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Why African American Men Diagnosed With Chronic Obstructive Pulmonary Disease Continue to Smoke

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Walden University
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Abstract

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VaShonda Allen

MA, Tennessee State University, 2013

BS, Tennessee State University, 2010

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

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Abstract

The purpose of this research was to explore why some African American men diagnosed with chronic obstructive pulmonary disease (COPD) continue smoking following their diagnosis. The theory of planned behavior (TPB) guided the development of this research. The research questions were developed to understand the attitudes, behavioral intentions, subjective norms, social norms, perceived power, and perceived behavioral control that influence their continuing or quitting smoking based on the TPB model. The study's research method was qualitative. A pilot study, using the same criteria as the main study, confirmed the reliability of the interview guide. Participants were informed about the study via flyers and posters located at public locations. Twelve respondents who were between the ages of 35-65, currently diagnosed with COPD, and currently smoked were selected for participation in the main study. Interviews were individually conducted video chat. All responses and nonverbal cues from the participants were recorded. NVivo 12 was used to organize the collected data. Data analysis was done via (a) compiling data, (b) disassembling data, (c) reassembling data, (d) interpreting the data, and (e) drawing a conclusions. Findings showed that although they were aware of the harmful effects of smoking, the participants had lifelong smoking habits that were difficult to break. This research contributes to a better understanding of the difficulties that face African American men with COPD who continue to smoke and can help family and health care providers to assist them, thus offering better smoking cessation support and individualized care for African American men.

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Dedication

This dissertation is dedication to my daughter, Jamiya Bean. If it were not for you, I do not know where my inspiration would have come from. Each day, I wake up to complete this dissertation for you. Also, I would like to dedicate this dissertation to both my father, James V. Allen, and mother, Lula Mae Robinson. You both certainly motivated me to continue in life. I would also like to dedicate this dissertation to the African American population in hopes that more awareness and solutions can be obtained about the health and challenges that are faced on a daily basis,

Acknowledgments

I would like to thank my committee members Dr. Magdeline Aagard and Dr. Diana Stark Ekman. You both are truly God-sent and excellent motivators. I would also like to acknowledge all participants throughout this study, places of recruitment and my family and friends who stuck with me throughout this journey.

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Chapter 1: Introduction to the Study

In this study, I employed a basic qualitative research design approach to analyze the motivations for smoking in African American men who were diagnosed with chronic obstructive pulmonary disease (COPD) and chose to continue to smoke. The theory of planned behavior (TPB) was the conceptual framework that I used to guide the development of the research questions and to analyze specific attitudes, beliefs, and behaviors in African American men who continue to smoke after being diagnosed with COPD (Larabie, 2011).

COPD is a leading cause of death worldwide (Yu et al., 2010). Smoking tobacco is the primary factor that leads to COPD (Menezes & Hallal, 2013). Although numerous studies have provided evidence that smoking cessation slows the illness and can reverse it in early stages, many COPD participants continue to smoke (Chatila et al., 2014; Klinke & Jónsdóttir, 2014). African American men are increasingly being diagnosed with COPD, but many continue to smoke, whether they want to quit or not, despite this diagnosis. My goal for this study was to investigate why African American men with COPD continue to smoke.

Chapter 1 includes the background of COPD, the reason COPD is becoming a more prevalent issue within the African American male population, the research questions, the purpose and significance of this research study, and the nature of the study. Chapter 1 also includes relevant definitions and assumptions, limitations, scope, and delimitations of the study.

Background

COPD is one of the top lung diseases that occurs because of smoking (Centers for Disease Control and Prevention [CDC], 2017; Chatila et al., 2014). COPD obstructs airflow in the lungs, leading to symptoms such as breathing difficulty and coughing. Over time, COPD worsens when not treated early or if the affected person continues to smoke. Eventually, the individual will not be able to do simple tasks such as carrying things or climbing stairs (Chandler & Rennard, 2013). COPD is the third-leading cause of death in the United States (World Health Organization [WHO], 2015) and is projected to be the leading cause of death worldwide by 2030 (Klinke & Jónsdóttir, 2014). COPD is also one of the leading causes of premature death (WHO, 2017).

One of the conundrums for government and other stakeholders involved in efforts to alleviate mortality rates for COPD is to encourage and increase smoking cessation among individuals. Smoking cessation remains the most effective way for people with COPD to curb its progression (Strasser et al., 2014). However, in comparison to other racial groups and ethnicities, more African American men diagnosed with COPD continue smoking regardless of the knowledge that smoking exacerbates the condition (Chatila et al., 2014; Eklund et al., 2012; Wetter et al., 2012).

Researchers identified that African Americans are at higher risk of developing COPD and lung cancer than their European American counterparts (Chisick, 2013; Menezes & Hallal, 2013; Mina et al., 2012; Grossman et al., 2011). The comparison may be due in part to African American men not having proper access to health care, which could affect their subsequent access to appropriate rehabilitation services for smokers

(Menezes & Hallal, 2013). Furthermore, current research has only gone as far as addressing smoking cessation challenges (Chatila et al., 2014); however, not much has been researched about the issue and the African American man (Davila et al., 2013). Few studies have been performed to examine why African American men continue to smoke after being diagnosed with COPD, though some assumptions have been made based on research involving other races. Thus, there is a necessity for qualitative studies to investigate why smoking cessation programs are not being used by this high-risk group. Research should both address the gap in knowledge and help health care providers have a better understanding of why African American men continue to smoke, which can, in turn, lead to better support strategies to cease smoking.

Problem Statement

Smoking is a growing issue in the African American male population (Chatila et al., 2014). Some African Americans cease smoking after diagnosis with COPD (Menezes & Hallal, 2013); however, many African Americans report that they continue to smoke to deal with stress and the difficulties of life (Chatila et al., 2014). Some even stated that just knowing they have COPD caused a continuation of smoking (Chatila et al., 2014). Nevertheless, with the overwhelming number of available studies focused on European Americans and Asian Americans in the United States as it relates to this issue, little research has focused on other races, including African American men (Cruz & Matthay, 2011).

There are also few studies directed toward understanding and finding ways to assist African American men with COPD to cease smoking (Eklund et al., 2012;

Grossman et al, 2011). Some studies were conducted comparing smoking rates by ethnicities (Menezes & Hallal, 2013). The research has converged at a single finding that European American men smoke more than African American men, but they have higher smoking cessation rates than their African American counterparts (Grossman et al, 2011). The purpose of this study was to explore why some African American men diagnosed with COPD continue smoking following their diagnosis.

Research Questions

Research Question 1 (RQ1): What beliefs and attitudes are associated with continuing to smoke after being diagnosed with COPD?

Research Question 2 (RQ2): How do the beliefs and attitudes of others influence the continuation of smoking after being diagnosed with COPD?

Research Question 3 (RQ3): What is the perceived level of control over smoking after being diagnosed with COPD?

These questions are relevant to the TPB model, which is used to identify a person's attitudes toward a specific behavior as well as the subjective norms of influential people (Larabie, 2011).

Purpose of the Study

The purpose of this study was to explore why some African American men diagnosed with COPD continue smoking following their diagnosis. Specifically, my goal was to understand the attitudes, behavioral intention, subjective norms, social norms, perceived power, and perceived behavioral control that influence their continuing or quitting smoking based on the TPB model. The findings of this research may be useful in

the planning of better smoking cessation interventions that can help decrease and or eliminate smoking within the participants. According to Balachandran (2011):

> Pessimism is provoked by the high relapse rates and the tendency of doctors to offer advice to those participants who are least likely to quit without extensive help. It is therefore important for physicians and other health care providers to be aware that scientific research has shown the efficacy of medical interventions in helping participants to stop smoking. (p. 34)

Therefore, this research could help health care professionals working with smoking cessation programs to increase their understanding of why African American men diagnosed with COPD continue to smoke.

Nature of Study

According to Merriam and Tisdell (2016), a basic qualitative research approach was derived philosophically from constructionism, phenomenology, and symbolic interaction and is used by researchers interested in (a) how people interpret their experiences, (b) how they construct their worlds, and (c) what meaning they attribute to their experiences (Tisdell, 2016, p. 23). The overall purpose of basic qualitative research is to understand how people make sense of their perspectives, beliefs, and attitudes (Tisdell, 2016, p. 23). Conducting this type of study allows the accurate collection of data, which leads to a structured description of experiences in general, which in turn leads to providing an understanding of a common issue experienced by participants (Creswell, 2018).

Operational Definitions

African American: A person having origins in any of the black racial groups of Africa with American citizenship (Farrelly et al., 2011).

Barrier: The limitations of information needed for a specific purpose but not available from sources that someone is willing or able to access (Silverman, 2017).

Belief: An acceptance that something exists or is true (Silverman, 2017).

Chronic obstructive pulmonary disease: A lung disease characterized by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible According to (WHO, 2017).

Smoking cessation: The process of discontinuing tobacco use; other terms used throughout this dissertation to describe smoking cessation include variations of *not smoking*, *quitting smoking*, and *stopping smoking* (Sudeep & Chaitra, 2017).

Assumptions, Limitations, Scope, and Delimitations

Assumptions

Gaining credible information comes from the assumption that all participants were correctly and currently under the diagnosis of COPD when they took part in the study. I assumed that participants would honestly answer the interview questions. Another assumption was that the inclusion criteria of the sample were appropriate. Participants had a genuine interest in participating in the study. I did not presuppose any other motivation of participants for participating in the study.

Scope and Delimitations

In this study, I aimed to understand why African American men diagnosed with COPD continue to smoke. The study took place in Decatur, Illinois. I recruited respondents based on their diagnosis of COPD and did not restrict participation by stage of progression of the disease.

The foundation for this study was supported by the inclusion criteria containing a literature review that examined the original peer-reviewed published articles and articles published from 2006–2018, and a 1947 article was included that that helped build a foundation for the current study. I only considered articles published in English and in the original full text for this study. The review included both articles employing qualitative and quantitative methods to gain knowledge of why African American men diagnosed with COPD continue to smoke. I used the literature of interest to investigate and gain understanding of why African American men continue to smoke after being diagnosed with COPD. The primary search terms used included *African American male*, *African American men, African American males in the U.S., African American men COPD gaps in literature, African American men in the U.S., Black males smoking, Black men smoking, Black males smoking in the U.S., Black men smoking in the U.S., Black males smoking cessation in the USA, Black men smoking cessation in the U.S., chronic obstructive pulmonary disease, COPD, COPD gaps in literature, chronic obstructive airways disease, smoking, smoking cessation, cessation barriers, and quit/stop/quitting/stopping was also used in place of cessation.*

Researchers use a variety of qualitative research designs to conduct social science research, including a basic research design, grounded theory, ethnography, and phenomenology (Barkhuizen, 2015; Baskerville & Myers, 2015; Bliss, 2016). After careful consideration and analysis, I chose the basic qualitative research design because of the alignment of the approach with the purpose of this research and the research questions. Basic qualitative research involves an exploration of a complex phenomenon using research and observations (Battistella et al., 2017).

The grounded theory is a research method concerned with the generation of philosophy that is rooted in data that has been systematically collected and analyzed (Burnard, 2014). The grounded theory would not have been beneficial to this study because I was not conducting research that involves individual cases, incidents, or experiences that I wanted to develop into conceptual categories to synthesize. The grounded theory leads to an explanation or understanding of individual data to identify patterned relationships within its area of concentration (Burnard, 2014). According to Barkhuizen (2015), Baskerville and Myers (2015), and Bliss (2016), the ethnographic design would not have been appropriate for this study because that design helps researchers study certain concepts within a specific cultural group which was not the case for this study. I did not consider the phenomenological design to be appropriate for this study because my goal in this study was not to study the lived experiences of participants concerning a phenomenon, but rather to identify the reasons why African American men continue to smoke after being diagnosed with COPD. Researchers who use

phenomenological designs explore and attach meanings to the lived experiences of the participants of the study (Barkhuizen, 2015; Baskerville & Myers, 2015; Bliss, 2016).

The purpose of this study was not to find the meaning of phenomena through the lived experiences of people or groups of people. Merriam and Tisdell (2016) described a basic qualitative research study as having been derived philosophically from constructionism, phenomenology, and symbolic interaction and as being used by researchers who are interested in (a) how people interpret their experiences, (b) how they construct their worlds, and (c) what meaning they attribute to their experiences (Tisdell, 2016, p. 23).

Limitations

People with rapidly progressing COPD might not have been able to complete the study, which would prove to be a limitation. The environment in which the study occurred might have led to biased responses because of knowing positive or negative facilitates or discouraging interactions among people and the subsequent benefits of social support (Egger et al., 2011). Egger et al. (2011) stated that, the environment may have influenced people's behavior and motivations to act because of certain stressors leading to a negative or positive impact on the individual's mood and bias their response to the interview's questions.

Significance

Smoking puts an enormous burden on public health (Tomar et al., 2013). This study could have a positive social impact by increasing awareness of smoking cessation challenges of African American adult men for health care providers, family, and friends,

and provide valuable information to health care providers, organizations, and stakeholders that may be needed to create newer models of interventions for smoking cessation for African American men after being diagnosed with COPD. The findings of this study could lead to providing a stronger overall social awareness for African American men diagnosed with COPD regarding the factors associated with smoking cessation, resulting in a stronger, healthier, and better society. This study could provide the foundation for changing society's outlook on helping African American men who continue smoking following the diagnosis of COPD by identifying barriers associated with smoking cessation.

Summary

Given the public health significance of tobacco use (Husten & Manley, 2013) and the high rate of the diagnosis of COPD generally and more specifically among African American men (Van Gucht et al., 2010) it is essential to identify barriers associated with smoking cessation, given the benefit this has on COPD diagnosis and outcomes (Hill et al., 2010). This research will contribute to an increased understanding of the beliefs, perceptions, motivations, acceptance, and barriers faced by some African American men who continue to smoke following COPD diagnosis, which may prove helpful for planning interventions that could improve smoking cessation rates in this population.

Chapter 2 will include discussion of the empirical literature associated with this topic. The studies found in the literature review helped to link older finding of why African American men diagnosed with COPD continue to smoke, with new results presented later in my research. Apparent factors that contribute to African American men

continuing to smoke, the challenges they face, and the rationale for continuing to smoke will be described.

In Chapter 3, I will present a description of the logic behind the research design and methods that were used for this study. I will also discuss the research questions, participant criteria, and recruitment process that were followed. Finally, I will discuss the role of the researcher as a primary instrument, data collection procedures, ethical considerations, and the protection of participants, data analysis process, the means of ensuring trustworthiness and validity of the study, and methods that were used to communicate the research.

Chapter 2: Literature Review

Smoking is a growing issue occurring within the African American male population (Chatila et al., 2014). Some African Americans cease smoking after diagnosis with COPD (Menezes & Hallal, 2013); however, many African Americans report that they continue to smoke to deal with stress and the difficulties of life (Chatila et al., 2014). The purpose of this study was to explore why some African American men diagnosed with COPD continue smoking following their diagnosis. I focused on the extent to which motivation affects smoking cessation attempt by African American male smokers diagnosed with COPD. During my study, I also focused on the how acceptance or disapproval of smoking cessation affects attempts by African American male smokers who have been diagnosed with COPD. My goal was to elucidate the factors that African American men diagnosed with COPD identify as obstacles to smoking cessation. Smoking was limited to the use of tobacco cigarettes for this study.

Chapter 2 includes the findings from various literature reviews. The reviews include findings that focused on what COPD is. I also documented statistics pertaining to different studies on smoking cessation of different ethnicities including Asians, Europeans, and African Americans. I later narrowed the literature and focused on African American men who smoke with COPD. This chapter will define the research gap regarding why African American men with COPD continue to smoke.

Literature Search Strategies

A literature review is a method of research that incorporates the collection and analysis of several studies (Blackmore, 2014). Researchers use literature review methods

to classify, choose, and critically analyze numerous articles to answer clearly defined questions (Blackmore, 2014). When conducting literature reviews, researchers review articles that relate to information from an original study, or use found information to present a new study (Blackmore, 2014).

When conducting a literature review, a researcher can group various sources based upon likenesses of information (Blackmore, 2014).The different pieces of information are more accessible to compare and the researcher can then focus on the study as a new context of the whole (Blackmore, 2014). The reason for a literature review is to minimize bias caused by singling out the data, confirm every piece of literature holds a solid and equal foundation, and to compare and evaluate information so that it is useful in the study (Blackmore, 2014, p. 53). Cronin et al. also stated that providing fact-based research in the health field can be encouraged if a literature review is used and results implemented (p. 61).

Databases Considered for the Study

Search for relevant literature ran from November 2016–February 2019. I conducted the research in November 2016 and then repeated it in April 2016 and again September 2016–February 2019 for new sources. I collected information from EBSCO, PUBMED, SAGE Journals, Medline, and the Joanna Briggs Institute EBP Database (s). I accessed these databases through the Caribbean Medical University and Walden University online electronic sources. I also used the Cochrane Library, but retrieved no relevant articles from this last source.

