're doing drugs, and they're drinking, and I see an influence on…the kids or the people around them. (Hawaiian male)

The effects of use were clearly seen on school grounds, including selling. Students displayed physical and emotional withdrawal symptoms at school, including twitching, perceived invincibility, anger, and irritability. Some students drew attention to, and perhaps exaggerated, withdrawal symptoms as a way to enhance their image (i.e., withdrawal symptoms are "cool").

> [It's] like third class and "I need a cigarette"…and then if you don't get it, "oh I need one now!" And [then] be angry. (Hawaiian male)

> Where they're all like…they're all twitching or what not…"you have a cigarette? I need a cigarette now." (Hawaiian male)

Other students saw withdrawal symptoms as a sign of powerful addiction and expressed a respectful fear about the effects that cigarettes and other substances could have on a person's mind and body.

Prevention and Treatment Interventions

When we asked about interventions for youth, all five groups were adamant that treatment interventions would not work unless a person wanted to quit.

> You're not gonna get help if you don't want it. You gotta accept it first. Even if you take a friend, you cannot force him to get rehabilitated. It's all on the person. (Hawaiian male)

Despite these beliefs, youth listed a variety of intervention options. They suggested programs featuring guest speakers with real-life examples and hands-on activities, such as role playing, learning new skills, saying "no" to peer pressure, and setting realistic goals for their future. Helping youth develop a plan for after high school (such as pursuing further education) was cited as a way to facilitate goal setting.

> They have plans and goals and…then they won't let anything stop them. (Hawaiian female)

The participants suggested that these components be incorporated into their existing health classes because that would be the best way to reach students.

> I know students that smoke and drink and everything but they still…have to go to class. That's the only way to get them…'cause they're not gonna go to programs. (Hawaiian female).

Professional, family, and peer counseling was a preferred treatment option, and success would depend on the ability to establish and maintain trust.

> If you trust the person enough then, I guess you can develop a bond between either a peer or…a parent or a teacher, or a coach…[it] just depends on the level trust that you have…[and] the quality of your relationship. (Hawaiian female)

School and community activities, including participation in organized sports, were suggested as ways to create structure, discipline, and something positive for all students.

> High school kids are more likely to do drugs in that time period from 3 to 6 p.m. If you fill...your day with positive activities, then you'll [be] less likely to smoke or drink. (Hawaiian male)

Participants also stated that those who sold illegal substances, especially youth, made very good money. In Hawai'i, with the high cost of living, the profitability of selling ice increases its attractiveness.

> They just sell just to get the money, but they don't wanna do it. I know some people they just sell it. They don't do it anymore, they know it's bad, but they need money so they sell. (Hawaiian male)

> When I watch a movie, they show the drug dealer..., they [have] a nice house, mansion, cars, everything. They can get money and everything. Maybe if they made it look like stupid...like people who do ice,...make it look dumb. (Hawaiian male)

Youth saw the media's portrayal of drug use and selling as sensational, especially getting "rewarded" for selling. They suggested more realistic portrayals of users and sellers, not a glamorized version in movies.

Discussion

What started as an investigation of teen smoking yielded valuable information about the complex lives of teens in a rural community in Honolulu County. The general question "What is a healthy teen?" stimulated rich discussion of a number of topics, including smoking, diet, alcohol, and illicit substance use; peer pressure; and difficulties with families, school, and community. Redirecting group conversation to tobacco was more difficult than anticipated. Rather, discussion was free flowing, jumped from topic to topic, and was very honest and candid.

In the end, students cast cigarette smoking as a small part of their concerns about substance use and its contributory factors. Within the larger context of normative use of alcohol/marijuana and ice-related family/community disintegration, smoking cigarettes was seen as rather benign. This was reinforced by parents who, according to participants, viewed cigarette smoking as preferable to other substance use.

