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Perspectives of Young Adults Toward Tobacco Use

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This is to certify that the doctoral dissertation by

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Walden University
2016

Abstract

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

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Abstract

Conditions related to tobacco use constitute the single most preventable cause of death in the United States. Approximately 443,000 U.S. adults die each year from smoking-related illnesses. During young adulthood, social and behavioral changes occur; experimentation with tobacco products such as cigarettes is common and may lead to a habit of smoking. A gap was identified in the literature on the perceived impact of family communication on young adults' decisions regarding smoking. The purpose of this descriptive phenomenological study was to address this gap by gathering information on the perspectives of young adults toward tobacco use. Fifteen young adults aged 18 to 26 from the northeastern region of New Jersey who were currently engaged in the use of tobacco products participated in open-ended interviews. Research questions were designed to investigate young adults' views and perceptions regarding cigarette use and to explore information regarding how smoking-related communication received from family members influenced young adults' decision to smoke. The theory of planned behavior and social learning theory provided the theoretical underpinnings and consistent themes by young adults from the study. Van Manen's data analysis strategy demonstrated thematic reports from young adults that behaviors, habits, attitudes, communications, including verbal and nonverbal cues and practices are learned from their parental figures in the home environment. Recommendations for future research include exploring young adults from other geographical locations regarding their perspectives toward tobacco use. This study may promote positive social change for the public and health practitioners by providing insight on family interactions regarding smoking behaviors for young adults.

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Dedication

I dedicate this dissertation to my daughter, Abisola Edith Adesanya, my one and only daughter that I ever wanted. She is my bliss in my life, through thick and thin. She has never wavered in all that I have done, and her faith, trust, love, and support kept me going throughout this process and in my everyday life. Thank you, honey, for everything that you are, and all that you do… My baby, Mommy loves you, always.

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until the end, through many, many obstacles, and never giving up. Omoalako … A job well done!

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Chapter 1: Introduction to the Study

Introduction

Smoking and tobacco-related diseases constitute the single most preventable cause of morbidity and mortality in the United States (Centers for Disease Control and Prevention [CDC], 2010). Since the first U.S. Surgeon General's report of 1964, smoking-related illnesses and diseases have affected approximately 20 million Americans (U.S. Department of Health Services [DHS], 2014). Each year, 443,000 U.S. adults die from smoking-related illnesses (CDC, 2013b). According to De Silva, Sinha, and Kahandawaliyanag (2012), illnesses that result from tobacco use are the second biggest cause of death and disability from non communicable diseases. Family dynamics and beliefs, including concepts and constructs that play a role in young adults' decisions to initiate the habit of tobacco use, have been identified as potential factors in smoking habits in young adults (Whittaker, Cox, Thomas, & Cocker, 2014). Smoking is a public health threat to adolescents and young adults.

The problem of cigarette smoking among adolescents and young adults has steadily increased in the United States, despite the State of Florida's publication of data indicating a decrease in teenage smoking of cigarettes (Florida Department of Health [FDH], 2011; U.S. Department of Health Services [DHS], 2014). Data from the 2011 National Health Interview Survey (NHIS) indicated that 19% of adults smoked cigarettes in 2011, and no significant change in adult smoking occurred from 2010 to 2011 (CDC, 2011). In related data from the CDC, even though Syamlal and Mazurek (2011) found that in the previous 5 years, the decline in smoking had slowed down in the United States, they also found that tobacco use was prevalent among the young adult population.

Consequently, Sherman and Primack (2009) and Garrett and Williams (2012) attempted to answer the central question of what worked to reduce smoking among young adults between 18 to 26 years of age. The researchers found that family influences at home, based on perceptions of communication such as "good communication," played a significant role in young adults' decision to smoke (Garrett & Williams, 2012).

The initial decision of a person to smoke, even when pressured by peers, is usually personal (Pavlin, 2013). Young adults who choose to start smoking due to pressure received from their peers may find it to be a daunting task to resist the temptation of smoking, or to say no when offered cigarettes (Urberg, Qing, & Degirmencioglu, 2013). Therefore, such decisions, even though made by these young individuals during their adolescence years, are usually linked with other issues including social, economic, family, and environmental factors (Hans & Van Ronan, 2011).

Improved understanding of the perspectives of young adults and communication in relation to tobacco use could add to the national effort to combat lung cancer and other tobacco-related illnesses. In addition, Simmon-Morton et al. (2011) found that when family members were engaged positively in adolescents or young adults' activities, the factors that influenced young adults to initiate the habit of smoking or tobacco use significantly decreased. Also noted were significant improvements in young adults' health, social behavior, athletic activities, and academic achievements. Based on these findings and the importance to good health, the U.S. Department of Health has continued to promote community programs in efforts to improve and promote the overall health of adolescents, young adults, and adults (DHS, 2014).