Keywords

I entered key terms in the search box of databases both individually and as a combination of words to identify relevant materials about African American men with COPD and smoking. Search terms included: *African American male, African American men, African American males in the USA, African American men COPD gaps in literature, African American men in the USA, Black males smoking, Black men smoking, Black males smoking in the U.S., Black men smoking in the USA, Black males smoking cessation in the USA, Black men smoking cessation in the USA, chronic obstructive pulmonary disease, COPD, COPD gaps in literature, chronic obstructive airways disease, smoking, smoking cessation, cessation barriers, quit/stop/quitting/stopping.*

Data Search Process

I used a database to find original published articles. Finding an assortment of articles for evaluation depends on the use of keywords, titles, abstracts, and reading of the chosen full text (Gannett-Tripp Library, 2018). The search strategy contains three steps to find information in the databases. First, I searched for keywords such as *COPD* and then combinations of terms such as *African American men COPD.* Lefebvre et al. (2017) stated that filters have to be applied in research in order to specify research. Next, I applied filters to limit the number of results produced including free full text, ethnicity (African American), English only, publication year (2006–2017), gender (men), age (all adults ranging from 30–65 years), and peer reviewed. I examined the results of the search and chose the ones that fit the criteria based on the terms contained in the titles and words used to describe the article. After screening the abstract of selected articles, I did another

elimination based on the inclusion and exclusion criteria noted below. Lastly, I read the full article to see how it was related to the research questions. Vardell and Malloy (2017), suggested that the Joanna Briggs Institute tool for critically appraising qualitative research is useful. Therefore, I also utilized this as a tool for my dissertation. The Joanna Briggs Institute tool assist in assessing the trustworthiness, relevance, and results of published papers (Vardell & Malloy, 2017). It provided quality checklists that helped structure the write up of my study, ensuring you present the recommended information.

Inclusion and Exclusion Criteria

It is important to use inclusion and exclusion criteria when conducting research to produce reliable results. The factors included in the research are referred to as "inclusion criteria," and the factors that are not allowed are called "exclusion criteria" (Patino & Ferreira, 2018). The criteria can contain several elements, and mine are as follows:

Inclusion

- Only original peer-reviewed published articles
- Only articles published from 2006-2018, except one seminal article from 1947;
- Only articles published in English;
- Both qualitative and quantitative studies; and
- African American men diagnosed with COPD;
- Only original published studies; and
- Only studies that are free and available in full text.

I initially screened 43 published articles. After careful elimination based on the inclusion and exclusion criteria, 12 articles were found to directly contain information about

African American male barriers faced when ceasing to smoke after being diagnosed with COPD.

Assessment of Methodology for Literature Review

Von Elm (2007) used a tool that improves the quality of reporting of observational studies referred to as the strengthening the reporting of observational studies in epidemiology (STROBE) method. I used this tool to enhance and strengthen the literature review. STROBE offers a checklist of 22 items relating to the title, abstract, introduction, methods, results, and discussion sections of articles (Von Elm et al., 2007). The STROBE statement shows how to improve the reporting of observational studies and facilitates critical, appraisal, and interpretation of studies by reviewers (Von Elm et al., 2007). I reviewed qualitative review articles for methodological validity using the Joanna Briggs Institute qualitative assessment and review instrument (JBI-QARI; Vardell & Malloy, 2017).

Typing in keywords from the previous databases resulted in a hit count of a 7,460 citation results. When limiting the data search, I applied search filters. As a result, filters applied based on the inclusion and exclusion criteria excluded 7,114 citations, leaving 349 articles in total. After a review of the remaining articles (abstracts, and in some cases, text) I deemed 45 articles as appropriate for this study. A more in-depth reading of these remaining articles showed that 15 were of most importance for understanding the relevance of this research study.

Framework

Theory of Planned Behavior

The theory of planned behavior (TPB) was a guide for this study. This theory was postulated by Icek Ajzen in 1980 (Larabie, 2011). Larabie (2011) found that the TPB model was beneficial for researchers who wanted to examine the attitudes and behaviors of individuals pertaining to certain events. The TPB was beneficial to my study because the more positive the attitude and the subjective norms are toward smoking cessation, and the greater the perceived control is, the stronger the individual's intention will be to terminate tobacco use, therefore, leading to potential interventions that can help African American men cease smoking (Larabie, 2011).

TPB offers two reasons why an individual (including the study's population of African American men) acts in a particular manner (Ajzen & Driver, 2002). The first is attitude, and the second reason is African American men's acceptance or disapproval of other people's attitudes concerning the illness and continuing or quitting smoking (Ajzen &Driver, 2002). This concept is evaluated by the motivation, positive and negative wishes of others (e.g., family, friends, care providers), and the observation of level(s) of control African American men have in the presence or absence of others (Larabie, 2011).

In following Kabat et al. (2014), this study, attitudes represent an individual's summary assessment of smoking; (good versus bad, beliefs that signify characteristics that follow or are associated with the object; attitude objects; and norms that represent beliefs about what the individual thinks others do or should do.

The qualified importance of the attitude and subjective norm components of behavior depends upon the intention, population, and the individual in question (Eisner et al., 2013). Despite specific refinements to Ajzen and Fishbein's theory there is general agreement that attitudes and subjective norms are essential antecedents of smoking behavior that are strongly supported by empirical studies in various cultural contexts (Pandey et al., 2017; Tonnesen et al., 2017). In literature about African American men, attitudes about smoking have been generally operationalized as questions about beliefs in the health risks of smoking and, more recently, norms and values regarding smoking as it pertained to society or the environmental perceptions (annoyance/tolerance) of African American men diagnosed with COPD who continued to smoke (Tonnesen et al., 2017). Some researchers stated that those who evaluate smoking behavior negatively do so at least in part because they know the adverse health effects of smoking and this negative evaluation contributes to the intention not to smoke (Tonnesen et al., 2017).

A consistent relationship has been demonstrated between smoking status and belief in the harm of smoking (Klesges et al., 2018). In a 1983 cross-sectional survey in Toronto, Pederson et al. (1987) reported that for both active and passive smoking, people who had never smoked had a greater knowledge of health effects than former smokers, who, in turn, were more knowledgeable than current smokers. Research pertaining to this study was repeated again 5 years later, and although there was no change in scores, more individuals in 1988 reported that they were always bothered by smoke and perceived fewer of their associates as smokers (Tonnesen et al., 2017). The authors concluded that

increasing knowledge about the harmful effects of smoking might not be as important for attitude change as other factors, such as social norms.

Recent literature has placed increasing emphasis on the normative component of smoking behavior reflecting the secular trend of a decline in the social acceptability of smoking since the first U.S. Surgeon General's Report in 1964 (Alberg, et al., 2014). Predictors of smoking behavior (Banks et al., 1981; Eisner et al., 2013; McAlister et al., 1984; Pederson & Lefcoe, 1982; Van Roosmalen & McDaniel, 1992) and smoking in the workplace (Iyer et al., 2012; Sorensen et al., 1986) have stressed the influence of the social environment on an individual's smoking behavior. Many studies of smoking behavior have included survey items to measure specific smoking beliefs and attitudes related to both smoking as a public health problem and to norms and values about smoking (Burke et al., 1992; Dixon et al., 1991; Eiser et al., 1989; Elder et al., 1992; Grube et al. 1986; Klesges et al., 2018, Pederson et al., 1992, Velicer et al., 1985).

Various instruments have been developed in smoking cessation studies. The Russell smoking motivation questionnaire (RSMQ; Russel et al., 1974) has been a useful mental scale to evaluate the motives of smoking, and the inventory of smoking situations (Annis & Martin, 1980) was designed to assess the temptations to try smoking in several situations among nonsmokers (Naquin & Gilbert, 1996). The original version four primary-order factors are adverse effects, positive social, peer situations, and curiosity (Epstein & Collins, 1977). The situation specific model for smoking behavior (Best & Hakstian, 1981) provides a basis for tailoring smoking modification procedures to personal reasons for smoking. The self-efficacy scales (Moe & Zeiss, 1982) allow a self-

report measure of self-efficacy (Candiotte & Lichenstein, 1981). The scale is correlated to emotion, optimism, and work satisfaction (Candiotte & Lichenstein, 1981). The reasons for smoking scales (Horn & Waingrow, 1966) were used as a self-assessment tool for identifying smokers' motives (Joffe, 1981; Shiffman & Prange, 1988). Wakefield (2016) noted that attitudes related to smoking behavior ranges from positive attitudes, which are in favor of smoking, to negative attitudes which are against cigarette smoking. As these attitudes vary in strength, so too would we expect the individual's susceptibility to smoke to change, making smoking more or less desirable or acceptable behavior to the individual (Wakefield, 2016).

Chronic Obstructive Pulmonary Disease

COPD is a progressive illness that weakens the lungs (Lopez et al., 2016) and worsens over time. The disease usually causes coughing, wheezing, and shortness of breath (Couch et al., 2008). As a result, it makes it difficult for an individual to breathe.

COPD is the third-leading cause of death in the United States (Johnson et al., 2017), and over 11 million people in the United States have been diagnosed with COPD (American Lung Association [ALA], 2017). Moreover, about 24 million more people may have the disease and not know it (Grossman et al, 2011). Globally, COPD affects approximately 65 million people (ALA, 2017). COPD most commonly occurs in people who are over age 40 and who have a history of smoking (MacNee et al., 2012). Various factors may contribute to the development of COPD, including prolonged exposure to air pollutants and dust. However, cigarette smoking is the leading cause of the disease

(MacNee et al., 2012). Smoking causes about 90% of COPD cases in the United States (Grossman et al, 2011).

When a person breathes in, oxygen-rich air goes down the windpipe and into small bronchial tubes located in the lungs (Grossman et al, 2011). Bronchia branch off into several smaller and thinner tubes, called bronchioles (Stanton et al., 2016). At the end of the bronchioles are small, round air sacs called alveoli, which have tiny blood vessels called capillaries (Stanton et al., 2016). When air enters the alveoli, oxygen moves through the capillaries and into the bloodstream (Stanton et al., 2016). Simultaneously, carbon dioxide moves into the alveoli, resulting in the exhaling of bad air. As a result, the walls between the air sacs thicken and become swollen (MacNee et al., 2012). The airways make more mucus than average, which then clogs airways, causing obstruction, therefore causing difficulty in breathing (Stanton et al., 2016).

Risk Factors of Smoking and COPD

Cigarette smoke contains harmful toxins that affect lung functionality. Toxins inhaled directly into the lungs over prolonged periods can lead to severe lung irritation, triggering the onset of COPD (U.S. Department of Health and Human Services, 2019). As long-term exposure to tobacco smoke continues, the lungs become even more damaged (U.S. Department of Health and Human Services, 2019). Long term exposure to smoking leads to inflammation and degradation of the lungs.

When a cigarette burns, it releases more than 7,000 chemicals, many of which are harmful (ALA, 2017). The toxins in cigarette smoke weaken the lungs' defense against infections, narrow air passages, cause swelling in air tubes, and destroy air sacs, which

are all contributing factors for COPD (Kamil, 2013). These risk factors are not a focus for this research study, but other risk factors can cause COPD, such as the environment. Long-term exposure to air pollution, secondhand smoke, dust, and fumes that can cause COPD (Grossman et al., 2011). A small number of people have a rare form of COPD, Alpha-1 deficiency-related emphysema (Sterling &Weinkam, 2016), caused by a genetic condition that affects the body's ability to produce Alpha-1 protein that protects the lungs (Sterling & Weinkam, 2016).

African American Men, Smoking, and COPD Risk

African Americans start smoking at a later age than European Americans (Sterling & Weinkam, 2016). Since 1970, the prevalence of smoking among African American men has increased (Cooper & Simmons, 2016). Even though many African American men are strongly motivated to quit smoking, fewer African American men than European American men stop smoking (Cooper & Simmons, 2016). Furthermore, African Americans are less likely to abstain from smoking for over a year (Roberts et al., 2016). Consequently, African Americans are more likely to be long-term smokers.

Compared to other groups, African American smokers are not heavy smokers (Bottorff et al., 2016). The average adult African American smokes significantly fewer cigarettes than the average European American male adult smoker (Bottorff et al., 2016). However, even though African Americans start later in life and smoke fewer cigarettes, they show higher levels of nicotine dependence (Besmer, 2012)

Overall Smoking Statistics

Cigarette smoking is the leading cause of preventable disease and death in the United States, accounting for more than 480,000 deaths every year, or about 1 in 5 deaths (U.S. Department of Health and Human Services, 2019). In 2016, more than 15 of every 100 U.S. adults aged 18 years or older (15.5%) smoked cigarettes (U.S. Department of Health and Human Services, 2019). The numbers show an estimated 37.8 million adults in the United States smoked cigarettes in 2016 (U.S. Department of Health and Human Services, 2019) and more than 16 million Americans live with a smoking-related disease (U.S. Department of Health and Human Services, 2019). Smoking declined from 20.9% (nearly 21 of every 100 adults) in 2005 to 15.5% (more than 15 of every 100 adults) in 2016 (Creamer et al., 2019). The proportion of ever-smokers increased, but smoking prevalence did not change significantly from 2015–2016 (0., 2019). Current smokers are people who reported smoking at least 100 cigarettes during their lifetime and who, at the time they participated in a survey about this topic, reported smoking every day or some days (Cornelius et at., 2019).

Smoking Statistics by Gender

Men are more likely to be cigarette smokers than women. An estimated 18 of every 100 adult men (17.5%) smoked in the United States, opposed to nearly 14 of every 100 adult women (Creamer et al., 2019).

Smoking Statistics by Age

In 2017, cigarette smoking was lowest among those aged 65 and older (Creamer et al., 2019). About 13 of every 100 adults aged 18–24 years (13.1%) smoked cigarettes,

and Creamer et al., 2019Approximately 18 of every 100 adults aged 25–44 years (17.6%) smoked tobacco (Creamer et al., 2019). Eighteen of every 100 adults aged 45–64 years (18.0%) smoked tobacco (Creamer et al., 2019), about 9 of every 100 adults aged 65 years and older (8.8%) smoked cigarettes (Creamer et al., 2019). These statistics noted that those who smoked were highest between the ages of 45 and 65, which research shows to be stressful years of life (Sui, 2015).

Smoking Statistics by Race or Ethnicity

According to Creamer et al. (2019) smoking statistics was highest among non-Hispanic American Indians/Alaska Natives and people of multiple races and lowest among Asians. Thirty-two of every 100 non-Hispanic American Indians/Alaska Natives (31.8%) smoked (Creamer et al., 2019). About 25 of every 100 non-Hispanic multiple race individuals (25.2%) smoked (Creamer et al., 2019). Nearly 17 of every 100 non-Hispanic Blacks (16.5%) smoked (Creamer et al., 2019). Almost 17 of every 100 non-Hispanic European Americans (16.6%) smoked. Eleven of every 100 Hispanics (10.7%) smoked (Creamer et al., 2019). Also, about 9 of every 100 non-Hispanic Asians (9.0%) smoked in the U.S. (Creamer et al., 2019). Even though the rate of smoking among non-Hispanic Blacks is not the highest compared to other minority populaces, it remains beyond their European American counterparts.

Smoking Statistics by Educational Level

Cigarette smoking is highest among persons with a graduate education degree certificate (GED) and lowest among those with a graduate degree (Creamer et al., 2019). According to Primack et al. (2013), about 24 of every 100 U.S. adults with 12 or fewer

years of education (no high school diploma; 24.1%) smoke. Nearly 41 of every 100 adults with a GED certificate (40.6%) smoke (Creamer et al., 2019). Twenty of every 100 adults with a high school diploma (19.7%) smoke (Creamer et al., 2019), and about 19 of every 100 adults (18.9%) with some college (no degree) smoke (Creamer et al., 2019). Those with an associate degree have a smoking rate of 16.8% (Creamer et al., 2019), whereas individuals with an undergraduate degree have been shown to have a smoking rate of 7.7% (Creamer et al., 2019). Also, nearly five of every 100 adults with a graduate degree (4.5%) smoke (Creamer et al., 2019). These statistics show that African Americans who have higher education are less likely to smoke.

Smoking by Poverty Status

As of 2017, cigarette smoking was higher among those living below the poverty level than those living at or above this level (CDCTobaccoFree, 2017). 25.3% of every adult who lives below the poverty level smoke. 14.3% of those who live above the poverty level smoke (CDCTobaccoFree, 2017). However, cigarette smoking was higher in the Midwest regions than in the lowest ranking of the West region, with the South coming in second and the North region (CDCTobaccoFree, 2017). Low-income African-American communities smoke in much higher numbers than the rest of the country, a disparity rooted in many inequities (Okuyemi et al., 2013). African American men who live in low-income communities have the least information about the health hazards of smoking, the fewest resources and social support, and often the least access to services to help them quit smoking (Creamer et al., 2019). African American men and Smoking

Smoking Initiation Amongst African American Men

African Americans tend to have a different smoking pattern across the age continuum than do non-Hispanic European Americans (Kim et al., 2012). Specifically, during early adolescence, smoking prevalence is lower among African Americans than European Americans, but during late adolescence and early adulthood, smoking initiation rates in African Americans begin to rise (Freedman et al., 2017; Kandel et al., 2011). By the time individuals are in their late 20s and early 30s, there are a greater number of smokers among African Americans and a greater number of people who have ceased smoking among European Americans, causing the prevalence of African American smoking to equal and often exceed that of European Americans (Belgrave et al., 2013; Chen & Jacobson, 2012; Kandel et al., 2011; Moon, 2013). This pattern is referred to as a "crossover" or "convergence" in smoking (Chen & Jacobson, 2012; p. 93).