Interventions on Multiple Fronts

These findings support an ecological model of health behavior. Ecological models recognize that individuals cannot be separated from their environments and that both individuals and environments need to be targets of change (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 2004–2005). Successful ecological interventions address multiple levels of influence, including those at the individual, interpersonal, and community/institutional levels (Glanz, Lewis, & Rimer, 2005; McLeroy, BiBeau, Steckler, & Glanz, 1988). Our participants suggested a variety of interventions that can be categorized at the individual, family, or community levels (Table 2).

TABLE 2 Reasons for use and recommended interventions for cigarette, alcohol, marijuana, ice, and any use

	Cigarette	Alcohol	Marijuana	Ice	Any Use
Focus group findings					
Reasons for use	Cliques, poor family and friend role modeling, and image	Used for celebrations, family using, providing, role modeling, and high home exposure	Peer pressure, liking the "high"	Easy to get, cheap	Curiosity/experimentation, peer pressure, escape from problems, wanting to belong, use leads to poor decision making, good money when selling marijuana and ice
Impact	Withdrawal	Withdrawal	Family/community disintegration	Family/community disintegration	
Intervention					
Individual		Change knowledge, attitudes about alcohol; provide skills to resist (NIAAA, 2004–2005	Provide skills to resist peer pressure		Resisting peer pressure, setting goals for future, provide information on health behaviors and risks (Rew & Horner, 2003)
	Help individuals recognize problems and give them skills to resist peer pressure. Professional/peer counseling.				
Family	Reduce or stop parent smoking, monitor child's behavior, reduce family conflict (Hill et al., 2005), reduce exposure to environmental tobacco smoke (U.S. DHHS, 2000)	Clarify alcohol expectations, set rules and consequences for violations, and reduce or stop family use and availability of alcohol in the home (NIAAA, 2004–2005)			Family-centered, culturally appropriate, nonstigmatizing, and community-based services to reduce substance abuse (Bouterie, Bell, & Goebert, 2003)
	Help families recognize problems and move through "stages of change." Family counseling.				

	Cigarette	Alcohol	Marijuana	Ice	Any Use
School	Reduce exposure to environmental tobacco smoke (U.S. DHHS, 2000), establish anti-smoking policies (Pentz et al., 1989)	Promote a school culture that does not tolerate use (Roundtree & Clayton, 1999)			
	Incorporate guest speakers, real-life examples, and hands-on activities into classes. Schedule activities during "high-risk" times (after school hours from 3:00 to 6:00 p.m.).				
Community	Reduce exposure to environmental tobacco smoke (U.S. DHHS, 2000)	Reduce alcohol availability and drinking opportunities, increase penalties for violating minimum legal drinking age laws, reduce community tolerance for use (NIAAA, 2004–2005)		Make items to manufacture difficult to purchase in large quantities, reduce community tolerance for use	
	Media portrayal of use should be realistic, including realistic consequences for using and selling.				
	Tax and price increases (U.S. DHHS, 2000; NIAAA, 2004–2005)	Tax and price increases (U.S. DHHS, 2000; NIAAA, 2004–2005)			

Note: Interventions with citations are suggestions from the literature and not the focus groups.

Our participants suggested that individual interventions be focused on changing youth knowledge, attitudes, and skills to resist tobacco, alcohol, and other substances. However, students were adamant that a person cannot quit unless they want to. The stages of change (transtheoretical) model was developed by Prochaska and DiClemente (1982) after examining smokers who were able to quit on their own and those who sought professional treatment. The premise of the transtheoretical model is that behavioral change is an ongoing process and that a person moves through five stages of change: precontemplation, contemplation, preparation, action, and maintenance. Each stage varies and requires a different message and approach. In precontemplation, a person has no intention of taking action, and the relevant change strategy is to increase the person's awareness for change by sharing information about risks and benefits. If a person is contemplating quitting, he or she needs to be helped toward setting a quit date. Once the person is preparing to quit, he or she may need help identifying potential barriers and ideas for overcoming them. This could include the use of pharmacological agents and a support system (e.g., counselor, friend, family member, peer group, church group), and these supports need to continue through the action phase. In a review of tobacco cessation interventions for youth, Grimshaw and Stanton (2006) found moderate success of programs based on the transtheoretical model at 1 and 2 years postintervention.