The potential social change implications of my study include the generation of critical insights that may contribute to the development of effective programs for smoking cessation and health outreach centers. Community outreach centers and ongoing awareness programs may use this information in promoting healthy lifestyle changes in the young adult population. My study was designed to influence people in the health services industry such as health care administrators, physicians, nurses, technicians, and primary caregivers to generate and maximize the use of available community resources to reduce or eliminate the factors that influence the use of tobacco among adolescents and young adults. The study was designed to support educational programs and treatment techniques that may lead to decreased insurance billings and expenditures, as well as to encourage preventative measures for smoking-related illnesses.

I have organized the rest of this Chapter into sections. The sections include the study's background, problem statement, purpose, research questions, framework, nature, definitions, assumptions, scope and delimitations, limitations, and significance, concluding with a summary. In Chapter 2, I provide an exhaustive literature review of prominent themes and concepts related to young adults and tobacco use.

Background

Issues of smoking during the teenage (13 to 17) and young adult (18 to 30) years have been studied (Hoet, Hoek-Sims, & Gendall, 2013; Watts, Lovato, Card, & Manske, 2010). However, the perspectives of young adults regarding the role that familial communication plays in their decision to smoke have not been extensively explored (Gerking & Khaddaria, 2011). Parents and family members play an influential role in young adults' choices and lifestyle patterns (Serinkan, 2012; Yokotani, 2012). How

parents or family members address a young adult often reflects on the young adults' perception of the parent's attitude (Okoli, Richardson, & Johnson, 2008).

Researchers have suggested that the role and perception of smoking among young adults indicate a misunderstanding of the effect of tobacco on their health, even though smoking-related illnesses and diseases are on the rise (CDC, 2010; Jones, Waters, Oka, & McGhee, 2010). Peer pressure influences cigarette use among youth, in addition to communicative messages in the home and lack of controlled tobacco products (Walker & Walker, 2014; Wong, 2014). Other researchers have explored positive smoking outcome expectancies, techniques, frequency, and quality of parental communication as antecedents of adolescent smoking cognitions and the onset of smoking (Lam et al., 2014). In corroboration with other researchers about the issue of smoking among adolescents and young adults, Li, Chan, and Lam (2014) provided insight as to what was successful in the prevention of adolescent smoking and the promotion of adolescent smoking cessation, as demonstrated by adolescents' risk perception, behavior, and attitudes (Dirtu & Soponaru, 2014).

Urban (2010) explored the expected outcomes of smoking among various young adults, such as engaging in an addictive behavior that becomes a pack-a-day habit, or the tendency to develop health problems that lead to lung and cardiovascular diseases, including fatal conditions. In corroboration, Urberg, Qing, and Degirmencioglu (2013) provided insight as well on the addictive behavior and particular relationships that influence young adults in their decision to embark on the use of any addictive substances, including cigarettes. In another investigation of young adults who receive familial communication from their environment, Simons-Morton et al. (2011) conducted a study

that provided information regarding peer and parental influences on smoking in the early adolescent years. Finally, Cheney and Mansker (2014) provided information on health intervention and prevention opportunities for smoking cessation programs, as well as cultural aspects of the perceptions and expectations of the African American smoker.

Although the history of smoking and other aspects of smoking-related diseases and adolescent health issues have been explored (Abdullah et al., 2012), several studies in this area of research have identified gaps in the literature that warrant more studies (Hoek, Hoek-Sims, & Gendall, 2013; Lucasse et al., 2014). One such area is the perception of the communication that young adults between the ages of 18 and 26 receive in their familial environment that plays a part in their decision to smoke (Hoek, Hoek-Sims, & Gendall, 2013; Lucasse et al., 2014). Within the literature reviewed, researchers published significant statistics related to smoking among adolescents and young adults, yet a gap exists concerning young adults' perceptions toward tobacco use (CDC, 2011).

Previous researchers have concluded that family efforts to promote healthy lifestyle changes, coupled with positive communication in the home environment, significantly benefit adolescents and young adults' health, thereby decreasing addictive behaviors (Urberg, Qing, & Degirmencioglu, 2013). Even with the vast amount of research that has been conducted relating to the perspectives of young adults and adolescents on smoking-related issues, there exists a gap in the literature on young adults' perceptions of smoking-related messages received from their families in their familial environment (Garrett & Williams, 2012). I used my study to address this gap in research literature on young adults aged 18 to 26. In existing literature on young adults tobacco use, recommendations for further research have warranted further study in the area of

young adults' perspectives and familial communication regarding smoking and tobacco use (Benson, 2010).

