

## **‘This Tobacco Has Always Been Here for Us,’ American Indian Views of Smoking: Risk and Protective Factors**

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### **Abstract**

We utilized eight talking circles to elicit American Indian views of smoking on a U.S. reservation. We report on (1) the historical context of tobacco use among Ojibwe Indians; (2) risk factors that facilitate use: peer/parental smoking, acceptability/availability of cigarettes; (3) cessation efforts/ inhibiting factors for cessation: smoking while pregnant, smoking to reduce stress, beliefs that cessation leads to debilitating withdrawals; and (4) protective factors that inhibit smoking initiation/ use: negative health effects of smoking, parental and familial smoking behaviors, encouragement from youth to quit smoking, positive health benefits, “cold turkey” quitting, prohibition of smoking in tribal buildings/homes. Smoking is prevalent, but protective behaviors are evident and can assist in designing culturally sensitive prevention, intervention and cessation programs.

### **Key Words**

American Indians • Native Americans • Indigenous • tobacco • smoking • community based research

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Smoking is a major public health issue among American Indians. Despite health warnings about the addictive nature of nicotine and its relationship to cancer and cardiovascular disease, data on tobacco use among minority populations report a significant increase in smoking among American Indians, whose prevalence rates for smoking are 30% higher than the general population (U.S. Department of Health and Human Services (DHHS), 1998; Centers for Disease Control and Prevention (CDC), 2005; Substance Abuse and Mental Health Services Administration (SAMHSA), 2005).

The three leading causes of deaths attributable to smoking are lung cancer, chronic obstructive pulmonary disease, and coronary heart disease (CDC, 2005). When compared with other racial and ethnic groups in the upper Midwest, where this study occurred, American Indians smoke earlier and have more serious health problems (Forster, Rhodes, Poupart, Baker, & Davey, 2007; Levin, Welch, Bell, & Casper, 2002; Indian Health Service (IHS), 2004; Seaverson, Perkins, Soler, Brown, & Bushhouse, 2005). For example, when compared with Indians living in other regions of the U.S., Indians in this region experience higher rates of lung cancer, diabetes, and cardiovascular disease (Casper et al., 2005; Denny, Holtzman, & Cobb, 2003; Forster et al., 2007; IHS, 2004; Rith-Najarian et al., 2002; Seaverson et al., 2005).

Given the deleterious effects on health, more research is needed to influence smoking prevention, intervention and cessation programs for American Indians. Implementation should be informed by studies of key risk and protective factors, as well as knowledge of the environments that directly influence behaviors (e.g., Phung, Bauman, Young, Tran, & Hillman, 2003; Gregory, Henry, Schoeny, & the Metropolitan Area Child Research Group, 2007). Although there are commonalities among American Indians living on different reservations and urban communities, there are also many cultural and environmental differences including particular norms, community resources, and different histories and customs. For example, Northern Plains tribes, who use tobacco ceremonially, have higher smoking rates (44%) than Southwest tribes (21%) who do not typically use tobacco ceremonially (Baezconde-Garbanti, Beebe, & Perez-Stable, 2007; Beauvais, Thurman, Burnside, & Plested, 2007; Henderson, Jacobsen, & Beals, 2005). Thus, prevention and intervention needs to be informed by and tailored to particular cultural features of a given community. The 2002 National Conference on Tobacco and Health Disparities concurred that research on small, understudied, underserved and ethnic minority populations is needed to address the sociological context of their tobacco use (Fagan et al., 2004).

In this paper we integrate data/stories about smoking and factors associated with smoking collected in eight focus groups conducted as talking circles on a U.S. Midwestern Indian reservation with available published literature. Four issues were explored: (1) the historical context of tobacco use on this reservation, (2) the key risk factors that facilitate use, (3) cessation efforts and inhibiting factors for cessation; and (4) protective factors that inhibit smoking initiation and use.

## **METHODS**

### **SETTING**

This study took place on a U.S. Midwestern Ojibwe reservation. There are over 6,000 enrolled tribal members; over 1,900 reside on the reservation. Tribal members elect a tribal chairperson and six-person tribal council to govern the tribe. Casino profits fund tribal social services and educational programs and are not distributed in per capita payments to individual tribal members. The study was first approved by the tribal chair, tribal elders, and then the Institutional Review board (IRB) of the institution with which the authors are affiliated.