Many factors may explain this racial convergence in smoking. For example, African Americans may have fewer resources to quit smoking (Aguilar & Pampel, 2017). Factors such as peer substance use (Brook et al., 2010), parent tobacco use (Brody et al., 2012), targeted advertising (Primack et al., 2013), and discrimination (Bennett et al., 2015; Gerrard et al., 2012; Gibbons et al., 2016) may also influence initiation among African Americans differently than European Americans.

African American high school students smoke at lower rates than their European American and Hispanic/Latino peers (Freedman et al., 2017). Indeed, 8.2% of African American high school students smoke, compared to 18.6% of European Americans high school students and 14% of Hispanic/Latino high school students (ACS, 2017).

African American Men and Smoking Cessation

Although African Americans tend to be lighter smokers; they have more difficulty quitting than do other racial/ethnic groups (Aguilar & Pampel, 2017). While more African American adult smokers want to stop smoking and more African American men make more attempts at quitting than European Americans or Hispanic/Latino smokers, African Americans successfully quit at a lower rate (Aguilar & Pampel, 2017). Every year, 59.1% of African Americans make a quit attempt, but only 3.3% succeed in quitting compared with 6.6% of European Americans (Kandel et al., 2011). African Americans are 11 times more likely to smoke menthol cigarettes than European Americans, with the highest rates of menthol smoking among African American youth aged 12–17 years (Aguilar & Pampel, 2017; Brook et al., 2010). Despite a later onset of smoking and fewer packs per day, African American menthol smokers successfully quit at a lower rate than non-menthol smoking African Americans (Brody et al., 2012).

Smoking Cessation Programs

Despite decreases in U.S. smoking rates over the past decade, men (18%) continue to smoke in more significant numbers than women (14%; Thabane, 2012). These trends indicate the importance of how providers need to rethink the delivery approach and comprehension process amongst men (Thabane, 2012). Although there is increasing evidence for the effectiveness of gender-specific health promotion programs, few male-centered tobacco reductions and cessation interventions have been developed or formally evaluated (Bottorff et al., 2016; Okoli et al., 2011).

Current research reveals men turn to the internet for health information (Bottorff et al., 2016). Websites and social networks influence men's lifestyles, enable information-gathering, and provide opportunities to engage in mutual help and content co-creation (Thabane, 2012). Specific to smoking cessation, web-based and mobile apps have emerged as commonplace, making possible on-demand and just-in-time information retrieval (Okoli et al., 2011). In turn, this fosters collective intelligence, drawing on men's preferences for autonomy in decision making related to mapping and monitoring their quit strategies (Thabane, 2012).

Once users are dependent on tobacco, quitting is extremely difficult. Nicotine dependence resulting from tobacco use hinders efforts to sustain abstinence from tobacco for a prolonged period (Thabane, 2012). Many tobacco users make multiple attempts to quit, often without the assistance that could significantly increase their chances of success. A substantial number of smokers want to stop smoking, but a significant proportion of them have never tried to quit (Kreuter & Wray, 2013). Most smokers go through various stages before they finally decide to attempt to cease smoking and ultimately succeed. Smoking cessation aids or other interventions appear to be effective by targeting an effort to ease smoking. Each year, about 2% of smokers succeed in quitting on their own initiative (Thabane, 2012).

Smoking cessation is difficult, and behavioral interventions alone have had only modest accomplishments; as a result, drug therapy has been increasingly relied upon to assist in smoking cessation. The most common of these pharmacologic interventions have been nicotine replacement therapy (NRT) (Okoli et al., 2011). NRT uses particular

products to give small, steady doses of nicotine to help stop cravings and relieve symptoms that occur when a person is trying to quit smoking (ACS, 2017).The most common of these pharmacologic interventions has been nicotine replacement therapy (NRT) Okoli et al., 2011), which NRT's uses particular products to give small, steady doses of nicotine to help stop cravings and relieve symptoms that occur when a person is trying to quit smoking (ACS, 2017)NRT products include nicotine gum, nicotine inhalers, nicotine nasal sprays, nicotine lozenges, and nicotine patches; some of which are available without a prescription. NRT products do not contain the other chemicals found in tobacco products (ACS, 2017).

More recently, research has focused on using antidepressant therapy for smoking cessation (Primack et al., 2013). Pharmacologic smoking cessation aids are recommended for all smokers trying to quit unless contraindicated; smokers should also be provided with counseling when attempting to quit smoking (Gerrard et al., 2012). Family physicians can play an essential role in the smoking cessation process, given that 70% of smokers consult family physicians annually (Okoli et al., 2011).

As mentioned, most smokers who attempt to quit do not use cessation aids, so they are usually unsuccessful, with two-thirds relapsing within 48 hours (Primack et al., 2013). For this reason, all smokers, including those who may be at risk for COPD and those who already have the disease, should be offered the most intensive smoking cessation intervention possible (Gerrard et al. 2012). Even a brief period of counseling at the doctor's office to urge a smoker to quit results in a 5 to 10% smoking cessation rate (Okoli et al., 2011). The percentage of successful smoking cessation at one year is 3–5%

when the patient tries to stop alone, 7–16% if the smoker undergoes behavioral intervention, and up to 24% when receiving pharmacological treatment plus behavioral support to quit smoking (Gerrard et al., 2012).

Pharmacologic agents are classified as first-line pharmacotherapy, including NRT and bupropion (Iyer et al., 2012). According to Iyer et al. (2012), a pharmacologic agent is an antidepressant that reduces nicotine withdrawal symptoms and cravings. Another agonist, varenicline, acts as a partial nicotinic acetylcholine receptor agonist. A second-line agents such as nortriptyline, a tricyclic antidepressant agent, and clonidine, an antihypertensive drug (Stead et al., 2018).Nonpharmacological smoking cessation strategies include brief interventions, such as patient education and advice, behavioral therapy, self-help materials, and telephone counseling (Stead et al., 2018).

A review of randomized or quasi-randomized trials of individual behavioral counseling for smoking cessation by trained therapists with six months or longer follow-up indicated that individual counseling was more effective than no intervention at all (Stead et al., 2018). Evidence shows that group counseling is more effective than self-help and other less intensive intervention methods for smoking cessation (Lancaster & Stead, 2015).

Self-help materials improve quit rates among individuals who smoke more than those who receive no intervention, but the effect is generally small (Lancaster & Stead, 2015). Proactive telephone counseling, in which the counselor initiates client contact, enhanced smoking cessation efforts. The telephone counseling approach has been consistent with successful smoking cessation and abstinence rates from 10–45% (Civljak

et al., 2011). Multiple sessions of telephone counseling improves smoking quitting rates (Civljak et al., 2011).

The Lung Health Study reported that 21.7% of unique intervention participants had stopped smoking at five years since study entry, compared to 5.4% of usual care participants (Civljak et al., 2011). The study was a randomized clinical trial designed to determine the potential benefits of smoking cessation. Inclusion criteria included asymptomatic airway obstruction, participants were of all races/ethnicities, and were randomized to receive a smoking cessation treatment program or no intervention. With all the findings, it was concluded that having a positive approach to smoking cessation could lead individuals to a more successful lifestyle by eliminating smoking all together (Lancaster & Stead, 2015).

Physical Effects of Smoking Cessation

Ceasing smoking is the most effective treatment for COPD. Smoking cessation correlates with a reduction in the risk of having a stroke, developing coronary heart disease, and being diagnosed with certain types of cancer and is associated with increased life expectancy (Di Stefano et al., 2015). Despite the ongoing inflammatory process, there is growing evidence that the rate of development of COPD can be reduced when people at risk of developing COPD stop smoking (Wagena et al., 2015). If a smoker with advanced COPD stops smoking, they will not recover lost lung function, but the rate of the rate of lung function decline is reduced and even halted when a smoker with advanced COPD stops smoking, even if lung function is not recovered (Murray et al.

2014). Smoking cessation at the early stages of COPD improves prognosis (Anthonisen et al., 2014; Murray et al. 2014).

Research has indicated that repeated attempts to quit smoking, even with relapses, can prevent loss of lung function, especially in those with mild COPD (Zielinszky & Bednarik, 2011). Kanner et al. (2015) added that continued abstinence from smoking is also associated with a reduction in pulmonary symptoms. Longitudinal cohort studies showed that those who continued to smoke had a more abrupt decline in lung function than those who had stopped smoking (Di Stefano et al., 2015). Ceasing smoking may reduce the smoking-related deterioration in lung function (Anthonisen et al., 2014).

African American Men and Smoking

According to Chen (2012), favorable attitudes toward smoking among African Americans are critical determinants of the desire to smoke. Some of the positive attitudes associated with cigarette smoking included the belief that those who smoke cigarettes have less stress (Chen, 2012). Similarly, a study conducted in Canada found that a high percentage of men believed that smoking provided a *happy moment* (Cox, 2011). Cox (2011) also found that a positive attitude towards smoking was likely to predict an individual's active smoking behavior in the past and the future.

Comparing smoking habits of Blacks and Whites, Kabat et al. (2014) found that African Americans diagnosed with COPD knew the dangers if they continued to smoke. Kabat et al.'s (2014) research offered five reasons why African American men who smoked said it was challenging to quit smoking after being diagnosed with COPD: already having the disease (COPD), lack of motivation to stop smoking, addiction to

smoking, not being at the right time, and the attitude that smoking is pleasurable. The authors demonstrated that when African American men cease smoking without a plan to maintain a nonsmoking status, their progress can be affected. This reasoning suggests that smoking cessation models should place greater emphasis on the dynamic nature of motivation to quit (Kabat et al., 2014).

Dey (2013) found the main reason men, in general, continued to smoke or relapsed was because it was their norm. Smoking had become part of their lifestyle, which led to negative self-esteem from feeling shame and guilt at not being successful at not smoking (Dey, 2013). Lack of resources influenced continued smoking or relapsing (Dey, 2013). This idea correlates with Adriaens et al. (2014), who demonstrated that behavioral motives such as using a behavioral approach to gain support to inform people about interventions helped them to cease smoking.

Summary

Many studies focused on why individuals continue to smoke after being diagnosed with COPD; however, few studies were specific to African Americans and more specifically to African American men. COPD is on the rise among African American male communities. Prior research has shown why COPD is increasing; however, there is a gap in the literature that focuses specifically on the reasoning to continue to smoke after diagnosis. Research is needed regarding the perceptions, views, and experiences of African American men who continue to smoke despite being diagnosed with COPD.

Chapter 3 will discuss the study's details, the qualitative method, and the study design used to understand the meaning the participants attributed to their personal experiences of smoking.

Chapter 3: Research Method

The purpose of this study was to examine TPB constructs and examine the reasons African American men diagnosed with COPD continue to smoke. A basic qualitative research approach was used for this study.

African American men diagnosed with COPD have been found to continue smoking regardless of the knowledge that smoking exacerbates the condition (Kulak et al., 2016). The purpose of this study is to understand why African American males with COPD continue to smoke. As a result, the findings may help to design effective interventions to help them stop smoking.

Chapter 3 includes the details of the study, the qualitative method, and the interviewing design of the study used to understand why African American men diagnosed with COPD continue to smoke. Chapter 3 details the research design and rationale for choosing it, defines the role of the researcher, describes the methodology, presents trustworthiness of the study, and details ethical procedures to ensure proper guidance for the dissertation.

Research Design and Rationale

Research Questions

Research Question 1: What beliefs and attitudes were associated with continuing to smoke after being diagnosed with COPD?

Research Question 2: How did the beliefs and attitudes of others influence the continuation of smoking after being diagnosed with COPD?

Research Question 3: What is the perceived level of control over smoking after being diagnosed with COPD?

Interviews are designed to collect a rich source of information from a small number of people about attitudes, behavior, preferences, feelings, opinions, and knowledge (Creswell, 2014). Specific interview questions asked are listed in Appendix J and Appendix K. I have identified a gap in the literature regarding why African American men diagnosed with COPD continue to smoke. I addressed this gap by gathering participants' personal experiences, personal and social attitudes and beliefs underlying their smoking, and participants' knowledge of the challenges or complications that could occur if participants continued to smoke.

Research Approach

The three primary research methods are qualitative, quantitative, and mixed methods (Turner et al., 2015). The qualitative approach was the most suitable for this study. Researchers use the qualitative method to gain an understanding of underlying reasons, opinions, and motivations. This method is used to gain insight into a problem or to develop ideas to address the problem (Trainor & Graue, 2014). In this study, I explored why African American men diagnosed with COPD continue to smoke. Qualitative researchers use open-ended questions to explore in-depth reviews of the responses of participants concerning the strategies they implemented within the purview of the phenomenon of study (O'Brien et al., 2014).

Quantitative methods are used when a researcher wants to compare variables, collect numeric data, conduct experiments, and may test the significance of different

hypotheses using statistical analysis (Denscombe, 2011) This method type would not have been suitable for this research.

Researchers use mixed-method designs when the study includes both a qualitative and a quantitative aspect (Morse & Cheek, 2014). In mixed-method research, the researcher gathers data to test the quantitative aspects of the study and also collects data to explore and describe the qualitative aspects of the study (Trainor & Graue, 2014). A mixed-method approach would not have been the most beneficial approach for any study where the researcher focus was on exploring the attitudes and beliefs of the participants (Duan et al., 2015). Due to not analyzing or integrating quantitative and qualitative data, I did not use the mixed-method approach for this study. he use of the qualitative method afforded me the opportunity of using a series of open exchange, open discourse, and open-ended questions to seek a deeper knowledge of the perspectives of the participants.

Qualitative Research Designs

Barkhuizen (2014a); Baskerville and Myers (2015); Bliss (2016); and Merriam and Tisdell (2016) stated that that in order to carefully analyze and conduct social science research, the research must include a research design. These designs include basic qualitative research, grounded theory, ethnography, and phenomenology. I chose the basic qualitative research design because of the alignment of the approach with this research and the research questions. Basic qualitative research involves exploring a complex phenomenon through the use of questions and observations (Merriam & Tisdell, 2016).

Grounded theory is a research method concerned with generating a philosophy rooted in data that has been systematically collected and analyzed (Burnard, 2014). The grounded theory explains or understands individual data to identify patterned relationships of emerging issues (Burnard, 2014). Researchers who use phenomenological designs can explore and attach meanings to the lived experiences of the participants of the study (Barkhuizen, 2015; Baskerville & Myers, 2015; Bliss, 2016). I did not focused on finding the meaning of phenomena through people's lived experiences or groups.

Merriam and Tisdell (2016) used the terminology "basic qualitative research" to describe research as having been derived philosophically from constructionism, phenomenology, and symbolic interaction and as being used by researchers who are interested in (a) how people interpret their experiences, (b) how they construct their worlds, and (c) what meaning they attribute to their experiences (p. 23). The questions that drive a basic qualitative research study are about the nature of the occurrence resulting in it being the best choice for my research. Ultimately, the purpose of this basic qualitative research was to improve practice in the health field and obtain an in depth understanding of why African American men continue to smoke after being diagnosed with COPD.

Role of a Researcher

According to Jacob (2014), qualitative study researchers collect, organize, and analyze data; group themes; identify ethical and confidentiality issues; and mitigate personal biases in the collection and analysis of data. Cronin (2014) noted that in

qualitative interviews, the researcher is the primary data collection instrument. In my role as the primary data collection instrument in this research, I collected, organized, analyzed, and categorized data into themes. Jacob (2014) noted that researchers should be familiar with the topic of study.

Currently, I am going to school to become an obstetrics physician and for a Ph.D. in health services. Although I do not work or oversee individuals who have been affected by COPD, I do have friends and family members who have been diagnosed with COPD. The issue presented itself to me when I noticed that a coworker diagnosed with COPD who continued to smoke. It dawned on me that maybe he did not realize the effects of what he was doing on his quality of life. After talking with him, he merely stated, "I know what I am doing, but there's no real help." This event was the first indication that there is a significant gap between individuals with COPD and their understanding of the impact of continuing to smoke.

Immediately, I asked myself why he would continue smoking if he knew it was causing further harm. I also asked myself, are physicians doing enough for people who are diagnosed with COPD? This thought led to the question of why. As I drew near to my studies and started my dissertation process, I decided I would conduct a study to bridge the gap between patients, the environment, and health care providers. There have been several studies done concerning European Americans and Chinese populations and continuing to smoke. However, few have focused on African Americans, specifically men. Although I have never engaged in smoking or knew why people would begin to smoke, I felt it was a need for society to understand and a need for social change to help

African American men who wanted to cease smoking or needed better support to stop smoking.