Youth were overwhelmingly concerned with poor family role modeling of tobacco, alcohol, and substance use. This concurs with research findings that regular (vs. experimental) smokers are more likely to have parents who smoked (Flay, Hu, & Richardson, 1998). Parental smoking, low parental involvement, and low parent–child bonding encourage smoking initiation (Fleming, Kim, Harachi, & Catalano, 2002; Hill, Hawkins, Catalano, Abbott, & Guo, 2005). Poor parental support is associated with progressive, regular smoking from young adolescence into adulthood (Tucker, Ellickson, & Klein, 2003). Family poverty over the life course increases chance of smoking (Gilman, Abrams, & Buka, 2003), as does the number of smokers in an adolescent's environment (Taylor, Conrad, O'Byrne, Haddock, & Poston, 2004). Similarly, parents who drink and view alcohol use favorably have children who drink more (NIAAA, 2004–2005). For marijuana, early onset and more frequent use among youth are linked to less time spent with parents and more time spent with peers who used drugs (Best et al., 2005).

Thus, a successful intervention for youth in this community should include family outreach. Previous research with parents also identified parents' desire for family-centered, culturally appropriate, nonstigmatizing, and community-based services to reduce substance abuse (Bouterie, Bell, & Goebert, 2003). Family interventions can increase parents' awareness of tobacco/alcohol/drug risks, teach them how to communicate, clarify their expectations, set rules and consequences about use, and monitor their child's behavior (NIAAA, 2004–2005). Educating parents is critical because parents often dramatically underestimate cigarette, alcohol, marijuana (Substance Abuse and Mental Health Services Administration, 2008), and illicit drug use (National Center on Addiction and Substance Abuse at Columbia University, 2006) by youth.

Neighborhoods with high levels of family and community violence, drug use, crime, unemployment, poor housing, negative role models, and limited opportunities for the future put youth at high risk (Burt, Resnick, & Novick, 1998). Despite living in a high-risk environment, resilience can be promoted by strengthening youths' knowledge of health behaviors and risks, competence, positive coping styles, sense of humor, connectedness to others (including schools), and caring and supportive relationships with adults other than parents (Burt et al., 1998). Protective factors against smoking for Hawai'i youth were higher levels of education and employment of the main wage earner, family support, parental expectations, and higher grade point average (Else et al., 2008), sense of coherence (Glanz, Maskarinec, & Carlin, 2005), and parents and peers not smoking (Glanz, Mau, Steffen, Maskarinec, & Arriola, 2007). Programs can counter family/community disintegration by focusing on the functional organization of behavior (smoking, drinking, school attendance, etc.), as well as psychosocial risk and protective factors that have been shown to influence problem behaviors (Turbin, Jessor, & Costa, 2000).

Schools with comprehensive policies have been shown to reduce youth smoking (Moore, Roberts, & Tudor-Smith, 2001; Pentz et al., 1989) and promote a culture that does not tolerate alcohol (Roundtree & Clayton, 1999). School programs that provide youth the skills to resist peer pressure are also successful (Hurry & McGurk, 1997). Schools can act at both the individual and environmental level by providing students with critical skills and knowledge and discouraging tobacco/alcohol/substance use on their campuses. Schools also can help foster positive youth relationships with teachers, counselors, and coaches; these are especially important for youth with absent and/or nonsupportive parents and guardians.