### **RESEARCH PROCEDURES**

Elder Ojibwe tribal members were consulted about the study and an elder female tribal member was hired as a research associate. This study employed focus groups as talking circles which are a traditional method of group communication in American Indian communities (Ambler, 1995; Becker, Affonso, & Blue Horse Beard, 2006; Montejo, 1994). Unlike typical focus groups in which the moderator plays an active role in eliciting information, in talking circles the moderator defers to elders. Additionally, an emergent design methodology for the talking circles was utilized in which the moderator, and the research associate, came to the initial circle with a plan and allowed the plans for subsequent circles to evolve from the input from that circle (Morgan, Fellows, & Guevara, 2008). This approach allowed tribal elders to have input into the composition of the talking circles, the content of the questions, and the appropriate moderating style for the subsequent sessions. Elders from the first two circles requested that young people be included in the study, and that the talking circles be divided by gender and age, referred to as segmentation in emergent design as it allows different perspectives to emerge (Morgan et al.). Elders also requested that select members be invited more than once, consistent with a multi-stage approach to groups which enables participants to gain comfort in speaking (Morgan, et al.). Additionally, a female elder was able to attend five of the talking circles to act as the historian and advisor.

Purposive sampling techniques were utilized with input from the research associate, the observer and the elder female tribal member. It was important at this stage of the process for the first author, a tribal member, to defer to the team, all reservation residents, in terms of selecting a somewhat representative sample. The consent forms were explained orally and in written format and the importance of the confidentiality of the information provided by other tribal group members was discussed. An observer took notes during the sessions. A semi-structured guide of tobacco use questions was used, for example, "We're trying to understand more about how people in our tribe

think about tobacco use, or smoking, can we talk about that?" Tribal members sat in a circle around a table, everyone had an equal opportunity to speak, and elders were not interrupted and were allowed to speak for as long as they wanted (which adheres to cultural norms). Dinner was provided, the sessions were digitally audio-recorded, and all tribal members were paid for their time and willingness to share.

Additionally, in the initial circle members took a break after an hour, so the research team decided to build in a break in subsequent circles. The first two circles were conducted in late 2006 to introduce the elders to the group/talking circle methods and get their input on study design. IRB changes to study design were made to adhere to the wishes of the elders, and then the remaining six groups were conducted in 2007. Names have been changed to protect the anonymity of the people.

### DATA/STORIES ANALYSIS

The voices/stories of the members of the talking circles were transcribed by a professional transcriptionist, and then had to be re-transcribed by the first author as the information was inappropriately transcribed with misinterpretations being evident to the first author who was present for all talking circles. All of the talking circle revised transcripts were analyzed, manually and with NVivo, using content analysis procedures to identify important codes, phrases, patterns, and themes (Krippendorff, 2004). First, the revised transcripts were read by all three authors to get an overall understanding of the content of the talking circles and to compare observer and debriefing notes to ensure that nothing was missed. Second, each author manually coded the transcripts and then the authors met to compare and contrast the most important aspects of the data/stories collected. As a group the authors decided to focus on those sections of the transcripts pertaining to tobacco use and smoking and subsequently coded and concurred on them. Third, the second author, who was proficient in NVivo, entered the codes and was able to further analyze the qualitative data/stories to cross check the manual coding. Lastly, the authors met again to concur on the themes that emerged from both sources of analysis. The second author, an Alaska Native and the third author, a non-Native felt that that was a good way to control for potential bias in interpretation by either the first author, a tribal member, or both Native authors.

## RESULTS

### TRIBAL MEMBER CHARACTERISTICS

Tribal members participated in eight talking circles. Of the 49 members 30 were female and 19 were male between the ages of 12 and 78 ( $M = 35$ ) (Table 1). Members reported on their smoking prevalence and overall 25 females and 10 males smoked (71.4%); of this group 15 were elders (55 and above); 15 were young adults; and 5 were adolescents.