Ryan et al. (2014) stated researchers can achieve objectivity by refusing to select participants with whom either a past or current personal or professional relationship exists. Researchers should avoid recruiting participants who do not offer objective responses to interview questions. I did not have any previous or current personal or professional relationships with the targeted participants. Similarly, I did not have any past or present association with the organizations selected to recruit participants for this study.

The geographical area of a research study is an essential factor for a researcher. Jacob (2014) indicated that researchers should be intimately acquainted with the geographic location of the study. I have lived in Decatur, Illinois, since birth. I moved away for college and, after six years, I returned. I am acquainted with the geographical area.

Gluck and Mciver (2016) stated qualitative study researchers must adopt a series of systematic ethical steps when carrying out investigations that involve the lived experiences of human subjects. Researchers who gather data from social interview engagements must demonstrate the following ethical requirements: (a) respect for individuals, (b) beneficence, and (c) justice (Gluck & Mciver, 2016). In this research, I demonstrated respect by being fair to every participant. I asked each individual the same set of questions in the same way via Skype or FaceTime. I practiced beneficence by attempting not to harm the participants, and I emphasized the principles of justice in my interactions with all participants.

Yan et al. (2014) stated researchers have a responsibility to proactively guard against the possibility of collating, analyzing, interpreting, and viewing data through personal lenses, perspectives, or biases. I acknowledged that my work experience as a medical student might cause potential biases. I mitigated potential personal bias by using the member-checking technique to reduce potential bias. Member checking is the process of having each participant review a summary of their responses for accuracy and exhaustiveness (Morse, 2015). Allowing the participants to verify the accuracy of data throughout the interviews helped me see if I injected any personal bias into the participants' responses. As Yan et al. (2014) noted, asking open-ended, semi-structured interview questions allows participants to offer more detailed and exhaustive answers to questions in their own words. Throughout the interviewing process, I asked follow-up questions, reiterated, and summarized responses to clarify participants' responses documented in a reflective journal where helpful.

I did not take a subjective view of the data. I recorded the data in a reflective journal and reported the data as found regardless of my opinions . I did my best to remain objective, neutral, and professional. After obtaining the consent of the participants, I also recorded the interview sessions using a digital audio recorder. I then summarized the responses of the participants, sent the transcribed versions of the participants' responses to the participants for member checking, uploaded the member checked, and outlined versions of the participant responses into NVivo version 12. NVivo is often-used data analysis software (Castleberry, 2014). Yan et al. (2014) use interview protocols to guide and standardize the interview process and minimize personal bias. I incorporated a

protocol (see Appendix I) to govern and regulate the sessions with participants. Yan et al. (2014), stated a protocol is a document that itemizes the specific steps and procedures required for the interview process. My rationale for using a protocol was to set the participants at ease, reduce my personal biases, encourage participants to share information freely, facilitate uniform data collection strategies for all interview sessions, and create a relaxed context and environment during the interview sessions (Jacob, 2014; Yan et al., 2014). I also used the protocol to minimize personal bias in the course of interviewing the participants in this study.

Methodology

Population and Sampling

Researchers such as Duan et al. (2015) and Mead et al. (2015) use purposeful sampling to selectively choose participants . The researcher considers each participant to be knowledgeable and eligible for the intended study based on the purpose of the study and the overarching research question (Duan et al., 2015; Mead et al., 2015). I purposefully selected participants based on specific criteria. In this study, I used a set of criteria as described in Chapter 1 to select 12 African American men who were diagnosed with COPD. Before sending out letters of invitation to the potential participants, I used an initial telephone/email script to determine if the individuals met the preset criteria (Appendix C). If the participant met the criteria, a follow-up script (Appendix D) was then read detailing the participants' of the time and date of the study. The other types of sampling methods I considered were convenience sampling, snowball sampling, and census sampling (Valerioe, 2016).

According to Valerioe (2016), when using the purposeful sampling technique, the researcher narrows down the participants in a study using a set of predetermined criteria to select a sample size out of the total population of potential participants. Researchers adopt the convenience sampling technique as a fast and easy way of recruiting participants (Valerioe, 2016). The convenience sampling technique was not appropriate for this study because qualitative researchers require the participants in a basic qualitative research study to possess relevant specialized knowledge. The snowball sampling technique occurs when the recruited participants suggest some other participants they know to the researcher (Valerioe, 2016). Researchers use the snowball method when recruiting participants proves difficult. I did not need to use snowball sampling because of African American men's availability for this study. The census sampling technique entails the use of every available sample in a given population. According to an article published by Valerioe in 2016, researchers use the census sampling technique in situations where the sample population is equal to the total population. Researchers use the census sampling technique in situations where the sample population is equal to the total population (Valerioe, 2016). I did not use the census sampling technique because my sample size was small (Kirk, 2017; Valerio 2016; Wolf, 2017).

Etikan (2016), Wuest (2015), and Molenberghs et al. (2014) stated that in a basic qualitative research study, a researcher must establish the eligibility criteria for potential participants. To be eligible to participate in this study, participants had to be African American men from 35–65 years old because most African American men have been diagnosed with COPD in this age range (Glanz et al., 2016). Each participant had to meet

other criteria: they needed to currently have COPD, currently smoke, and understand the study purpose and intention. Each participant had to provide voluntary consent to participate in the study, after being informed of its purpose (see Appendix F).

According to Etikan (2016), Molenberghs et al. (2014), and Wuest (2015), a qualitative researcher must attain data saturation, which occurs when the questioning of participants no longer produces any new information, codes, or themes. There is the ability to replicate the study, providing one asks the same participants the same questions in the same timeframe (Fusch & Ness, 2015). O'Reilly and Parker (2013) stated that saturation determines the sample size in basic qualitative research. Saturation, in turn, indicates that adequate data is collected for a detailed analysis. To ensure data saturation, I presented the same set of interview questions to both interviews and the pilot sessions (Appendix E and Appendix F). I provided the participants with a copy of the summarized versions of their responses to the interview questions. I also asked for additional information throughout the interviewing process. Offering the participants the opportunity to add to their responses helped me reach data saturation (Yan et al., 2014). It is useful to know that if I had not achieved saturation with the interviews, I would have incorporated the participants' responses from the pilot interview, later presented in this chapter.

Instrumentation

The basis for an interview protocol is to establish a list of questions explored during an interview. The purpose of an interview guide is to ensure the same protocols are followed for each person being interviewed(Lancaster & Stead, 2015). The

interviewer uses the guide to openly explore, probe, and ask questions to elucidate and illuminate that particular subject (Colegrave & Ruxton, 2016). The interview guide is a checklist followed throughout the interview session (Lancaster & Stead, 2015). The advantage of a guide is to direct and focus the interviewer and the participant during the session (Colegrave & Ruxton, 2016). The guide helps make interviewing different people more systematic and comprehensive by delimiting the issues to be explored (Colegrave & Ruxton, 2017).

Interview protocols help ensure the researcher will not forget critical concepts that need addressing throughout the interview. The protocol reminds the researcher to relay relevant information, such as stating (or restating) the purpose of the interview, what will happen to the data obtained, and any confidentiality concerns(Lancaster & Stead, 2015). The components of my protocol focused on establishing the study's objective, identifying the participant's reasons for participating, understanding the challenges the participants face when continuing to smoke with COPD, and directing the interview session and providing a reliable closing (Appendix I).

Pilot Study

A pilot study is a small experiment designed to test logistics, gather information before the actual more extensive research, and to improve its quality and efficiency (Lancaster & Stead, 2015). A pilot study can reveal insufficiencies in the design of an experiment or procedure, and these can then be addressed before being expended on a larger scale study (Lancaster & Stead, 2015)**.** Qualitative interview questions need to articulate what a researcher wants to know about those involved' intentions and

perspectives. My committee chair evaluated my interview questions to ensure they were sufficient to answer the pilot research questions. Once the interview protocol was approved, I was able to begin the pilot study.

The protocol used in the pilot study was the same as planned for the main study. I recruited three participants who met the same criteria as in the main study. I did not include the data obtained from the pilot study in the main study. I only used information collected from the pilot study to assess the validity of the interview questions. The pilot study's recruitment was done by posting flyers on grocery store boards, barbershops, hospital boards, community help boards, Facebook, and other social media sites, churches, and other religious communities relevant to the population study (Appendix E). Once contacted by the participant, I read a phone script to see if the participant met the criteria in Appendix C, and then the follow-up script was read to them (Appendix D). Because of an ongoing pandemic(COVID-19) over the study period, I changed all interviews from in person to email or video chats. All consent forms were emailed or mailed out to participants and returned to me before beginning the interviews.

Procedures for Data Collection

Describing and documenting the data collection technique of a research study establishes the trustworthiness of the data collection process(Battistella, 2014; Elo et al., 2014; Seitz, 2015). After receiving Walden University's IRB approval (03-06-20-0450718), I conducted a pilot study to evaluate the content validity of my data collection instrument. Once I established the validity of my data collection tool, I began collecting data from the participants of this study using interview sessions.

Leung (2015) stated that the advantage of using an interview strategy to gather data provided researchers the opportunity to ask to follow up questions to clarify anything being said and attach real significance to the wording. However, an interview relies heavily on an assisted discussion to produce results; consequently, the dialogue's facilitation is critical (Leung, 2015). I began recruiting participants by posting flyers on grocery store boards, barbershops, hospital boards, community help boards, Facebook and other social media sites, churches, and other religious communities relevant to the study population (see Appendix B). Once contacted by the participant, I read a phone script to see if the participant met the criteria in Appendix C, and then the follow-up script was read to them (Appendix D). Because of an ongoing pandemic(COVID-19) over the study period, I changed all interviews from in person to email or video chats. All consent forms were emailed or mailed out to participants and returned to me before beginning the interviews. Etikan (2016), Marshall and Rossmann (2016) and Newington and Metcalf (2014) all stated that a qualitative researcher uses an informed consent form to provide the details of the roles of a participant in a study. Presenting an informed consent form to the participants for this study enabled them to make informed decisions about their roles in the research and whether they wanted to participate (Appendix E). Researchers must inform participants of their right to withdraw from the research study at any time and for any reason(Battistella, 2014; Butler, 2014; Seitz, 2015). I informed each participants of their rights to either continue or discontinue the interview for any reason at any time without consequences.

Researchers such as (Battistella (2014), Butler,(2014) and Yan et al. (2014) use interview protocols to standardize the interview process. Each interview was scheduled for 90 minutes in a private setting via video chat or email due to COVID-19. Seitz (2015) stated that researchers might document sessions using note taking, audio recording devices, video recording devices, or a combination of them. For my research, data was collected and reported using: (a) an iPhone digital recorder and (b) note taking. My notes also included observations of the participants' body language and nonverbal communication when possible.

According to Battistella (2014), member checking ensures validation of data (Battistella, 2014). To do member checking I asked follow-up questions and present a summarized version of participant responses to each participant. After each interview, I outlined the participant's responses and presented the summarized version to the participants.

Data Organization Techniques

Researchers such as Wuest (2015), Rowlands et al. (2015) and Yan et al. (2014) researchers should organize raw data from their interview sessions into emerging concepts and themes (transferred all the relevant documents such as the member-checking document, journal notes, and other records obtained into NVivo for Mac iOS version 10.13.4 for coding, analysis, and storage. NVivo for Mac iOS version 10.13.4 is an online data analysis software used to identify themes and concepts in a document (Rowlands et al., 2015; Wuest, 2015; Yan et al., 2014). Rowlands et al. (2015) noted that many researchers prefer NVivo over other types of data analysis software such as Atlas.ti

and MAXQDA because NVivo is more user friendly, supports small and large data sizes, and is specific for basic qualitative research works. I prefer NVivo because of this qualitative study's small sample size and the program's user friendliness.

Researchers should store their studies' raw data in secure and protected locations(Yan et al., 2014). I created a digital folder to organize and track the raw data and emerging understandings from this study. I stored the handwritten and summarized notes in a secured safe that will require a PIN for five years. Only I have access to the security box. After five years, I will retrieve and shred the physical folder's contents and destroy the electronic files. Researchers should use coding techniques to preserve the research participants 'confidentiality. I used P1, P2, and P3's codes to identify participants and 1, 2, 3 for both the pilot study and the actual study.

Data Analysis Technique

Data analysis is the process of attaching meanings to raw data(Wuest, 2015). Qualitative researchers commence data analysis after conducting and collating the raw data from their semi-structured interview sessions (Yan et al., 2014). Yan et al. also identified the following five-step data analysis process to be a useful data analysis procedure for qualitative research: (a) compile data, (b) disassemble data, (c) reassemble data, (d) interpret data, and (e) draw conclusions.

Compiling Data

Researchers should organize raw data in the compiling phase of data analysis in an orderly form to create a database (Rowlands et al., 2015; Thomas, 2015; Yan et al., 2014). I collected the data from this study by importing member check responses from

participants and information from my personal and direct observation of the participant's activities into the NVivo for Mac version 10.13.4 software for categorization (Leech & Onwuegbuzie, 2011). NVivo for Mac version 10.13.4 is the data-assisting analysis software that I used to analyze the data from this study.

Disassembling Data

Researchers should divide their accumulated data into fragments and labels at the disassembling data analysis phase through a coding process(Rowlands et al., 2015; Thomas, 2015; Yan et al., 2014). The data-coding process includes naming, describing, and grouping the data using NVivo into codes. The data-coding process consists of identifying portions of data, specifically written excerpts with references to create core themes(Rowlands et al., 2015; Thomas, 2015; Yan et al., 2014). Researchers should create central themes in the NVivo software by labeling all the data with codes to identify relationships, patterns, organized thoughts, and themes. The disassembling process also includes using visualization techniques in the NVivo software to interpret relationships among codes (Rowlands et al., 2015). Researchers can also identify the responses from the different respondents with labels to establish emerging themes in their responses (Rowlands et al., 2015; Thomas, 2015; Yan et al., 2014).

Reassembling Data

Researchers should cluster and categorize the labels into sequencing and groups in the reassembling data phase (Rowlands et al., 2015; Thomas, 2015; Yan et al., 2014). I reassembled the data from this study using critical functionalities in the NVivo software

process of sequencing and grouping to arrange the emerging common patterns and themes in the data into sequences and data groups.

Interpreting Data

Researchers should create narratives from the sequences and groups in the interpreting data phase(Rowlands et al., 2015; Thomas, 2015; Yan et al., 2014). My focus of interpreting the data was to establish understandings and meanings using the assistance of the NVivo software between the sequences and groupings in the data to validate the process of data analysis through the process of methodological triangulation (Edwards-Jones, 2014; Thomas, 2015; Yan et al., 2014). Methodological triangulation is the process of using multiple sources of data to increase the validity of a study (Yan et al., 2014). To accomplish methodological triangulation in this study, I relied on the member checks, summarized versions of participants' responses from the interview sessions, findings and results from prior and current researched literature findings, and research relationships to the TBP model.

Drawing Conclusions

Researchers aspire to link core themes from results with other sources of data that present similar findings(Rowlands et al., 2015; Thomas, 2015; Yan et al., 2014). To conclude my data analysis, I checked for common patterns and themes from the emerging data that: (a) was in alignment with the TBP, (b) identified common themes that helped to indicate why African American males diagnosed with COPD continue to smoke, (c) presented the evidence from previously published literature, and (d) provided evidence from newly published research studies.

I used the NVivo for Mac version 10.13.4 data analysis software for this study to code, label, categorize, count, and tabulate themes and patterns into useful information, including tables. Houghton et al. (2014) cautioned that computer-aided software products such as NVivo function to identify the common themes and patterns in data more effectively after the researcher performs four data analysis stages on the raw data (i.e., comprehending, synthesizing, theorizing, and re-contextualizing). After saturation is reached, comprehension is achieved by demonstrating that any new information obtained in the study would not add much to the phenomenon's description(Payne, 2013). This concept was followed in my study. Synthesizing was achieved by putting the pieces together from the data collected and coding them using the NVivo software (Northway, 2017). At the end of this stage, I made general statements about the phenomenon and the participants in the study. After synthesizing the collected data, the findings were clarified using TPB model. Lastly, recontextualizing was used to propagate further reasoning using the TPB model as a guiding theory (Morse & Cheek, 2014).

NVivo software organizes, stores, retrieves data, and backs up findings with evidence. The program takes over the marking, cutting, and sorting tasks that the researcher would usually do manually(Mays & Pope, 2015). NVivo helps maximize efficiency and speed up grouping the collected data according to categories and retrieving coded themes (Renold, 2017). As a result, I had to synthesize the data and interpret the meanings extracted from the data. Therefore, I used NVivo to organize and help reduce and store the collected information to ensure it is efficient and manageable (Welch & Patton, 2013).