Community interventions that reduce tobacco, alcohol, and other drug availability and increase penalties for selling tobacco, alcohol, and drugs to minors such as increasing costs and taxes for cigarettes and implementing communitywide antismoking media campaigns have been shown to reduce community smoking prevalence (Fishman et al., 2005). Media campaigns that help change individual perceptions about tobacco use have the potential to change the image that smoking and withdrawal symptoms are cool. Our findings also support collaborative community and university partnerships that examine large-scale, multilevel systemic intervention efforts (Jason, Pokorny, Ji, & Kunz, 2005).

Tobacco use is not a Hawaiian tradition. In select American Indian/Alaska Native tribes in which tobacco was considered sacred, it was used occasionally for ceremonial purposes where its cultural significance was taught at early ages (Unger, Soto, & Thomas, 2008). Comprehensive knowledge of sacred tobacco use among American Indian and Alaska Native adults was protective against commercial tobacco use (Choi et al., 2006). Perhaps similar cultural messages (e.g., 'Imi Hale's [Native Hawaiian Cancer Network] "smoking is not a Hawaiian tradition") can be effective with Hawaiian youth and adults as part of smoking prevention and cessation.

Following the focus groups, school officials reported that teen participants had very positive feedback about their feelings of safety and comfort with our researchers. This may be due, in part, to the local and ethnic backgrounds of researchers (Hawaiian, Samoan, Japanese, Filipino), representing ethnic groups in Hawai'i and supporting the development of researchers who are more representative of Hawai'i communities. The participating school has a long history of working with our department and its researchers. Building trust and keeping one's word about how research is done and how findings are presented are essential in good community-based research (Braun et al., 2006).

Limitations of the Study

Limitations must be noted. First, participants were from a single school/community in Honolulu Country, thereby limiting generalizability. Second, none of our 26 participants reported smoking regularly. Perhaps participants did not want to admit to cigarette use because smoking is not allowed at school and because of the presence of strong antitobacco messages. Indeed, smoking

behaviors and smokers themselves have been highly stigmatized and labeled as being deviant, resulting in isolation and severe embarrassment (Bayer & Stuber, 2006). This stigma may explain why these youth did not disclose smoking but freely reported alcohol use (35%, $n = 9$). Youth also may have perceived themselves as occasional (vs. regular) smokers, especially if comparing themselves to family habits. Indeed, 69% ($n = 18$) of the participants reported having family members who "smoked cigarettes regularly." By adulthood, Hawaiians have the highest smoking rate in Hawai'i (24.3%) and smoke between a half pack to a full pack a day, well above the adolescent average of two to five cigarettes daily (Ichiho, 2001). If a family member smokes a pack or more a day, Hawaiian youth may have a high standard for "regular smoking." Finally, we asked for students willing to speak up in a focus group, so participants may have been among the more assertive and insightful of high school teens.

Conclusion

Our study joins a growing number of similar qualitative studies that add often overlooked teen voices to the issue of tobacco use (Amos, Wiltshire, Bostock, Haw, & McNeill, 2004; Highet, 2004). Our finding, that cigarette use is preferable to illicit drug use, is not a common one and adds further complexity to youth smoking. Future studies that include youth perspectives in other Hawaiian communities are needed before designing and testing a multiple-level youth intervention.

This study makes several contributions to youth health. First, we found that Hawaiian youth perceived smoking as harmful to health but felt it was preferable to other more dangerous substances. Youth reported high levels of cigarette, alcohol, marijuana, and ice use among their friends and family and in their school and community. Students recognized that this was a complex problem that should be addressed on multiple fronts and, in line with the ecological model of behavior change, suggested interventions that could be developed at the individual, family, school, and community levels. Finally, our most important lesson learned was to openly listen to youth concerns. In this case, we assumed that cigarette smoking was a primary concern and instead found that youth saw smoking as one small part of larger systemic issues in their school, family, and community.