**TABLE 1: CHARACTERISTICS OF TRIBAL MEMBERS (N= 49)**

<b>Characteristics</b>	<b>Number</b>	<b>%</b>
Age		
<18	10	(20.4)
18–35	19	(38.8)
36–54	9	(18.4)
55+ (elders)	11	(22.4)
Gender		
Male	19	(38.8)
Female	30	(61.2)
Marital Status		
Never married	26	(53.1)
Married	10	(20.4)
Divorced	7	(14.3)
Other	6	(12.2)
School Status		
Full time	11	(22.4)
Part time	4	(8.2)
Not in School	34	(69.4)
Highest grade completed		
Grade school	5	(10.2)
Some high school	10	(20.4)
High school or GED	15	(30.6)
Some education beyond high school	19	(38.8)
Working for pay		
Yes	19	(38.8)
No	30	(61.2)
Total household income		
≤\$10,000	7	(14.3)
\$10,000–\$20,000	9	(18.4)
\$20,001–\$40,000	11	(22.4)
\$40,001+	4	(8.1)
Don't know	18	(36.7)

## HISTORICAL CONTEXT OF TOBACCO USE AMONG OJIBWA

Ojibwe Indians believe that tobacco or asemaa is a gift from the Great Spirit and provides a connection to the spirit world (Flannery, Sisk-Franco, & Glover, 1995; Hirschfelder & Molin, 1992; Winter, 2000). In 2002 Struthers and Hodge interviewed Ojibwe spiritual leaders and traditional healers about the sacred use of tobacco and respondents agreed that the original sacred tobacco was kinnikinnick, or the bark of the “red willow” (Struthers & Hodge, 2004; Densmore, 1979, p. 145). One key informant in that study relayed the story of how the creator gave Waynaboozhoo, the first man, the red willow seed to plant to communicate with the creator (Benton-Benai, 1988). Messages could be sent via smoking kinnikinnick or placing it near the base of a tree. Wayanaboozhoo gave kinnikinnick to the people as they had nothing to offer when communicating with the creator (Struthers & Hodge, 2004). Europeans thought the Indians domesticated tobacco (Winter, 2000), however, an Ojibwe informant from our study disagrees as he only remembers kinnikinnick as being the source of “tobacco” as he states, “I never heard my grandparents...ever talk about tobacco [commercial tobacco] like that ...we never used [commercial tobacco] or passed it on to the next generation.” Frances Densmore in *Chippewa Customs* (1979) confirmed this view when she interviewed Ojibwes in the early 1900s who reported that the earliest materials used were dried leaves of bearberries, dried roots of the aster, and red and spotted willow bark. American Indian peoples, including the Ojibwe, lacked ready access to tobacco, wild or domesticated, and obtained it from Indians living in the south or fur traders (Winter, 2000). An Ojibwe elder in the study offered insight into these early or alternative uses of tobacco and theorized about why Indian people smoke, and offered a similar view that connects smoking or the use of tobacco to Native culture:

Ted (65, elder): ...this tobacco has always been here for us. And they grew it themselves, the gardens. But it's a purer tobacco than it is now. There's driftwood they call it smoke wood...And once you light it you could puff it, you know, it never went out...Yeah, you get big ones like that or, you go around on the river and look for 'em, smoke wood they call it.

Despite the long history and ubiquity of tobacco on the reservation, the smoking of commercial cigarettes is currently prohibited in all of the tribal administrative, health and social service buildings, however, the Ojibwe continue to use tobacco in many aspects of everyday life and for spiritual ceremonies and traditional medicinal practices. In certain ceremonies a spiritual leader uses, or leads the ceremony involving tobacco but in other aspects of daily life any tribal member can use tobacco. For example, it was placed in water to calm it for safe travel and today it is sprinkled around, or on, a car for a safe journey for the passengers. If tobacco is given as a gift, or to seal a contract, as in treaties, it made the agreement more binding (Winter, 2000).

### KEY RISK FACTORS THAT FACILITATE SMOKING

**Peer influence on smoking.** Like other groups, initiation into smoking for the people in this study was influenced by peers. This pattern held true regardless of age, the elders and the youth told similar stories of trying cigarettes.

Serena (44): I smoked cuz my friends smoked.

Rita (18): Yeah. I smoked cuz my friends smoked too.

Terry (21): That's what everybody did in high school.

Ted: (65): Well, we did that in high school too, but like I said, money was—if it was really tight maybe only one person had a pack of cigarettes. Remember that?

Delores (60): Yeah, I think if I would've, um, quit back when I first started, it wouldn't, but you know when you're young, you, you like want to fit in. You want to...

Gertrude (78): Be with the crowd.

Delores: Yeah...and I think that was one of the reasons I started to begin with.

Theresa (38): Me, too.

Delores: Mm-hmm.

Lori (36): Yeah, that's when I tried to smoke 'cause I was... trying to hang out with her and her friends.