The participants were involved in member checking throughout the interview session, presenting each participant with a summarized version of their responses to the interview questions for verification. I also asked the participants for any additional information if needed. After member checking, comprehending, synthesizing, theorizing, and recontextualizing the raw data, I transferred the member checked data, written documents, and notes from direct observations of the participants into NVivo for coding and identification of common themes (Leech & Onwuegbuzie, 2011). During this time, I established data categories and subcategories in alignment with my study's research questions.

NVivo

When importing the data into the NVivo software, I did the following: (a) downloaded the NVivo for Mac version 10.13.4 software into my computer and (b) created different subfolders with names labeled as interview transcripts, notes, observations, and other data relevant to this study. NVivo helps organize and analyze unstructured data(Renold, 2017). NVivo software allows users to classify, sort, and arrange information; examine relationships in the data; and combine analysis with linking, shaping, searching, and modeling(Renold, 2017).

I tested my conceptual framework, identified trends, and cross-examined information using its search engine and query functions. Themes presented from findings were linked to previous literature and the newly published literature related to why African American men diagnosed with COPD continue to smoke.

Trustworthiness

Trustworthiness in a qualitative study refers to the dependability of the study's findings, while validity refers to the credibility, confirmability, and transferability of the results of the study(Morse, 2015). Barry et al. (2014) indicated that a qualitative researcher must adopt the research findings to the demands of reliability and validity. I addressed reliability in the section addressing dependability. I discussed validity concepts as they related to credibility, confirmability, and transferability in this dissertation.

Dependability

Qualitative researchers equate reliability with the process of enhancing the concept of dependability (Barry et al., 2014). Dependability refers to the stability, consistency, and reproducibility of data over time. and conditions.(Wuest, 2015) Expert review of questions, protocols, transcript review, member checking of data interpretation, methodological data triangulation, and ensuring data saturation are strategies to enhance dependability in basic qualitative research (Barry et al., 2014; Chetty et al., 2014; Morse, 2015). I enhanced dependability in this study by asking each participant the specific interview questions aligned with the research question. I consistently followed a stepwise approach of an interview protocol during each interview (see Appendix I). I then transcribed the responses of the participants verbatim using Google Voice Typing without personal bias. Once completed, I summarized the participants' replies, and used member-checking to ensure that I captured the exact meaning each participant conveyed and ensured data saturation.

Credibility

Credibility is the level of accuracy of the findings in a study as documented from the perspective of the participants (Cope, 2014; Fusch & Ness, 2015; Morse, 2015). Yan (2014) suggested that researchers can enhance their studies credibility using member checking and data saturation. I achieved credibility in this study by ensuring that the participants checked the summary of their responses for accuracy and exhaustiveness. I probed for more answers during the interview to ascertain that the participants exhaustively responded to the interview questions.

Confirmability

Confirmability is the ability of other readers to corroborate or support the study results (Morse, 2015). Qualitative researchers must ensure that their study findings are confirmable (Cope, 2014; Morse, 2015; Yan et al., 2014). I gained confirmability through transcript review and reflexivity. Reflexivity involves the disclosure of the researcher's personal biases (Cope, 2014). I used reflexivity to ensure that my own opinions remained undisclosed to the participants. I did not interfere with or alter the views of the participants. I also documented data from the perspective of the participant.

Transferability

Transferability is the level to which future researchers may apply the findings from a particular basic qualitative research study to other research settings in the course of future research(Morse, 2015). Current qualitative researchers enhance the potential for the transferability of research finding for future researchers who may want to apply the findings of a particular study to other settings (Morse, 2015). Researchers who detail and

sequentially document their research procedures enhance the potential transferability of their research findings by future researchers (Cope, 2014; Morse, 2015; Yan et al., 2014). I increased the transferability of this study by documenting and describing this study's entire research process in a sequential format to encourage the possible replication of similar results in different population settings by future researchers. I described every stage of the research process, starting from my role as the researcher, to the study's findings in a precise sequence for easy comprehension and possible replication in other settings by future researchers.

Ethical Research

The objective of ethical research in a qualitative study is to protect the participants in research from any potential physical and psychological harm that may occur consequent to a research study(Oliver & Barr, 2014). I initiated contact with the potential participants for this study after receiving the Walden University Institutional Review Board's (IRB) approval (03-06-20-0450718). Murray et al. (2014) noted that participants should sign informed consent forms to indicate their willingness to participate in a research study before joining the study. An informed consent form is a document that details the specific details of a research study that will enable each participant to make informed decisions about their willingness to participate in the study (Murray et al., 2014; see Appendix E and F). I presented an informed consent form to each participant in this study to ensure they made an informed decision concerning their willingness to participate before the study began. I told participants that the study was voluntary, and they could withdraw from the research for any reason during the study.

Researchers are responsible for informing the participants in a research study about the presence or absence of incentives for participation. (Fiske & Hauser, 2014). I informed the participants that there were no monetary or nonmonetary incentives for participation in this research study. Researchers use The National Organization for Health Services as a guideline for establishing ethical boundaries in a research study, which is a code of conduct established to maintain ethical standards in the course of participant research to maintain the protection and privacy of the participants in a research study(Oquendo et al., 2014). I abided by these standards for this study.

Researchers support the participants' confidentiality in a research study by using assigned identification numbers and codes (Morse & Coulehan, 2015). I kept the confidentiality of each of the participants in this study by assigning identification numbers to each. I used codes to identify participants during the analyzing process. Researchers have a responsibility to store research documents in a safe and retrievable place for five years (Oliver & Barr, 2014)and I followed this practice.

I recorded and transcribed the data, summarized versions of participants' responses, collected written notes and other relevant documents in a file folder that will reside in my locked safe and on my personal computer. I will be the only person with access to the files for five years. After five years, I will destroy the paper file folder by shredding everything inside and deleting it on my personal computer.

Summary

Chapter 3 entailed a discussion of the research design, sample selection, the

Researcher's role, and the study method. Additionally, I outlined methods of collecting data, data analysis, and data interpretation. I also explained the means of establishing trustworthiness. This chapter also detailed the participant's ethical protection process to establish participant privacy and confidentiality.

Chapter 4: Results

The purpose of this research was to explore why some African American men diagnosed with COPD continue smoking following their diagnosis. I conducted this study to understand the attitudes, behavioral intention, subjective norms, social norms, perceived power, and perceived behavioral control that influence their continuing or quitting smoking based on the TPB model. The findings of this research could be useful in the planning of better interventions by providers of health services facilities or organizations that can help decrease and potentially eliminate smoking within the participants.

Research Questions

Research Question 1: What beliefs and attitudes were associated with continuing to smoke after being diagnosed with COPD?

Research Question 2: How did the beliefs and attitudes of others influence the continuation of smoking after being diagnosed with COPD?

Research Question 3: What is the perceived level of control over smoking after being diagnosed with COPD?

Chapter Organization

Throughout this chapter, I detail the importance of the pilot study, the main study, and the settings and demographics for my participants. This chapter also includes the data analysis process, details obtaining trustworthiness, final results, and a summary of the data collecting process.

Pilot Study

A pilot study is a small-scale test of the methods and procedures to be used on a larger scale (Porta, 2008) that allows researchers to find out what could go wrong so the researcher can fix them before they start the larger study (Chan et al., 2017). I recruited for the pilot study by posting flyers on grocery store boards, barbershops, hospital boards, community help boards, Facebook, other social media sites, and local churches (see Appendix B). Once contacted by a potential participant, I provided information about the study by reading or emailing a short script that included an introduction of myself and my study.

I described the required criteria to participate in my study: each participant had to be an African American male aged 35–65 years, diagnosed with COPD, and a current smoker. If the participant met the criteria for the study (Appendix C), the next script was read which informed the participant of the time and date of the interview (Appendix D). Due to the COVID-19 pandemic. I scheduled interviews via webcam . My cellphone and email were provided to participants if there were any questions or concerns. I then informed participants of the pilot study and what their role was for a pilot study. I also explained if saturation were not reached with the main interviews their information from the pilot interviews be used.

The participant was emailed or sent a consent form that stated the purpose of the study, risks, benefits, and voluntary nature of the study . Each consent form and demographic information was labeled with P1, P2, or P3 to protect the confidentiality of the participant. Before starting the interview, the participant was informed again that the

study was voluntary and that he may leave at any time without consequence. Each participant had to show his signed consent form copy via webcam or verbally agree via phone call for verification purposes. After acknowledging the signature, the interview began. Each pilot study interview lasted approximately 45–60 minutes. The first pilot study interview was only about 15 minutes long. As a result, I had to probe for more answers and clarity during the next interviews. At the end of the interview, each participant had a chance to ask any questions. Upon ending the interview, I asked participants to keep the interview information confidential. Each participant was informed that he would be mailed or emailed a copy of the interview transcript. He was informed that by checking over the transcript and ensuring I had documented all his answers correctly he would help provide me with feedback for the main interviews. If anything needed to be corrected, if the participant had questions, or if clarity was needed, I told each participant to contact me either via phone or email as soon as possible. None of the interviewees contacted me regarding needed changes or feedback. I did not need to incorporate any pilot study data for the main study due to meeting saturation.

Some challenges occurred while conducting the pilot study. The pilot study allowed me to identify questions and information that needed to be improved for the main interview. I found areas where I needed to probe for more clarification. This also helped lengthen the interview time and provide more in-depth information. This helped bring confidence to my interviewing by decreasing my anxiety. There was also the challenge of trying to observe and write down nonverbal cues. This was difficult because the interviews were done over a computer or phone, so the interpersonal interaction was

omitted during phone interviews. More of an effort had to be made to engage in conversation and to make the participant comfortable with me. I assured the participant that I would be unbiased throughout the interview and that he would not be judged by any response. I noticed when the participant would be reluctant during specific questions, and I then would help direct the question to become more understandable for the participant.

Table 1

Demographics of Pilot Study Sample Size of African American Males with COPD Who Continue to Smoke.

Name	Age	Initial Starting age of smoking	Past 12 months have you attempted to cease smoking	Marital Status	Income Level (dollars $)	Education Level	Employment Status
P1	63	11	yes	Married	<75000	High School	Full Time
P2	55	13	yes	Married	<55000	Some college	Full Time
P3	52	11	yes	Divorced	<70,000	Masters	Full Time

After completing the pilot study interviews I was provided the approval to conduct the main study interviews.

Interview Setting for Full Study

Over a 4-week and 5-day period, I was successful in recruiting and hosting the main study interviews. There were flyers displayed and distributed throughout Decatur, Illinois in local hospitals (St. Mary's Hospital and Decatur Memorial Hospital). I also put up flyers in the local grocery stores, barber shops, and Churches of the Living God

(COLG) Temples 14. Within 4 days of the flyer's being displayed and distributed, I received phone calls in response. I recruited a total of 15 participants, three for the pilot and 12 for the main study. The interviews were initially to be conducted in the Decatur Conference Center in Decatur, Illinois. However, due to the outbreak of COVID-19, all interviews were conducted via FaceTime or Skype to present a safer environment for the participant and myself. I conducted a total of 12 interviews to gather results for the main study. During the interviews, I associated each participant with a specified number rather than by name for ethical research purposes, INT1, INT2, INT3, respectively. After welcoming the participants and thanking them for agreeing to participate, I provided a briefing of the interview process (Appendix I).

I again reviewed and acknowledged consent verbally from the participant via webcam or phone (as approved by Walden's Office of Research Ethics and Compliance approval # 03-06-20-0450718). After verifying the signature, I began the interview. I saved every individual consent form in my personal lockbox. After transcribing each interview, I provided the participant a copy of the interview transcription via email or mail for member checking. All demographic information was collected after the informed consent was obtained and prior to the interview questions. During the interviews there were no personal or organizational conditions that emerged that would have influenced participants or their experiences at the time of the study.

Demographics

The participants in my study were African American male COPD patients between the ages of 35-65 who still smoked. Table 1 displays participants' demographics relevant to this study.

Table 2

Demographics of Main Study Sample Size of African American Males with COPD who Continue to Smoke

Name	Age	Initial Starting age of smoking	Past 12 months have you attempted to cease smoking	Marital Status	Income Level	Education Level	Employment Status
INT1	52	16	yes	Single	<30,000	High School	Full Time
INT2	60	12	yes	Single	<30,000	High School	Disability
INT3	35	9	yes	Single	<30,000	Bachelors	Full Time
INT4	44	23	yes	Married	<80,000	High School	Full Time
INT5	56	8	yes	Married	<50,000	Some College	Full Time
INT6	58	12	yes	Single	<30,000	High School	Unemployed
INT7	63	25	yes	Married	<45,000	Some College	Full Time
INT8	41	12	no	Single	<54,000	Some high School	Unemployed
INT9	55	15	yes	Single	<30,000	High School	Unemployed
INT10	64	12	yes	Single	<30,000	High School	Part Time
INT11	53	13	yes	Divorced	<45,000	Bachelors	Full Time
INT12	61	11	yes	Single	<30,000	High School	Part Time Disability

Data Collection

Twelve participants offered the data collected for this study. All participants and I were located in Decatur, Illinois. Initially the interviews were going to be conducted in person at the Decatur Conference Inn, Room 2. However, due to the 2020 COVID-19 pandemic, I conducted all interviews via Skype, FaceTime, or phone. Two interviews were conducted per day for four weeks and five days . Each interview lasted from 45–60 minutes.

To collect the data, I recorded each participant using: (a) an iPhone X digital recorder and (b) by taking handwritten notes. Nine of the interviews were done using the webcam. By doing so, I pretested the recorder, microphone, and sound the day before the interviews started. I set my recorder next to the speaker so that I could hear the interviewee clearly. I also kept a notebook to record nonverbal cues from participants. My notes also included observations of the participants' body language hesitations, withdrawals, and excitement pertaining to the questions when they were conducted by webcam. There were no unusual circumstances that presented while collecting my data.

Data Analysis

Creswell (2014) described six steps of data analysis . The first step requires the researcher to organize and prepare the data for analysis through transcribing interviews. The second step is reading or looking at all the data. The next phase in qualitative data analysis is coding the data. Then the coding process is used to draw up different categories which then can be used to present themes for analysis. Lastly comes presenting an interpretation of the findings (Creswell, 2014).

I recorded all responses and nonverbal cues from the participants. In addition, the nonverbal notes from the participants were handwritten in my personal notebook. NVivo 12 was used to organize the collected data. Interview data were analyzed in accordance with the thematic TPB framework originally proposed by Icek Ajzen and later influenced by Martin Fishbein, to allow for themes to emerge from the data, alongside analyzing preexisting concepts inferred by previous research (Larabie, 2011).

I read the transcripts several times to identify codes, categories, and themes. After several discussions with my committee member, I developed a coding frame using Microsoft Excel. Common words from the participants were color-coded and highlighted. If new codes emerged, the coding frame was changed and the transcripts were reread according to the new structure. Once those codes were grouped together, categories were formed. The categories were developed after grouping the coded segments. This was done to reduce the number of different pieces of data in my analysis. A rigorous and systematic reading process was then done and after repeatedly going back to the transcripts I had to condense the categories into themes. After doing some critical thinking, I saw that themes emerged and were fully developed.

Interpretative analysis involved grouping together similar key points to identify recurrent themes which revealed attitudes and behaviors, outside perspectives, and self perspectives of why African American diagnosed with COPD continue to smoke (Sutton, 2015). The emerging codes, categories, and themes were presented in tables 3-5.

Research question 1: What beliefs and attitudes are associated with continuing to smoke after being diagnosed with COPD?

Themes: Impossibility, Psychological dependence

Table 3

Codes to Categories to Themes Transition to Research Question 1

Codes	Categories	Themes
Smoking helps with stress (14)	Stress Control	Psychological dependence
Smoking calms my nerves (5)	Stress Control	Psychological dependence
Smoking is Enjoyable (2)	Happiness	Psychological Dependence
Smoking did not harm me (4)	COPD due to other issues	Psychological Dependence
The smell is dissatisfying (2)	Characteristic dislikes of smoking	Psychological Dependence
Smoking leads to a better life (3)		
Balancing the impact on health of smoking is hard (1)	Life improvements	Psychological Dependence
	Characteristic dislikes of smoking	Psychological Dependence
I am just not sure if I should stop (1)	Doubt conflicts with trying to cease smoking	Impossibility
I am not sure if I should stop (1)	Lack of Motivation	Impossibility
I do not have the motivation to stop (1)	Lack of Motivation	Impossibility
What reasons do I need to stop (1)	Lack of Motivation	Impossibility
I am not feeling quitting (1)	Lack of Motivation	Impossibility
I am too tired to quit (1)	Lack of Motivation	Impossibility
Everything else has left and this is all I have to look forward to (1)	Lack of Motivation	Impossibility
It is not in me to stop even though I want to (1)	Lack of Motivation	Impossibility
Apprehensive (2)	Lack of Motivation	Impossibility

Research question 2: How do the beliefs and attitudes of others influence the continuation of smoking after being diagnosed with COPD?