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Acknowledgments

This article was supported by the National Center for Indigenous Hawaiian Behavioral Health (National Institute of Mental Health Grants R24 MH5015-01, R24 MH57079-A1), the Centers for Disease Control and Prevention (Asian and Pacific Islander Youth Violence Prevention Center Grants R49/CCR918619-05, 1 U49/CE000749-01), the National Institute on Alcohol Abuse and Alcoholism (Alcohol Research Center of Hawai'i Grant UO1AA014289-01), 'Imi Hale–Native Hawaiian Cancer Network funded through the Special Populations Network program of the National Cancer Institute's Center to Reduce Cancer Health Disparities (Grant 1 U01 CA 86105), and the National Center on Minority Health and Health Disparities. The authors would also like to express their appreciation to the researchers and administrators of the National Center on Indigenous Hawaiian Behavioral Health, the Asian and Pacific Islander Youth Violence Prevention Center, and the Alcohol Research Center of Hawai'i.

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Appendix
Study Survey and Focus Group Questions

Hawai'i Adolescent Health Project
University of Hawai'i at Mānoa
John A. Burns School of Medicine

Except where blank lines are provided, please CIRCLE the number or word for your answer that best describes you.

Today's date: _____ / _____ / _____
month day year

1. How old are you now? 11 12 13 14 15 16 17 18 19 20

2. What is your date of birth? _____ / _____ / _____
month day year

3. What is your gender? Male Female

4. What is your grade in school right now? 9 10 11 12

5. On the average, what were your grades on your last report card? (Please circle only one answer.)

   A A- B+ B B- C+ C C- D or less Don't know

6. What is your biological *mother's* ethnic background ("nationality" or race)? Check *all* that apply.

   _____Hawaiian
   _____Japanese
   _____Filipino
   _____Korean
   _____Samoan
   _____Black/African American
   _____Puerto Rican
   _____Other _____
   (specify)

   _____Chinese
   _____Caucasian
   _____Portuguese
   _____Hispanic
   _____Tongan
   _____American Indian/Alaska Native
   _____Don't know

7. What is your biological *father's* ethnic background ("nationality" or race)? Check *all* that apply.

_____Hawaiian
_____Japanese
_____Filipino
_____Korean
_____Samoan
_____Black/African American
_____Puerto Rican
_____Other _____
(specify)

_____Chinese
_____Caucasian
_____Portuguese
_____Hispanic
_____Tongan
_____American Indian/Alaska Native
_____Don't know

8. Which of the following do you *strongly identify* with? You may check more than one.

_____Hawaiian
_____Japanese
_____Filipino
_____Korean
_____Samoan
_____Black/African American
_____Puerto Rican
_____Other _____
(specify)

_____Chinese
_____Caucasian
_____Portuguese
_____Hispanic
_____Tongan
_____American Indian/Alaska Native
_____Don't know

9. The main wage earner is the "breadwinner" who brings the main money support into the family. How much school did the main wage earner have? Circle only *one*.

1 = 8th grade or less
2 = Some high school
3 = High school graduate or G.E.D.
4 = Some college or community college
5 = College graduate
6 = Master's degree
7 = Doctoral degree (PhD, Medical, Law)

10. Yes No I have sometimes drunk too much beer or other alcoholic drinks.
11. Yes No I smoke cigarettes regularly.
12. Yes No Members of my family smoke cigarettes regularly.

Smoking and Alcohol Use Focus Group Questions

1. What is a healthy teen?
   Do definitions of healthy vary by ethnicity (a healthy Hawaiian)?

2. Why do teens smoke? (why do youth smoke?)
   Are reasons different for males and females?
   Are reasons different by ethnicity (Hawaiians)?

3. Do teens who smoke also drink? And vice versa?
   Do you see patterns in:
      Your family?
      In Native Hawaiian culture?
      By males and females?

4. If you were to design a program for teens that would focus on health/wellness/safety, what would it be like?
   Specific for Native Hawaiians?
   Specific for males/females?
   Would it be through your school? Community?

5. Any other thoughts on smoking and drinking?