PI: Peter, where'd you start getting your cigarettes?

Peter (15): Um from my friends.

These findings are consistent with other studies that found peer influence on smoking was a significant predictor of adolescent smoking (Chassin, Presson, Pitts, & Sherman, 2000; Tyas & Pederson, 1998). And, presently, a concern is that American Indian youth continue to have the highest number of smokers among all racial groups (39.4% for girls and 41.1% for boys (Henderson et al., 2005; Steinman & Hu, 2007).

**Parental and familial influence on smoking.** Tribal members also indicated that another pathway to smoking was through parents and family members. Home environments provided situations where Indian youth would begin smoking at parties where family members and other adults were smoking and this progressed to smoking outside of the party environment.

Peter (15): The people you hang out with, I guess...my family.

Paul (42): I was into parties...my mother had parties, you know. And so I was there as, you know, they were partying in the house, my house... And started my brothers and sisters all smoking, so, you know, I had a, a puff too, you know...I guess it was passed from generation to generation, mother and father doing this, you know.

Researchers found that a strong predictor of the initiation of adolescent smoking among northwestern U.S. adolescents (N=4,130), was having a parent who smoked (Forrester, Biglan, Severson, & Smolkowski, 2007). And, Burgess et al.,(2007).found that American Indian youth family member's smoking contributed to their smoking initiation.

**Acceptability and availability of cigarettes.** The desire to fit in and to do what peers and family members were doing, as it felt like "everybody smoked," coupled with the fact that cigarettes were easily available, contributed to people's smoking behaviors. Tribal members of all ages shared that they started smoking at an early age and had easy access to cigarettes from their peers, parents, family members or other adults.

PI: How long have you girls been smoking?

Anne (23): Like 10 years.

PI: Where'd you first get your cigarettes?

Aurora (23): Over at Bingo.

Rita (18): Grandma.

Aurora: Remember when they used to, they used to have Bingo over at the Center? We used to always grab cigarettes like, everybody's pack.

Theresa (38, female): Yeah. Grandpa always left his laying around.

Rita: Grandma always left hers in the freezer.

Researchers report a high degree of acceptability among Indian people regarding smoking (Burgess et al., 2007). And, on this and other reservations cigarettes are available at local venues for a reduced rate for enrolled residents and are not taxed. Additionally, across generations stories were told of stealing cigarettes and smoking them outside the gaze of adults, for example:

Michelle (67): A big thing to do with it, you know. I know my mom and dad both smoked, and my friend and I used to run behind my shed.

RA (66): We stole their cigarettes.

Michelle: And we would steal their cigarettes and go back there and smoke (group laughter). So you know kids will do what they see in the home.

Paul (42): And then stealing cigarettes from Mom and you know, getting a friend to buy a pack.

## CESSATION EFFORTS OF SMOKERS: INHIBITING FACTORS

**Smoking while pregnant.** Smoking while pregnant was a controversial topic among the people. American Indian women struggle with smoking cessation during pregnancy and smoking around young children. In 2004, American Indian and Alaska Native women had the highest rate of smoking during pregnancy (18.2%) compared with non-Hispanic white (13.8%) and non-Hispanic black (8.4%) women (CDC, 2007).



PI: What about smoking around kids, babies?

Ruth (17, pregnant): No.

Peter (15): No.

PI: And while you're pregnant, any opinions on that?

Peter: It's bad for...

Michelle (67): They're smaller.

Ruth: It even says it on the pack, too, now that when, if you're pregnant, it'll put your baby as a preemie and everything.

Michelle: But I think, too, the woman has to think about herself because if you're smoking when you're pregnant, think of what it does to your own body. And what happens to you happens to your baby and that's with the constricted blood vessels, there's not enough energy getting to you, getting to the fetus. There's a lot of things that, there're a lot of implications there. And they say the second hand smoke is just as...

Ruth: It says its worse.

The above conversation indicated that tribal members had been exposed to materials on the harmful effects of smoking. Disagreement occurred among them regarding smoking while pregnant as the following discussion among the younger women reveals. The younger women have never tried to quit smoking and have smoked through their pregnancies. This is consistent with the research on American Indian youth and smoking. As Beauvais et al., (2007) and Henderson et al., (2005) found, Indian youth's attitudes towards tobacco use, and what is reported, are beliefs and behaviors that regular smoking does not cause harm. Additionally, this conversation highlights the discord, for some of the people, between the beliefs about the harm of smoking and the contradictory health behavior of continued smoking.