Themes: Importance of family and Friends, Identity Conflict, Need help

Table 4

Codes to Categories to theme Transition to Research Question 2

Codes	Categories	Themes
Family/Friends (9)	Family/Friend Influencers	Importance of family and Friends
Intended to quit for my wife (1)	Family/ Friend Influencer	Importance of family and Friends
Being a part of a crowd (3)	Fitting In	Identity Conflict
I feel normal after smoking (3)	Conflicted	Identity Conflict
Want to stop smoking, but I just go with it (2)	Fitting in	Identity Conflict
Not a real smoker, only at times When I am with friends (1)	Fitting in	Identity Conflict
Smoking made me feel grown up (1)	Fitting In	Identity Conflict
I am not sure if I could (3)	Doubt conflicts with trying to cease smoking	Need Help
Gaining support (22)	Need Specialized equipment/aid	Need help

Research question 3: What is the perceived level of control over smoking after being diagnosed with COPD?

Themes: Positive Expectation, Low Control, Do not need to change

Table 5

Codes to Categories to theme Transition to Research Question 3

Codes	Categories	Themes
Could Quit Smoking (11)	Self-efficiency	Positive Expectation
Trying is a start (2)	Self-efficiency	Positive Expectation
What would really be the point (3)	Futility	Low Control
It would be useless (1)	Futility	Low Control
It is not worth it (3)	Futility	Low Control
Waited too long (1)	Lack of Motivation	Low Control

Evidence of Trustworthiness

Trustworthiness refers to the degree of confidence in data, interpretation, and methods used to ensure the quality of a study (Polit & Beck, 2018, pp.45-56). To be accepted as trustworthy, I had to conduct data analysis in a precise, consistent, and thorough manner by recording, systematizing, and disclosing the analysis methods with enough detail to enable the reader to determine credibility. Thus, this research validated the data collected and described the process in which I collected data and the quality of

the research obtained. For this basic qualitative research project, I achieved trustworthiness by applying credibility, transferability, dependability, and confirmability.

Credibility

Credibility is involved in establishing that the research results are believable (Brinkmann & Kvale, 2005). I established credibility during this study by using a protocol to keep each interview the same; I used an iPhone X recorder to track my process from the recruitment of the participants throughout the interview. Recording the interviews also ensured credibility because it allowed me to transcribe each interview verbatim, supporting the authenticity regarding the participants' responses regarding their lives. Each nonverbal cue was detailed, noted, and tracked in my personal notebook so that the findings could later be added to my research. Tracking and recording were done so that when reporting the results, the findings would be clear to understand and demonstrate to other readers or researchers.

Transferability

Transferability pertains to the degree to which research can be transferred to other contexts (Polit & Beck, 2018, pp.45-56). For this purpose, the reader can observe the specific details of the study and methods and compare them to similar studies that they may be more familiar with (Polit & Beck, 2018, pp.45-56). During my research, there was only one interview per participant. I conducted two interviews each day until completion. This study provided individual responses, specific characteristics of the demographics, and a clear focus throughout the study, enhancing my research's

trustworthiness. The study also ensures applicability in the fact that this research can be duplicated by other researchers.

Dependability

Dependability confirms that the research findings are consistent and can be repeated (Connelly, 2016). For this study, I measured dependability by the standard by which the research was conducted, analyzed, and presented. I documented the protocol for the study process in detail to enable others to repeat the research study and gain similar results. By doing so, it allows readers to understand the research methods used and their usefulness.

Confirmability

Confirmability occurs when findings support collected data (Connelly, 2016) . This process assumes that qualitative research allows the research to bring a sole perspective to the study, which helps eliminate any potential bias supported by the researchers (Polit & Beck, 2018, pp.45-56). To enhance the study's confirmability, I took notes of the participants' verbal and nonverbal actions. I recorded each interview so that if any researcher wanted to repeat the study, they would have specific guidelines to follow or observe and then be able to compare the results. I documented references from prior literature and other findings, therefore, strengthening the confirmability.

I manually coded my data using my notebook and used NVivo to organize and store data. I ensured that I had an audit trail for each participant to establish confirmability detailed the data collection process, data analysis, and interpretation of the data. Recorded questions and responses collected were combined with my written notes

to gather thoughts about coding. Combining both recorded and manual responses provided the rationale for why codes emerged and came together to form categories that lead to the developing themes. In my analysis, I also used the technique of reflexivity. I had to reexamine my background and position to see how these two components influence the research process (i.e., selecting the topic, choosing the methodology, analyzing the data, interpreting the results, and presenting the conclusions). To aid me in doing so, as discussed in chapter 3, I kept a reflexive journal.

Results

Following each of the research questions are the themes that emerged from collected data and analysis and associated findings relative to the TBP theory.

Research Question 1: What beliefs and attitudes are associated with continuing to smoke after being diagnosed with COPD?

The two themes that emerged to answer the first research question were impossibility and psychological dependence. While interviewing the participants, I saw that attitudes and beliefs were the main focuses of why the participants continued to smoke. Attitude is an emotional position or mental statement that a person holds about a fact or statement (Stangor, 2014). Beliefs form people's values. According to Antwi et al. (2020), beliefs are thoughts with a direct influence on a persons' attitude toward a behavior. It is important to understand what people's beliefs are. Understanding others' beliefs helps gain understandings of how they perceive things (Antwi et al., 2020). Beliefs serve as the link between behavior and the outcome that the behavior is expected to produce or bring about (Antwi et al., 2020). For this research, I wanted to understand

the attitude and beliefs that African American men have about continuing to smoke after being diagnosed with COPD. Appendix K lists the questions and sub questions asked during the interviews to obtain the data that was analyzed to answer research question one. Each interviewee had identified personal and individual attitudes and beliefs about why he continued to smoke despite currently having COPD; however, data analysis led to identification of commonalities that are seen in the themes of impossibility and psychological dependence.

Psychological Dependence

Participants felt that smoking was a method of relaxation, based on their comments. Smoking helped provide a sense of relief to everyday struggles. In their minds, smoking provided a sense of peace that could not be achieved in any other way. "Smoking is a way of feeling in control of yourself," stated IN7. IN3 stated that smoking gave him "happiness," and he stated, "No matter what I may have going on and what I may be doing if I need anything at that moment I will turn to my cigarette. That is my happiness, that's my go to." IN8 commented that smoking "made life easier." Smoking decreased his daily stress by becoming something to calm his mind. When he would go without smoking "chaos*"* would come and in order for him "to live I have to have at least seven [cigarettes] a day, at least'!

"Psychological dependence" refers to the process by which a person's mind and body come to depend on a substance, so they keep feeling a certain way (McCaffery et al., 1990). The participants expressed how smoking allowed them to feel calm and less stressed. The participants' belief that smoking was caused them to relax was an important

indicator as to how the participants' attitude toward smoking was encouraged. In my study, participants felt smoking would alleviate majority of the stress that would come with the day.

Impossibility

Smoking cessation was a concern for most of the participants. IN11 stated that he had smoked for so long "there was no use to not smoking." He believed that because of everything he had done throughout his life that "not smoking would not benefit him much." IN7 stated, "What would be the point, want to [quit]? Yes, will I . . . don't see it happening. It's not in me to stop smoking." IN3 did not want to cease smoking and admitted to it by saying "I don't want to stop smoking." He had no reason why he would need to stop. He did not feel anything was wrong or harmful with his smoking. Three participants were apprehensive about smoking. IN7 stated, "I'm not sure if I should stop." IN1 mentioned, "I just don't know. I mean, I know it would make me happier, but would it really make my body happy?" IN9 said, "I'm not so sure if I should stop smoking. What are the reasons if I already have COPD?*"*

Participants frequently emphasized the attitude of smoking cessation as impossible.. They felt that it was impossible to cease smoking because they had a lack of motivation to do so. All of the participants had smoked for ten or more years, indicating that they had developed strong smoking habits. Smoking for long periods causes a mental and physical teardown of the body and mind (Tweed et al., 2012). If the participant knows that smoking provides a sense of relief, then it would be difficult to give up that comfort level. The positive effects that the participants described from smoking were

impacted by the addictions to cigarettes, making it hard for the participants to cease smoking.

The two emerging themes, physiological dependence, and impossibility, focused on the attitudes and beliefs of each participant about continuing to smoke after being diagnosed with COPD. Physiological dependence presented the mental struggles faced by the participants, as illustrated in their responses. Impossibility related to the lack of motivation some of the participants felt when they considered the possibility of smoking cessation but did not think they would be successful in this endeavor. This played a role in participant's attitude was in regard to smoking. Smoking made the participants feel better. Smoking was their companion, their friend, and their way of destressing. If the participant wanted to cease smoking but could not, stress developed, which in turn caused the participant to smoke.

Research Question 2: How do the beliefs and attitudes of others influence the continuation of smoking after being diagnosed with COPD?

Normative behavior refers to how the person thinks other people think about someone engaging in a behavior (Stangor, 2014), which in this case was continuing smoking after being diagnosed with COPD. Appendix K lists the questions and sub questions asked during the interviews to obtain the data analyzed to answer RQ2. The three themes that came from the data analysis were the importance of family and friends, identity conflict, and needing help.

Importance of Family and Friends

Eleven of the 12 participants stated that their family and friends wanted them to cease smoking. Some family members even went as far as to stop associating with the individual because they could not watch the individual continue life smoking. IN4 stated, "Everyone asked me to stop. They felt it was bad for me." However, he could not cease smoking. He was "addicted." Although he wanted to stop, he knew the journey was difficult and that "added more pressure to me, which in turn made me smoke more." IN9 had children aged 12 and 14. He stated, "My girls hate the fact that I smoke. They won't even come around me or get in the car if I'm smoking." He felt alone most of the time because he knew that smoking kept his children away. When I interviewed IN10, he admitted:

> [Family and friends have] always been on edge about it. Especially my momma. She is up in age now so I just do not smoke anything around her. My family they are against it especially when they all found out I have COPD. They always ask why I still do it. (Laughs) Some of my friends are split in between" some stay on my case and some pretty much just let me do what I want.

IN5 said, "I'm divided with my choice because I know I want to quit smoking but I don't know if I'm more so able to . . . I don't have anyone around that wants me to stop smoking." He "enjoys smoking and doesn't think anything is wrong with it" despite

having been diagnosed with COPD. He said, “This is the cards I was dealt, so I have to live the way I am to live, right?”

Identity Conflict

It was interesting to learn that several of the participants felt that when they smoked they became a different person. This person was allowed to be free, free of stress, free of fear, and free of anything that was presenting issues for that individual that day. However, once the effects of smoking subsided, the participants admitted that life struggles and stressful thoughts quickly reappeared. As a result, they wanted another cigarette. IN1 stated that when he smoked he was a “new person." When I asked him what did meant, he simply stated, “I become outside of myself. This eases my mind and makes me feel more in control of myself . . . my life.” IN11, although hesitant, stated that smoking made him feel like “the man.” He said that although he knows that smoking is harmful and has known this for a very long time:

> The feeling that I get when that first puff comes over me is calming. All of my feelings of regret or hurt or thoughts of having this darn disease cuz [because] that’s what it is, it’s a disease that killing me, leave and I feel like I don’t have it. It’s not hard for me to breath at those times, it’s not hard for me to concentrate. It makes me feel like my younger self. The self I was before smoking. The 25-year-old me.

Three participants stated that they initially started smoking as a way to fit in, join peers, or be acknowledged by someone in an inner circle. IN1 stated, “I started smoking when I wanted to be a part of the crowd. I saw all of my friends doing it and didn’t want to look

lame." IN12 stated that he wanted "to stop smoking but keeps doing it just to go along with the norm that he's around." IN9 stated, "I wasn't ever a real smoker; only times I do it is when I was around friends; then somehow it just became my life." This brought me to the conclusion that those individuals started smoking as a way to feel accepted. This led to the other, so some of the participants had a lack of motivation to cease smoking. IN6 stated, "Not being able to stop smoking caused my family to separate from me." This played a role in his feeling accepted. By smoking, the participant felt they he fit in with his peers because "most of them smoke and don't have a problem with it; it's my family."

Need Help

Eleven out of the 12 participants stated that they need help ceasing to smoke. They were willing to take the chance of getting help if they found proper help. Some participants expressed feeling that doctors did not care about their health and were more concerned with the benefits of having the title of doctor on his or her resume. IN3 expressed that there was "no real local help" in Decatur, Illinois. When asked for further explanations, IN3 stated, "Decatur does not have long-term rehabs, the doctors only look out for themselves and their image and the programs that are [in Decatur] are not for people like us. Black people don't get treated right!" IN7 felt that the healthcare system "doesn't value African Americans in general." Others were in search of help but met a dead end. . IN5 stated that he went to his physician for a checkup and upon his arrival was asked about his condition only to be told that he "should let smoking go and that [he] would be seen 6 months later." He stated, "The doctor just told me I needed to stop smoking. He didn't try to offer me no help, no solution, just stop smoking." As a result,

he “lost confidence and trust” in his physician. He said, “I won’t be going back to him, that’s for sure!” This experience demonstrated the crucial role physicians and healthcare providers play in influencing African American men who continue to smoke after being diagnosed with COPD. IN2 stated that if he were “given aids and places he could go maybe for support groups or just to be around others like him that would be of help.” Participant IN3 was mentally affected by smoking cessation attempts. He was tired of trying and failing. He stated:

> If I got the help that I needed to stop smoking I honestly would do it, but no one wants to help they expect you to do it yourself. Do you know how hard it is to stop something that has control over you just suddenly is? Trust me, I have tried and tried, and believe you me I have failed, failed, and failed. But I am willing to keep trying, just not alone.

Through the analyses, the three emerging themes demonstrated how outside influences have a great impact on African American men diagnosed with COPD who continue to smoke, whether those influences be friends, family, healthcare providers, or other potential sources of help and support. Smoking provided some of the participants with a sense of freedom and the feeling of being someone else. With the help and support of others, participants could learn the strength and importance of self and have some of the help they said they needed to stop smoking. Additionally, having support from healthcare providers and ongoing resources to quit smoking were regarded as important influences in stopping smoking.

Research Question3: What is the perceived level of control over smoking after being diagnosed with COPD?

This research question is important because it deals with the participants perceived level of control over smoking. Perceived behavioral control refers how the individual perceive the ease or difficulty of continuing or not continuing to smoke (Martinez & Lewis, 2016). Appendix K lists the questions and sub questions that were asked during the interviews to obtain the data that was analyzed to answer research question three. The two themes that came from the data analysis are positive execution and low control.

Positive Execution

The data analysis showed that two out of 12 participants knew they could cease smoking. IN1 stated:

> I was going to go to a rehab center within the next 6 months and that was going to be his starting point of getting better. I had a good support system. My provider was supportive and I was ready to stop smoking.

This individual had been smoking for 18 years and had been diagnosed with COPD 2 years ago. He stated that "It has been a struggle for me knowing I caused himself to have COPD so I would have to get my finances, paperwork, and mind ready for the challenge." IN1 stated that he could cease smoking. He was "ready to stop smoking after smoking for 25 years." He was diagnosed with COPD 5 years prior. However, he "got his motivation to cease smoking from his kids and his brother." His brother had passed away from COPD recently and he "did not want that for my family."

Low Control

The ability to refrain from smoking is influenced by a number of psychological, social, and environmental factors such as addiction, proper guidance, and support. Eleven of the participants stated they had made more than one attempt to quit smoking; however, none of them was able to successfully quit smoking. They explained that smoking had a great impact on their daily lives and that they did not have the strength not to smoke. . Four of the participants explained that they were simply addicted to smoking, which is why it was so hard for them to stop. IN8 stated, "It's a fight with your brain every time you try to stop." However, with the proper guidance, support, and aid, 11 out of 12 participants felt they could cease smoking even though they had several failed attempts along the way. IN1 stated, "I can try and keep trying I do know this but will I ever get to the point to where I am done trying and actually doing . . . that is the question." IN2 stated:

> I have tried several times, but most of them have been on my own, and I just can't kick the habit. I am ready to stop smoking. I have been ready but I do not have the self-control, but I can do it. I know I can. I just need to start off with someone holding my hand, unfortunately.

IN6 stated he would need to "change my environment." By doing so this would "help with my stress level," which is the trigger for his smoking. IN5 suggested that he "could stop smoking if my wife stopped smoking" also. He said, "Having someone who is smoking right next to you and you smelling it makes you want to join in. [*laughs*] We're both tired of it, though we both should actually look into ways to stop."

Eleven out of 12 of the participants felt ceasing smoking was difficult without the right support. Although some of them wanted to cease smoking, they were not sure how to do so. Therefore, a low sense of control was present. Many spoke about the quitting attempts and how they were not successful at stopping for long periods of time. However, the participants were willing to cease smoking with the proper help and felt that they could cease smoking for a long period of time. Eleven of the twelve participants wanted help, and they spoke of needing proper guidance, support, and aids.