Problem Statement

It is unknown how family communication and family implicit messages influence young adults' choices to smoke. There is a need to understand what young adults think about smoking and how they view the issue of smoking based on what their parents or guardians think. The problem may also relate further to what their parents or guardians demonstrated in their home environment regarding cigarette use with subtle messages of familial communication.

The research literature supports the premise that parents' involvement in the lives of their children promotes a healthy lifestyle (Simmon-Morton et al., 2011). It also supports the premise that additional research is warranted due to the gap in literature regarding the role that communication plays in young adults' decisions to initiate the habit of smoking. Although there have been many research studies conducted in relation to smoking and its effect on adolescents and young adults (De Silva, Sinha, & Kahandawaliyanag, 2012; McCool et al., 2012), there is still a gap in the literature related to the perception of smoking-related communication and role of smoking in young adults. To build upon previous studies conducted in the last 5 years, through this study I extended the literature by addressing the research gap and gained an in-depth understanding of the views and perceptions of young adults toward tobacco use. I also expanded on the research phenomena based on the type of familial messages young adults received from their parents or guardians relating to tobacco or cigarettes that influenced their use of tobacco or cigarette smoking.

Purpose of the Study

For the purpose of this study, I explored the perceptions of young adults toward tobacco use, as well as their thoughts on how family communication influenced their choice to smoke. Further, I investigated whether young adults used information from their parents or guardians to form their own perceptions of smoking and, therefore, whether their parents or guardians influenced them to begin the habit of smoking. This research is an important contribution to the research domain pertaining to young adults' perspectives on smoking-related messages from their familial environment.

Young adults who volunteered to participate in this research were between 18 and 26 years of age, as indicated in the age description of a young adult (King, 2012). I used an open-ended questioning technique in interviews to investigate the perceptions of participants and thereby gain an in-depth understanding of young adults' thoughts, perspectives, and viewpoints. I also explored whether participants remained aware of their emotions and were able to recognize the role of the familial communication they received, as these may have contributed to their participation and engagement in the risky behavior of smoking.

Research Questions

All research is guided by questions. The research questions (RQs) for this qualitative study were the following:

Research Question 1: What are young adults' perceptions of the information or behaviors they receive from family members regarding smoking?

Research Question 2: What are some perceived smoking-related communications or behaviors from family members that influence a young adult's decision to start smoking?

Subquestion1: What do young adults perceive to be facilitators to start smoking?

Subquestion 2: What do young adults perceive to be barriers to start smoking?

Theoretical Framework of the Study

Theoretical Foundation

This study's theoretical foundation blended concepts relevant to social and learned behavioral patterns in young adults. Bandura initially developed social learning theory (SLT) in 1977 and updated it in 1986. SLT established that parents, teachers, and society positively influence children through social contexts of observation, learning, monitoring, and interacting. SLT corroborates the notion that a young adult's choice for the use of cigarettes or tobacco products usually occurs by learned behavior, as evidenced by familiar messages received from family members, as noted in the findings of Sherman and Primack (2009) as well as Garrett and Williams (2012). Consequently, SLT provides an explanation of how individuals may develop this type of habit by watching and imitating the people who surround them, such as their family members and peers (Bandura, 1977, 1986).

Moran and Sussman (2014) suggested that a social contextual analysis of young adults ' quest for cigarette smoking is made up of a large scale of written works that existed and recommended further research on the role of peer influences on adolescents and young adults. In prior studies, even though researchers applying SLT have addressed relationships between youth cigarette use and adult cigarette use, there have been

noteworthy gaps concerning influences and interactions between family members and young adults' choice to smoke cigarettes. These identified gaps also apply to verbal and nonverbal cues or information observed from family members or parental figures that play a role in young adults' decisions to start the habit of smoking (Ennett et al., 2010).

I also used the theory of planned behavior (TPB) in this study. Higgins and Conner (2003) used TPB in prior investigations. The logical connection of TPB to this study and the rationale for its use were its strength in identifying young adults' intentions to engage in cigarette usage and behaviors (Higgins & Conner, 2003). In Chapter 2, both theories are detailed in a tabular format indicating the constructs that relate to the research phenomena of young adults ' perception of tobacco use based on familial communication of smoking-related messages.