PI: You ever tried to quit?

Vicky (24): Nope, never wanted to.

PI: Even when you were pregnant?

Vicky: Well, I smoked through both of my pregnancies.

PI: And you?

Ruth (17, pregnant): Right now I'm still smoking.

Terry (21): I smoked through all a mine, too.

**Smoking to reduce stress.** Struggling with cessation of smoking was a common theme among the women who shared stories about quitting. Several women quit and started again or were never able to quit smoking but had the desire to do so. They talked about the number of years they had been smoking and then shared their difficulties with trying to quit.

Michelle (67): I tried to quit and couldn't do it. And you know, to me, I, I mean, I used to fool around with drinking, but it was nothing for me to quit drinking, but I can't quit cigarettes.

PI: You don't smoke Delores?

Gertrude (78): Yes, she does.

PI: How many years?

Delores: About 40 years.

Theresa (38): I've been smoking since I was 12.

PI: Have you ever tried to quit?

Theresa: No.

Gertrude (78): 50 years.

Pauline (75): I did quit for about nine months, but I lost my daughter and I started right back.

Gertrude: Oh, I did the same thing.

Pauline: Nine months I quit.

Gertrude: The only thing I know is smoking, keeps my nerves down.

Pauline and Gertrude's comments corroborate other reports by Indian women that they smoked in order to cope with the stress and demands of everyday family life and it is believed that these stressors and the accompanying anxiety hinders efforts to quit smoking (Burgess et al., 2007).

**Beliefs that cessation leads to debilitating withdrawal symptoms.** A pervasive discourse among Indian people is that the information about the harmful effects of smoking and their views about quitting smoking are at odds. This creates a complicated paradox of people wanting to quit, not being able to quit, seeing people smoking without looking ill, and viewing the physical decline of people who quit, as a reason not to quit. Beliefs are that quitting is worse than continuing to smoke and there is resentment towards being told to quit or being forced to quit because of health issues. An elder woman shared:

Gertrude (78): Like when my husband, before he passed away, the doctors made him quit smoking, so he quit smoking. And um, when he quit smoking, everything just, you know, his health started going downhill. And he said, "Look at all my friends," he said, "I chummed with," he said, "they're all still smoking," he said, "and they're all still walking around the casino."

Pauline (75): My sister-in-law, too. She quit smoking. It wasn't long after that she started going downhill, nursing home and she died.

One person shared that living with the withdrawal symptoms was an inhibiting factor for quitting. The need for recognition that smoking is as hard to quit as other drugs was discussed.

Michelle (67): You go through withdrawals. It's like you do if you were on drugs. When you get the nervousness, you get the diarrhea, and your mood swings. One minute you can be happy, the next minute you're crying because—and you don't know why. And that's all withdrawal from trying to quit. And it's exactly the same way like if you were on heroin or, or any other, the street drugs that are out now. And in fact, I think it's harder to quit smoking than it is to quit the other drugs.

These women's views are not uncommon among Indian people. Smoking cessation efforts are thwarted by several factors which include historical and contemporary factors: a justifiable mistrust of Western medicine; a mistrust of Western pharmacology, as in smoking cessation patches or pills; a view of smoking as an issue that should be, or is only, addressed by someone other than a physician as it is not viewed as an imminent health risk; and debilitating withdrawal symptoms (Burgess, et al., 2007; Fu et al., 2007).

#### PROTECTIVE FACTORS THAT INHIBIT SMOKING INITIATION AND USE

Negative health effects of smoking and parental and familial smoking behaviors. Even though smoking is a pervasive social norm among Indian people on this reservation, there are some positive factors that are becoming protective factors against starting to smoke or continuing to smoke. Some people tried smoking and did not continue and others resisted smoking altogether. Even people in the circles expressed surprise at their own ability to avoid smoking in an environment where most people smoke. Tribal people tried smoking and did not continue for a variety of reasons with several sharing that they became ill and others relaying that they had parents who smoked and that motivated them to refrain from smoking.

PI: Margaret, do you smoke?

Margaret (77): Never did?

Group: Wow.

PI: Why do you think you didn't ever smoke?

Margaret: I didn't like it.

Gertrude (78): I don't like it either, but I still do (group laughter).

Lori (36): I smoked when I was like in 7th grade for like maybe twice....and then I got really sick and puked, so I never did it again.