Discrepant Cases

A discrepant case (e.g., negative case, outliner case) is when respondents' experiences or viewpoints differ from the main body of evidence (Welch & Patton, 2013). For discrepant cases, the researcher has a responsibility to address and add the discrepant instances in the data analysis and data reporting (Creswell & Creswell, 2018). There was one discrepant case in this study: IN4 viewed smoking as something positive. He wanted to continue to smoke. He enjoyed smoking, and he was not concerned about how smoking affected his health. He learned to accept everything that came with his lifestyle. There was a specific reason as to why the gentleman liked it. It “lessened his stress.” He also stated that smoking "gave me motivation, and it provided him with a sense of relief rather than pain and anxiety throughout the day." He also acknowledged that he was “aware of what continuing smoking will do with my COPD, and I am and is willing to accept the consequences of doing so.”

Summary

Three research questions provided insight on why African American men diagnosed with COPD continue to smoke. The responses presented their attitudes and beliefs, their normative perspectives, and how they perceive themselves concerning being able to cease smoking or continuing to smoke. The themes derived were impossibility, psychological dependence, family and friends' importance, identity conflict, needing help, positive expectation, and low control.

Research question 1 asked, what beliefs and attitudes are associated with continuing to smoke after being diagnosed with COPD? This question aimed to understand the attitudes and beliefs the participants had regarding smoking despite being diagnosed with COPD. Based upon the analysis of the data from the responses provided by the participants, two themes emerged, impossibility and psychological dependence. The participants had doubts that they could cease smoking. There was a lack of motivation that participants felt based on the analysis of the data. Some participants felt that they had tried to quit smoking so often that it was impossible to quit smoking altogether. The participants recognized their psychological dependence symptoms and reported that they felt out of control of their smoking.

Research question 2 focused on how others' beliefs and attitudes influence the continuation of smoking after being diagnosed with COPD. This question looked into how the outside world viewed the participant and smoking. Nine out of 12 of the participant's family members and friends did not approve of their continuing to smoke. They felt that smoking was bad for the participant's health. With the data analysis, three

themes emerged to answer this research question. The importance of the family and friends theme demonstrated how the opinions of these people affected the participant. The participant whose family did not want to be around him made him feel lonely, and it gave him a reason to want to cease smoking. Seeing other people die or have health issues due to smoking was another reason for alarm.

The second theme for research question two of identity conflict appeared to occur long before the diagnosis of COPD. When asking when participants started smoking and why they started smoking, participants stated they started smoking to be accepted or become a part of something. This theme led to the next developing theme, which was needing help. Eleven of the 12 participants knew that they would need help to stop smoking. They needed guides, support from friends, family, and health care providers, and strength from within.

Research question 3 asked about the perceived level of control over smoking after being diagnosed with COPD. This question aimed at understanding the individual's belief about their capability of ceasing or continuing to smoke. Eleven out of 12 participants declared that they could quit smoking with help. Eleven participants felt they could indeed stop smoking if they had proper support. They wanted to cease smoking. They did not like how smoking affected their health, and they wanted to live a healthier lifestyle. For those who tried to stop smoking, interventions to promote smoking cessation targeting African American men could help this population develop confidence in their ability to quit smoking. It could also increase their sense of control over withdrawal/addiction symptoms to increase their chances for cessation.

There was one discrepant case where the participant found no need to cease smoking. The participant was able to cope with all that had come along with his smoking and diagnosis. He enjoyed smoking and felt that he did not have any reason to cease smoking.

This chapter detailed the participants' findings, results, and demographics, a description of the codes, uses, and how they developed into categories that transpired into the themes mentioned previously. In the next chapter, I will discuss the results of my findings from Chapter 4. I will also discuss possible implications for social changes with African American men who continue to smoke after being diagnosed with COPD, friends and family, and healthcare providers.

Chapter 5: Conclusion

The purpose of this study was to explore why some African American men diagnosed with COPD continue smoking following their diagnosis. Specifically, the study was to understand the attitudes, behavioral intentions, subjective norms, social norms, perceived power, and perceived behavioral control that influenced their continuing or quitting smoking based on the TPB model. The findings of this research could be useful in the planning of better interventions for providers of health services or organizations that can help decrease and potentially eliminate smoking by participants. This research could help health care professionals working with smoking cessation programs to increase their understanding of why African American men diagnosed with COPD continue to smoke.

Key Findings

Research questions addressed in this study included the following:

Research question 1: What beliefs and attitudes are associated with continuing to smoke after being diagnosed with COPD?

Research question 2: How do the beliefs and attitudes of others influence the continuation of smoking after being diagnosed with COPD?

Research question 3: What is the perceived level of control over smoking after being diagnosed with COPD?

During this research investigation, I discovered seven themes based on the coded and analyzed responses provided by participants. The first research question generated the themes of psychological dependence and impossibility. The second research question

revealed the importance of family and friends, identity conflict, and needing help. The third research question's resultant themes were positive expectations and low control. These findings directly align with the research questions. African American men diagnosed with COPD who continue to smoke have several reasons to continue to smoke regardless of being diagnosed with COPD and whether they want to cease smoking. The participants expressed the need for help and support to cease smoking. Ultimately, beliefs and attitudes, social norms, and perceived norms affected each participant. Focusing on their responses helped me gain an understanding of their reasons for smoking with COPD.

Interpretation of the Findings

Smoking cessation is the most effective intervention to reduce the ill effects and maintain quality of life for people who are diagnosed with COPD (Creamer et al., 2019). While most individuals understand the benefits of smoking cessation, and some patients who are diagnosed with COPD quit smoking, many continue to smoke (Chatila et al., 2014). In my study, I reviewed qualitative studies to examine why individuals diagnosed with COPD continued to smoke. I focused on the African American male population because there was a gap in the literature addressing African American men with COPD and their reasons for smoking. The findings of this dissertation revealed the difficulties faced by African American men with COPD who continued to smoke. The findings indicated that smoking is connected to daily life situations or events such as work, family life, daily routines, social influences, and so on, which then leads to both positive and or negative experiences, which makes it difficult for the smoker to quit. The findings

revealed several themes as important justifications for the inability to cease smoking. The sum of the experiences keeps the smokers engaged in their behaviors, which in turn makes it difficult to cease smoking.

Psychological Dependence and Impossibility

I identified challenges experienced from participants' lifelong smoking habits. , which was challenging to break from even though they were aware of the risks of continuing to smoke. Smoking is both a physically and psychologically addictive behavior. Lopez (2017) pointed out that COPD is also a progressive disease, so people diagnosed with this disease are not likely to spontaneously recover. The dual nature of the addiction, and the perceived balance of benefits versus drawbacks of smoking, create a situation where many African American male smokers may not ever feel that they can quit. Klesges et al. (2018) found a relationship between smoking status and the belief in smoking's harmfulness.

In this study, which only included African American male smokers diagnosed with COPD, there was an overall understanding that smoking was directly associated with the diagnosis. There was an understanding of known harm due to smoking that correlated with the perceived values. The participants described incidents in their lives that explained why they never ceased smoking. They described a reliance on smoking to provide structure throughout the day. These participants handled difficult situations and stress through smoking. They need to make an effort to change daily living habits to create a healthier lifestyle.

It is important for health care providers to understand that during patient visits and consultation, they should educate patients who are similar to the participants in this study about strategies for a healthy lifestyle, such as stress management, alternative means to relax, and ways to deal with social and perceived needs.

Identity Conflict

Identity is an important influence on behavior and having an identity as a smoker is a defining characteristic for many people (Tombor et al., 2015). Making a significant change in one's identity and stress or coping mechanisms just as one is living with a life-altering diagnosis may be difficult to manage. Some of the positive attitudes associated with cigarette smoking include the belief that those who smoke cigarettes have less stress (Chen, 2012). Similarly, a study in Canada found that a high percentage of men believed that smoking provided a *happy moment* (Cox, 2011 p. 107). It was evident that the participants started smoking to *fit in* or to *be a part of something*. Tajfel and Turner (1986) suggested that people identify themselves with the social groups to which they belong; evaluate the meanings, beliefs, and feelings they attach to their group memberships; and are motivated to act in ways that maintain a positive social identity.

For the participants in this study, smoking tended to be an identity trademark that participants could use to differentiate themselves from others and express both their individuality and feeling of belonging to a group of smokers. The participants concluded that being a smoker could increase social influence because it helped them feel included with the group or groups that smoked.

Brown et al. (2011) found that being a smoker could be considered an acceptable, even desirable, identity around friends and other smokers. However, as the context changed to either a more private or a professional situation (e.g., being around family members, employers, or clients), the smoker's identity often needed to be hidden (Brown et al., 2011). Some of the participants expressed that they simply hid or tried hiding the fact that they smoked because they were embarrassed. Referring to my study, one participant stated he could not smoke in front of his mother and even tried to hide it from some coworkers. He stated, *I just did not feel like it was a good look*. Participants also believed that others might perceive them differently from how they saw themselves. In turn, this evoked feelings of shame and regret. These stereotypical negative smoker characteristics were incompatible with the individuals' own self-image; thus, the smokers wanted to avoid this unattractive identity either by not being seen publicly as a smoker or by ceasing to smoke.

Importance of Friends and Family

Findings from this research highlighted the importance of the support needed by those participants who hesitated to make the decision to cease smoking and those who were trying to cease smoking. The men trying to cease expressed how they become mentally overwhelmed and experience feelings such as guilt, fear, tiredness, stress, uselessness, and criticism from themselves, friends, and family, and even health care providers (Roberts et al., 2016). As a result in my findings, the participants sought relief through destructive strategies, which, in turn, were risk factors for unsuccessful quit attempts. African Americans are less likely to abstain from smoking for more than a year

(Roberts et al., 2016). The African Americans men who participated in the study were long-term smokers. Therefore, increasing awareness about early detection, identifying symptoms of COPD, and getting the proper diagnosis for African American men will help improve overall health outcomes (Manfredi et al., 2012).

The participants expressed issues with having a lack of motivation to stop smoking, having an addiction to smoking, not finding the right time to cease smoking, and finding smoking pleasurable, this also ties in with Kabat et al. (2014) study where they stated that lack of motivation in smokers who have an addiction issue tend to use reasonings such as not having the time or enjoying the effects of smoking although, the smokers are aware of the possible harmful outcomes. Larabie (2011) research demonstrated that African American men who tend to cease smoking suddenly rather than having a successful plan during progress can be negatively affected. Factors such as peer substance use (Brook et al., 2010) and parent tobacco use (Brody et al., 2012) also influenced smokers with COPD decisions. The findings in these studies are mirrored in my research because the participants who stated they had multiple quitting attempts admitted that they relapsed because of the stress that came with cessation attempts, which in turn were related to the lack of support and the lack of motivation, which then led to feelings of failure.

Needing Help

All smokers, including those who may be at risk for COPD and those who already have the disease, should be offered the most intensive smoking cessation intervention

possible (Gerrard et al., 2012). Even a brief period of counseling at the doctor's office to urge a smoker to quit results in smoking cessation rates of 5–10% (Okoli et al., 2011).

Self-help materials have been demonstrated to improve quit rates among individuals who smoke compared with those who receive no intervention, but the effect is generally small (Lancaster & Stead, 2015). Health care providers are critical to the delivery of smoking cessation messages and interventions. Lancaster and Stead (2015) stated that providers are critical when delivering the smoking cessation messages and interventions to individuals who expressed the need to cease smoking. Health care workers should encourage all individuals who smoke to quit (Lancaster & Stead, 2015). During the interviews, participants expressed the fact that they did not have resources that would provide long term help to cease smoking. The information correlates with Aguilar and Pampel (2017), who suggested that African Americans may have fewer resources to quit smoking. Dey (2013) also stated that many of the patients wanting to cease smoking lacked resources; not having resources influenced ceasing smoking or relapsing.

There was an evident gap in the literature for studies that specifically addressed smoking cessation for African American men, so this research focused on African American men. Thabane (2012) pointed out that men (18%) continue to smoke in more significant numbers than women (14%). He concluded that it is critical to rethink how smoking cessation services to men are delivered. According to the literature, few male-centered tobacco reductions and cessation interventions have been developed and formally evaluated (Bottorff et al., 2016; Okoli et al., 2011). As the participants

demonstrated, every African American male is not the same. The participants needed individual assessments based on their specific needs and motivations.

Positive Execution

The attitudes of, and support from, friends, family, and health care providers are essential for African American men success when trying to cease smoking. To help African American men achieve successful, lasting smoking cessation, providers must understand in an unbiased manner the difficulties smokers experience that influence their efforts to quit smoking. It may be beneficial to ensure that African American men are ready and willing to ease smoking rather than being forced to. African American men must be motivated internally before any meaningful action can take place. Several of the participants in my research expressed the need to maintain their autonomy and cease smoking when they are ready rather than being forced or coerced to cease smoking. Based on my findings, the participants' responses indicated that perceived normative about their smoking was related to the importance of ceasing to smoke and the hope of successfully ceasing to smoke.

It is important that providers, friends, and family understand the individuals' feelings so that they can offer the best possible support. The evidence from my research demonstrated that the reasons for not quitting and the reasons leading up to the decision to quit smoking differ among individuals. The finding regarding positive attitudes associated with cigarette smoking from this study included the belief that those who smoke cigarettes have less stress. This finding was confirmed by Chen (2012), who concluded that many people who smoke do so because they believe it calms them.

Researchers have shown that nicotine is a mood-altering drug, and it seems to lower feelings of frustration, anger, and anxiety when it is taken (Chen, 2012). Therefore, when providing smoking cessation support, providers must understand how nicotine plays a role in each African American male lifestyle. As a result, providers can address individuals in regard to their smokers' feelings, apprehensions, and motivation to cease smoking into account. According to my findings health care professionals also need to understand that smoking cessation is not a single problem to be solved.

To achieve successful smoking cessation, people need support regarding other situations in their life, such as loneliness, stress, depression, enjoyment, and happiness. The literature on successful smoking cessation indicated that ceasing to smoke occurs in cycles (Royce et al., 2013). These cycles include smoking attempts, stress, being unsuccessful, retrying, becoming motivated, and being able to successfully cease smoking completely (Royce et al., 2013).. This often puts pressure on the individual who wants to cease smoking but has the feeling of failure or a lack of motivation and support to do so. This pressure was described by the participants in my study. They had a will to cease smoking but needed to understand smoking cessation as a process that required time and that success could not happen overnight. They discussed constantly facing the reality of not fully succeeding ceasing smoking. The participants noted excuses for smoking such as the positive effects of cigarettes, Some participants were aware that smoking was the cause of their disease and were looking for excuses to continue smoking. One refused to believe that smoking had anything at all to do with his condition.

According to many of the participants in my study, smoking held value, resulting in feelings of security and well-being, relief from anxiety, and a reduced sense of loneliness. The findings in this study have been mirrored by earlier studies, including Glanz et al. (2016) and Tonnesen et al. (2017), who demonstrated that smoking is a companion and provides a sense of relief and comfort. Although evidence has shown smoking provide feelings of relief and comfort, the relief and comfort is only temporary. This results in a coping mechanism used to sooth feelings by several smokers. (Yu et al., 2010).

The effects of smoking, even though short-lived, provide immediate satisfaction and a somewhat stable lifestyle. After conducting my research I found that regardless of sound evidence that smoking cessation is beneficial to health generally, and specifically to individuals diagnosed with COPD, individuals must understand the need for behavior change, and they must take responsibility for their health before change will occur. Friends, family, and providers must appreciate African American men behavior in the context of their culture and previous experience. Most of the participants said that they had a will to cease smoking. They all had reasons why they never succeeded before but felt that they needed to cease smoking. This had not succeeded because they not only had become physically dependent on smoking but also that there was a strong emotional and psychological dependence (King, 2017). It is important to remember that most of these participants had smoked for years. This factor alone led to addiction and dependence. Smoking nicotine affects behavior, mood, and emotions(Chen, 2012). If a smoker uses tobacco to help manage unpleasant or pleasant feelings and emotions, it can become a

problem when they try to quit (Chen, 2012). The smoker, as with the participants in this study, may link smoking with social activities and with stressors. All of these factors make smoking a hard habit to break (Anthonisen, 2014).

Low Control

In my research, many of the participants admitted that quitting was necessary, but they struggled against several barriers to successful and lasting smoking cessation. Some participants had made numerous attempts to cease smoking. African Americans are less likely to abstain for more than a year and are more likely to be long-term smokers (Roberts et al. (2016). Once users depend on tobacco, quitting is extremely difficult (Roberts et al. (2016). Thabane (2012) stated that nicotine dependence resulting from tobacco use hinders efforts to sustain abstinence from smoking for a prolonged period. Many users make multiple attempts to quit, often without the assistance that could significantly increase their chances of success. A substantial number of smokers want to stop smoking, but a significant proportion have never tried (Borland, 2012). Most smokers who attempt to quit do not use cessation aids, and as a result, they are usually unsuccessful, with two-thirds relapsing within 48 hours (Primack et al.,2013).

Viewing previous quit attempts as positive attempts rather than failures is another aspect of helping individuals to cease smoking. This can prepare the smoker for a more prosperous future. My research demonstrates that providers have to understand the difficulty of smoking cessation, and for this reason, no individual trying to cease smoking should feel judged for past failed attempts. In my study participants expressed that smoking cessation is challenging and providers must realize that a smoker will require

multiple attempts to quit smoking. Therefore, smoking cessation should be discussed consistently and in-depth at every visit. Based on my findings, health professionals should listen to the participants, be compassionate, and discuss the barriers and fears in ceasing smoking.