Despite the leniency towards smoking and some citing their family as influence, some young men used the smoking behaviors of family members as motivation for not smoking.

Wesley (14): My whole family smokes though [he does not smoke].

Buddy (23): I guess you know it was actually a challenge for me in my house because, well, my dad smokes now, but at the time he didn't. My ma smoked. And my sister smoked, and my brother actually smoked for a while... I just kind of stayed away from it. You know, I tried it, you know, but it's something that I'll never do, you know. It's just a honestly, to me, it's a disgusting habit. It makes you stink. It makes your house stink.

Art (27): I think I've only smoked two cigarettes ever in my life, and I was drunk when I did it, tried to do it...and it didn't work out well. I was only 18 when I tried it, but I never, never wanted to do it again. Nasty!

These results are contrary to prior research which found that when a child is in 3rd grade, and his/her parent is a smoker, the later transition to smoking initiation and subsequently to escalating from smoking monthly to daily in the 9–12th grade is significant (Bricker et al., 2007; West, Sweeting, & Ecob, 1999).

**Encouragement from youth to quit smoking.** Some young family members encouraged older family members to quit smoking. One mother relates a story about the pressure from her daughter to quit smoking coupled with her own awareness of the effects of smoking on her lungs. She and her daughter were exposed to prevention materials where they visually demonstrate the effects.

Rachel (41): For sure. They do at home. C's been riding me for the last week about smoking. Rehashing all this stuff I already know. I've seen the old lung and the gizzard in the jar. I know.

**Positive health benefits.** One person discussed the struggle with smoking in the face of physical health consequences which kept him from participating in healthy physical activities like baseball.

Paul (42): I wouldn't play sports because that's, you know-that deterrent of ah smoking, and you feel-feel drawn down from that...I quit here, smoking for a year, started to play baseball again, and started smoking again and then I quit sports again. So, you know, that's the effects that you don't feel like you can be as competitive as you need to be when-you know, if I didn't smoke, I felt good enough to get out there and give it a shot. You know? When I am smoking, I don't feel that I'm up to, you know, it's kind of a fear of overdoing it and heart attack and, you know that kind of stuff.

Quitting “cold turkey.” Cold turkey quitting was a method employed by the people in the circles. This is consistent with prior research on American Indians and quitting smoking (Burgess et al., 2007). As illustrated by the following excerpt:

Teddy (29): I smoked for about five years. And I’ve been straight for four years.

PI: And how’d you do it?

Teddy: I had a cold one day and for like two weeks. I had hard time breathing and just gave it up.

**Smoking prohibited in tribal buildings and homes.** Families are following the lead of tribal institutions that promote environments where smoking is prohibited in order to foster smoking cessation. The people stated that they have rules about not smoking in their homes. This is a relatively new practice on the reservation and indicates a readiness to adopt protective factors to combat smoking.

Agnes (63): But at home I won’t let those boys smoke in the house (pause) no way. My son will sneak a cigarette in the bathroom. I can smell it all the way through the house.

PI: When you go to be at their house, do you, you’re allowed to smoke?

Delores (60): Hell, no. She’s gotta go outside....I don’t care if it’s 50 below out there.

In 2000 Proescholdbell, Chassin, and McKinnon found in a Southwestern U.S. study of 8,886 adolescents that parental restrictions on home smoking were associated with less likelihood of smoking initiation for the students.

## **DISCUSSION**

### **LIMITATIONS**

We note the following study limitations that should be considered when interpreting results. The numbers of tribal people involved in this study were small and purposively selected. Results cannot be generalized beyond this reservation. This study does not address all relevant questions regarding the prevalence and patterns of tobacco use and abuse on this reservation. For example, it would be beneficial to conduct a reservation wide quantitative survey of tobacco use and abuse to better determine prevalence rates. Despite these limitations few such stories exist on American Indian tobacco use on reservations that share tribal people’s views in their own words.