Findings from this research identified beliefs and motivations of African American men diagnosed COPD who continue to smoke. Understanding the health beliefs of this demographic can raise the awareness of healthcare professionals about their motivations to continue to smoke after being diagnosed with COPD. This awareness could lead to healthcare providers ability to suggest approaches to create motivational change for African American men diagnosed with COPD who continue to smoke.

Limitations of the Study

The strength of this study design was gathering data from a small-scale qualitative study to give a vivid and extensive understanding of why African American men with COPD continue to smoke. Although I tried to remain unbiased throughout the interviews, participants may have felt judged or uncomfortable in interviews or during member checking. Another limitation may be that participants were not completely truthful when answering interview questions. Due to the COVID-19 pandemic, having direct, face-to-face contact to conduct interviews was not possible, which could have impacted communication and the ability to pick up on nonverbal cues.

Recommendations

This research provides preliminary evidence of barriers for African American men diagnosed with COPD who want to cease smoking. Further research on this subject

to identify the right tools to help these individuals is warranted. I would recommend research regarding African American men who smoke between the ages of 35-65 but do not have COPD to compare different attitudes and beliefs. This in turn world provide insight to different perspectives of the importance of ceasing to smoke. Research to gather more evidence about the perceived barriers to smoking cessation from the African American male perspective would also be beneficial. .

Understanding the role of family, friends, and providers in smoking cessation for African American men diagnosed with COPD who continue to smoke could be another critical area for future research. Additional knowledge about the communication strategies between providers and African American men with COPD is needed. Researchers can conduct studies on the most effective ways that providers can encourage this high-risk group in the African American male population to enroll in smoking cessation programs. A study that examines if quitting smoking without help is more effective than joining an organized group or program is also essential.

Implications

Implications for health care providers from the findings of this study include that African American men diagnosed with COPD need help and support to quit smoking and minimize the possibility of relapse. According to Tonnesen et al. (2017), considering that smoking cessation is the most effective way to stop COPD's progress, a better understanding of the difficulties African American men with COPD encounter during quitting attempts is needed.

This study demonstrates that smoking cessation is not a single problem to be solved for African American men diagnosed with COPD and health care professionals need to be made more aware of this. Based on the findings of this study, to achieve successful smoking cessation for African American men diagnosed with COPD, we must include support for them when they encounter situations such as loneliness, stress, depression, and problems with family life. Findings from this study shed light on smoking-related issues that explain why African American men diagnosed with COPD continue to smoke. They are not personally able to cease smoking and need support from health care professionals to cease smoking.

Culturally appropriate smoking cessation programs are needed. Health care professionals can play a significant role in providing this kind of support. A greater emphasis by health care providers must occur so that African American men have regular contact with their providers once diagnosed with COPD and throughout the journey. Understanding the individuals attitudes and beliefs, social norms, and perceived norms related to their continued smoking, despite being diagnosed with COPD, raises awareness in both the individual and the supporter. Understanding why African American men diagnosed with COPD have difficulty ceasing to smoke, the lack of motivation they experience, the support or lack thereof, and the emotional aspects of smoking from societal norms can lead to new and improved avenues regarding how they can change their lifestyle while minimizing the urge to smoke.

Conclusion

Even though participants were aware of the effects of smoking, their lifelong habits were difficult to break. Failed attempts at quitting, lack of motivation, negative attitudes toward smoking, positive smoking expressions, and lack of support from family, friends, and health care professionals all contributed significantly to these participants' continuing or ceasing to smoke.

African American men diagnosed with COPD who continue to smoke can achieve successful smoking cessation and prevention of relapse by first ensuring that they have the right internal motivation to decide to quit. Health care professionals should adopt a patient-oriented approach and provide individualized care for those who want to cease smoking (Buczkowski et al., 2014). A patient-oriented system and individualized care could motivate African American men with COPD to talk about their worries and seek the necessary support.

This study helps fill the literature gap regarding African American men who have COPD and continue to smoke. As a result, the learnings can provide health care providers and society with a better understanding of why they continue to smoke and offer better ways to help those in need. It will help health care providers acquire information on how to help African American men diagnosed with COPD with smoking cessation. It will help the African American man diagnosed with COPD gain the confidence to follow a healthier lifestyle.

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Appendix A: Request to Post Flyers in Partner Facilities Letter

Recruitment Letter

11/01/2019

Dear XXX

I am a student recruiter from Walden University. I am conducting research and presenting a dissertation on Why African American Diagnosed with COPD continue to smoke. I am looking to use your facility/lung departments/COPD areas of study in order to recruit possible participants for me research.

COPD is rising worldwide. It has been a known cause of mortality; however, it has impacted the African American population more than ever now. In particular the male population. This can be due to several hidden issues or concerns. The aim of this dissertation is to seek out why? This in turn can help those individuals, stakeholders, and provides to better assist those in need.

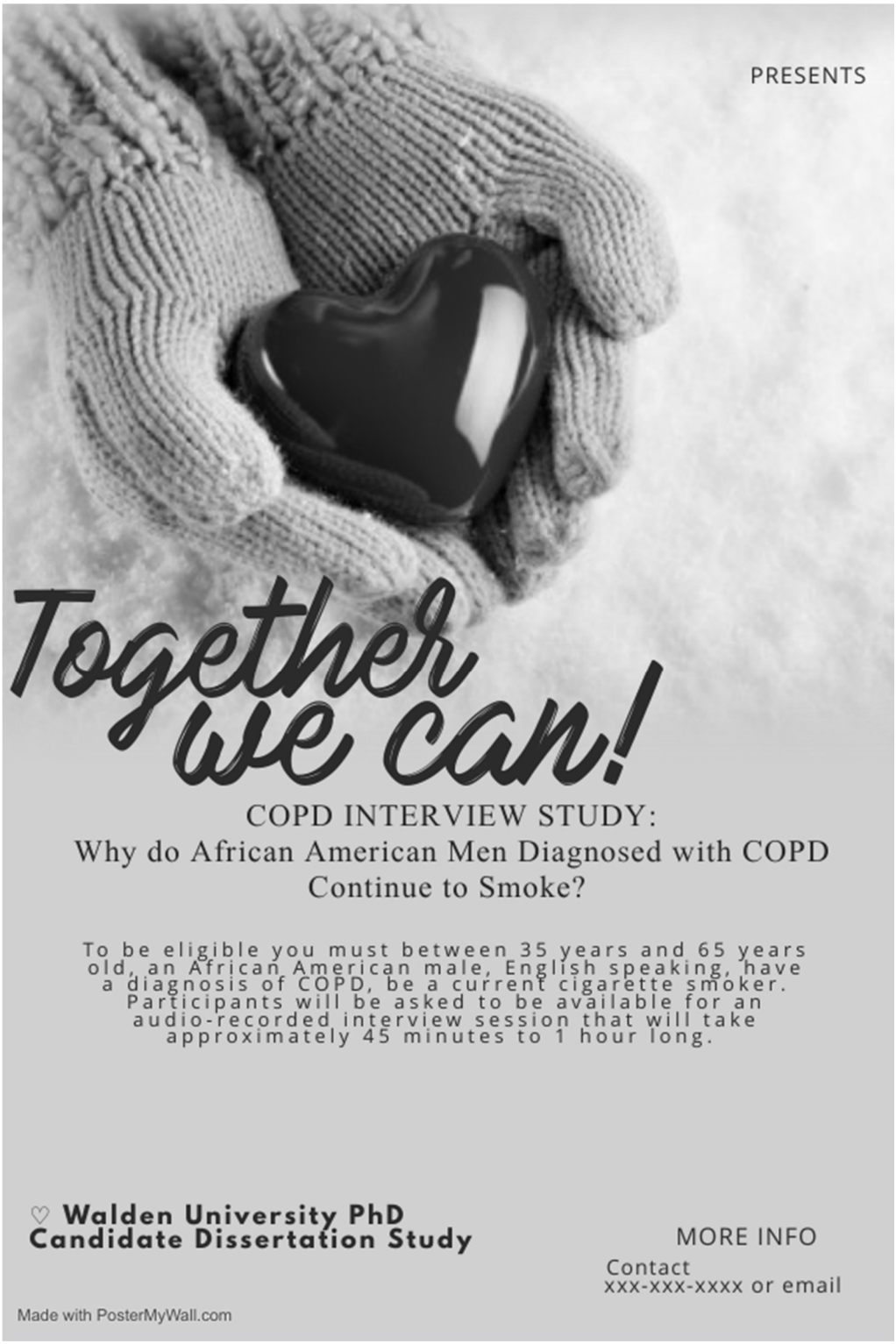
Prerequisites for the position of include the following: A pre diagnosis of COPD, of the African American male descent, Any level of education is ok, English comprehension and speaking, comfortable being in an interview style setting, and thy must be between the ages of 3565.

I am sure that many of your patients would be interested in this opportunity and ultimately find satisfaction in becoming an advocate to promote better wellness, if they are made aware of the opportunity.

Thank you for your time and attention. Please contact me if you have further questions or concerns @ xxx-xxx-xxxx

Sincerely,

Appendix B: Recruitment Flyer



Appendix C: Initial E-Mail/Telephone Script Prescreen

Hello, my name is . I am a student at Walden University doing a doctoral study on why African American men diagnosed with COPD continue to smoke here in Decatur, IL. I based my assessment of on helping individuals and healthcare providers gain an understanding as to why this occurs and what can be done to promote change whether it be better interventions, a wider approach to increasing awareness. If you meet the following criteria, I will send you a consent form. Would you be willing to voluntary participate in this study? If yes proceed through the pre-screening questions.

1. Are you an African American male between the ages of 35–65?
2. Have you been diagnosed with COPD?
3. Do you currently smoke?
4. Do you meet the following criteria

(If so, proceed to the actual invite in Appendix D.) If not thank the participant for his time.

Thank you and enjoy your day!

Appendix D: Approval Phone Call Script

Dear Mr. XXX,

Thanks so very much for agreeing to participate in the *Why African American men diagnosed with COPD continue to Smoke* interview. I genuinely appreciate your willingness to share what you know so that society can gain a better awareness as to why. Here are the details you need to know:

The interview will take place on MM/DD/YYYY. I respect and value your time. I will start your video chat right on time and will complete the interview within 90 minutes. This will be a closed session, therefore only you and I will only be inside the room. The interview discussion will be led by myself. If you have questions, please do not hesitate to email, or call me at xxx-xxx-xxxx or email xxx@xxx.xxx. If a last minute emergency prevents you from attending, please call my cell phone at xxx-xxx-xxxx Again, thank you for your generosity in agreeing to help others why African American men diagnosed with COPD continue to smoke. I will see you on MM/DD/YYYY!

Sincerely,

Student Researcher for Dissertation at Walden University

Appendix E: Hospital Approval Letter

Respiratory Care Department

November 8, 2019

Dear XXX:

Thank you for reaching out with your dissertation proposal. The team at Decatur Memorial Hospital is committed to lung health and your project fits nicely with our mission “to improve the health of the people and communities we serve.”

This letter is to relay our intention to allow a flyer to be distributed to interested individuals for recruitment for research purposes only and that no other research will be done at this facility.

Sincerely,

XXX

Appendix F: Church of the Living God PGT(s) Approval Letter

Church Approval Letter

JAN 0 2 2020

December 30, 2019

Letter of Cooperation

To Whom It May Concern:

XXX has requested permission to present flyers to the local XXX at the XXX locations. All locations include XXX. I as the head Bishop of the temples have been informed of the study and the nature of the research procedures. I have also been given an opportunity to ask questions of the researcher.

As a representative of the USA XXX Temples, I am authorized to grant permission to have the XXX possibly recruit research participants with the sole use of flyers. I will not nor will my partner Bishops, Pastors, Elders, Deacons, Missionaries or ministerial staff promote or have hand in assisting XXX with her research work unless she needs assisting placing the flyers or invitation on our bulletin boards. XXX is permitted to post flyers between church hours which areMondays 7pm-9pm Wednesdays 6pm-8pm Saturdays 7am-10am and Sundays 9:30am- 1:00pm. If you have any questions, please contact me at XXX-XXX-XXXX.

Sincerely,
XXX
XXXX
XXXXX

Appendix G: Protocol

Topic: Why African American Men Diagnosed with COPD Continue to Smoke?

Step 1: Introduction. Thank the study participant for taking the time to participate in this study.

Step 2: Purpose of study. Introduce that the purpose of this study is to research the perspectives, attitudes, and beliefs in order to gain understandings of why African American Men Diagnosed with COPD Continue to Smoke.

Step 3: Describe why the participants are participating. Mention that the information provided by the participant will be of value in supporting my fulfillment for the award of the degree of Doctor of Public Health in Walden University.

Step 4: Describe the benefits of participating. Explain that hearing from the participant will open up doors for health care providers.

Step 5: Discuss ethics. For ethical standards and protecting of individual privacy and confidentiality, request permission to keep notes of the entire session including the opening discussion and set the ground rules by stating:

Participation in the interview is voluntary.

It is all right to abstain from discussing specific topics if you are not comfortable.

All responses are valid—there are no right or wrong answers.

Try to stay on topic; I may need to interrupt so that we can cover all the material and so that I can verify accuracy of your responses therefore, ensuring that this study is true to you, other participants, and myself.

Speak as openly as you feel comfortable regarding the questions being asked.

Avoid revealing detailed information about your personal health.

Help protect the privacy of this study by not discussing details outside the interview.

Step 6: Discuss confidentiality. Mention that information provided will be confidential and that research records will be in a password protected database. I will only have access to the records. Inform participant that all files pertaining to data supplied will be destroyed 3 years after the completion of the research. Any material resulting from this session will be confidential and only used for the purpose of the study and presented in the doctoral study. Additionally, the notes will be destroyed immediately upon transcription.

Step 7: Ask if the participant has any questions.

Step 8: Transition to the interview questions. Conduct the interview by asking semi structured questions. Ask probing questions as required, observe and record body language, and verbal cues.

Step 9: Wrap up. Thank you for your time. To ensure that I have interpreted your data correctly, I will check the accuracy of your responses throughout the interview. If you need anything else regarding this interview feel free to reach me at xxx-xxx-xxxx or you can email me at xxx@xxx.xxx. Rest assured again that all information is confidential and you are one part of several voices that are needed to be heard. Do you have any questions or anything that you need to be clarified? Once all information has been transcribed you will receive a copy of your responses. If anything is not correct please correct it and

resend the document back to me. If not I will assume all is correct. Again, thank you for participating in my research study.

Appendix H: Individual Questions When Entering the Interview

1. How old are you?
2. How old were you when you initially were diagnosed with COPD?
3. During the past 12 months, have you tried to stop using tobacco?
4. How many times have you tried to quit using tobacco in your lifetime?
5. How likely is it that you will attempt to quit smoking in the next 3 to 6 months?
6. What is your marital status? (1) Single (2) Married (3) Married but Separated (4) Divorced (5) Widowed
7. What is your education level? (1) Less than high school, (2) Graduated high school/GED, (3) Some College/trade school, (4) Graduated College/trade school, (5) Postgraduate
8. What is your work status? (1)Unemployed, (2) Unemployed yet seeking work, (3) Part time worker, (4) Graduated College/trade school, (5) Postgraduate

Appendix I: Interview Questions

Warm up questions are intended to introduce the general topic of the interview in a nonjudgmental way.

The Following Warm Up Questions are proposed:

1. How old were you when you started smoking?
2. How many times have you attempted to quit smoking?

The first set of questions are meant to assess **attitudes and behavioral beliefs.** Attitudes refer to the degree to which a person has a favorable or unfavorable evaluation of the behavior of interest. It entails a consideration of the outcomes of performing the behavior. Behavior refers to the motivational factors that influence a given behavior where the stronger the intention to perform the behavior, the more likely the behavior will be performed.

3. What is enjoyable or positive about smoking?
4. What is less enjoyable (or negative) about smoking?

The next questions will assess **normative beliefs**. This refers how the person thinks other people think about him/her engaging in the activity of topic. It will also focus on how important those people (close and social) beliefs are to the individual. Has anyone you know been diagnosed with COPD or other illnesses related to smoking?

5. How do the important people in your life feel about you smoking?
6. Has anyone you know been diagnosed with COPD or other illnesses related to smoking?

    a. Follow up: If so, have you talked with this person about continuing/ ceasing to smoke since you both have been diagnosed with? Smoking related illnesses?

I will conclude by asking about **Perceived behavioral control**- This refers to a person's perception of the ease or difficulty of performing the behavior of interest. The following question addresses this factor.

7. How difficult would it be for you to stop smoking?
    a. Follow up: What in your daily routine would you need to change in order to have control over smoking?
8. How confident are you that with proper tools (physicians, aids, hep centers treatments etc.) are you that you will stop smoking?
9. If you were to stop smoking how would this affect your life?