### **IMPLICATIONS FOR TREATMENT**

The information relayed to us by the tribal peoples of the talking circles confirm what is already well known about American Indians and smoking, however, there are shifts in viewpoints about smoking that are gradually occurring

among tribal members. For example, members openly recognized the influence of peers, parents and family members on their smoking behaviors, but some reported that having parents who smoked motivated them to refrain from smoking. Also, young people appear to be able to influence elders. One mother relayed how her daughter urged her to quit smoking as her daughter had seen smoking prevention materials. These shifts in viewpoints about smoking could be used as a foundation for treatment programs. For example, the tribal and familial community is very strong on this reservation and intergenerational interactions and connections are a very valued commodity. Designing programs that address smoking as a social, family, or tribal concern is one suggestion from Indian Country (Beauvais et al., 2007; Fagan et al., 2004; Fu et al., 2007). In previous smoking studies Indian elders were more interested in organized programs or groups and less interested in quitting on their own and preferred group over individual counseling or peer counseling (Burgess et al., 2007; Forster, et al, 2007; Fu et al., 2007). If elders participated in cessation groups their positive influence on other members of the group could be very beneficial in preventing and decreasing smoking in the younger generations. Conversely, if Indian youth receive smoking prevention materials and then attend the groups and describe the negative health effects of smoking to elders, and urge elders to quit smoking, this could impact cessation efforts. In California, a Tobacco Use Prevention Education program was formed to introduce Indian youth to the dangers of tobacco use by educating them about tobacco company tactics used to entice them to smoke (California Department of Education, 2008). If young Indian people could be purveyors of this kind of knowledge for the elders on the reservation this could possibly change the behavior of smokers. One elderly male (65 year old) did state that he quit smoking because his four year old granddaughter urged him to quit.

Another important finding is that smoking is acceptable and cigarettes are available; this appears to be a contributing factor for starting to smoke, Pokorny, Jason and Schoeny (2003) found that 5,234 Midwestern youth who reported higher levels of retail tobacco availability had increased odds of initiating smoking. On a more positive note tribal anti-smoking policies in tribal buildings appear to have been adopted in some tribal members' homes. For example, tribal members reported an awareness of the need to smoke outside of homes and cars to avoid second hand smoke exposure for other family members, especially children. In 1995 Hall et al. found in a study of tobacco policies of 39 Indian tribes in four geographical areas of the U.S., that a statistically significant link exists between anti-smoking policies and practices and smoking and suggests that more stringent policies could lead to healthier environments inside tribal buildings. The hope is that eventually, as tribal members no longer smoke in tribal buildings, this smoking behavior will be transferred to their homes, reducing the levels of acceptability of smoking and availability of cigarettes for youth to initiate smoking.

Conflicting views exist about the health effects of smoking. Young mothers openly admitted to continuing to smoke throughout their pregnancies and reported that quitting smoking can cause more harm because of debilitating withdrawal symptoms. Conversely, other people reported being aware of the negative health effects of smoking and wanting to quit to be able to participate in sports. Within the groups there was little discussion about efforts to prevent young people from starting to smoke, to prevent pregnant women from smoking, or about available treatment programs. The concern is that beliefs about the effects of smoking are erroneous and treatment knowledge is not readily available. In an ethnic minority study of 16 focus groups, which included American Indians, personal beliefs about smoking and lack of treatment knowledge were reported to be determinants of whether or not treatment was received (Fu et al., 2007). In Minnesota, the ClearWay research program in 2006 found that among Indians there is a need for culturally trusted sources of information about tobacco cessation (ClearWay, 2006; Schillo & Willoughby, 2007). Innovative programs which focus on the use of tobacco in its sacred form are important as well in assisting in cessation of non-sacred use of tobacco. A traditional American Indian tobacco seed bank and education program was initiated in 1997 at the University of New Mexico to educate Indians about the dangers of tobacco misuse and provide tobacco leaves for ceremonies ("Traditional," 1997). These kinds of culturally appropriate programs for dispensing knowledge about tobacco should be designed and funded for other Indian communities. On this reservation treatment programs appear to be non-existent and researchers report that knowledge of the most culturally sensitive treatment programs is limited and Indians report a need for treatment programs as few currently exist (Baezconde-Garbanti et al., 2007; Lawrence, Graber, Mills, Meissner, & Warnecke, 2003).

Gathering tobacco use stories about the sacred and non-sacred use of tobacco from tribal communities that is specific to their culture is important. Also, researchers and practitioners need to be able to recognize that change, however slight, is gradually occurring on reservations in regards to attitudes towards smoking. Researchers recommend tribal involvement in all aspects of treatment in order to reduce smoking among American Indians (Healton & Nelson, 2004; Green, Daniel, & Novick, 2001). Therefore, further studies with Indians on how these stories can be translated into effective and culturally sensitive tobacco prevention, intervention and cessation programs are needed.

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