According to Anfara (2010), the theoretical foundation of a research study is the base to explore a construct or build on theories such as social learning theory and theory of planned behavior systematically in relation to a research problem and phenomenon. As such, for the premise of this study, using a blended theoretical foundation of SLT and TPB, I investigated and explored young adults' perceptions of cigarette smoking based on communication received from their families. Miles, Huberman, and Saldana (2014) argued that one or several formats may be used to describe the key factors presented in the theoretical foundations of a research study, such as narrative, tabular, or graphical form. I used a tabular and a narrative format in Chapter 2 in relation to the parental or family construct of the study.

Conceptual Framework

I used a phenomenological descriptive design for the study and sought an in-depth perspective on young adults and familial communication toward tobacco use. The two theories used for the study, SLT and TPB, were used in several studies by other researchers who presented backgrounds from the field of health care administrations and health services (Dirtu & Soponaro, 2014; Serinkan, 2012). In Chapter 1, I address the theoretical foundation of the study; in Chapter 2, I use a tabular list to detail the theories of origin and how they relate to the research questions and constructs for this qualitative phenomenological descriptive study. The concepts and constructs were about young adults' perception, recognition, behavior, and construction of communication received from their families relating to smoking and tobacco use. The constructs aided in the promotion of healthy lifestyle habits and behaviors, health concerns, and issues, in addition to addressing and clarifying disparities in the family dynamic at home.

The goals of this investigation were to examine the ideas that these groups of young individuals received, including these ideas' interaction with their determination and the choice to use cigarettes. My theory rationale was in the realization that children are influenced positively or negatively by their parental figures through socialization, observation, and learned behaviors. Therefore, the role of parental figures in a young adults' life should not be undermined (Ganley & Rosario, 2013). Consequently, it was pertinent to research the regularity of the adult interaction concerning cigarette use as well as the rationale of the combination of the two components within the theoretical foundations (Hilliard et al., 2014).

The study was logically connected to the problem in that I sought to gain an in-depth understanding of the views and perceptions that young adults have regarding the use of cigarettes based on information provided by their parents or guardians. With understanding gained from the results of this study, family members, especially parents or guardians, may attempt to modify or decrease the messages that they convey to young adults. Such awareness and understanding from family members may play a significant role in minimizing or eliminating the beginning stages of the habit of cigarette smoking in young adults.

For a more thorough, detailed explanation in Chapter 2, I used the study's semi structured questions to explore smoking-related messages that young adults receive from their family members using verbal and nonverbal communication techniques. I explored the young adults' decisions and the style of parenting they received based on the SLT and the TPB for the study. I also used the theories to create and align the research questions, which specifically explored the young adults' perspectives in terms of aspirations, influence, observation, ideas, and monitoring.

Nature of the Study

For this study, I used a qualitative phenomenological descriptive design to conduct interviews with 15 to 20 young adults aged 18 to 26 years, with the use of convenience-based sampling to recruit volunteer participants. The rationale for the selection of a small participant pool within this age bracket was based on the recommendation that a phenomenological study have between 5 and 25 participants (Creswell, 2013). Phenomenology also allowed for in-depth analysis to develop knowledge of the viewpoints of the participants from the data collected (Creswell, 2009,

2013). Evans et al. (2005) and King (2012) argued that adolescence is marked by periods of physical, cognitive, emotional, social, and behavioral changes as well as the accomplishment of identity, which usually take place between the onset and offset of puberty. Current knowledge of brain development indicates that brain maturation persists into the early 20s; therefore, the population for this study encompassed the 18-to-26 age group (King, 2012).

The phenomenological approach provided knowledge related to the perceptions and views of young adults based on the communications they received from their families regarding smoking and their decision to start the habit. According to Patton (2002), the approach selected for a study is what determines the purpose of the study. The method also defines the methodology, the data collection process, the analysis of the study, and finally, the role of the researcher(s) conducting the study (Creswell, 2013: Web Center for Social Research Methods, 2006).

The phenomenological method involves studying the lived experiences and perspectives of research participants regarding a targeted construct (Morrisey, 2011). Young adults' lived experiences and perceptions in a familial environment regarding smoking cannot be quantified, therefore making it necessary to gain an in-depth understanding through exploration of the social phenomena and thoughts of the young adult individuals (Klein, Sterk, & Elifson, 2013). For this reason, I used a phenomenological approach to investigate young adults' perspectives on tobacco usage.

This study targeted young adults between 18 and 26 years of age living in the suburban northeastern region of the State of New Jersey. The strategy I used for this phenomenological study included interviewing respondents by telephone, by Skype, or

face to face. I asked participants to describe their perceptions of the familial communications or messages they received from family members in their environment.

I made use of tabular, narrative, and graphical format to convey critical factors within the framework of a descriptive phenomenological research study (Miles, Huberman, & Saldana, 2014). Data collection and analysis were performed in accordance with Van Manen's eight-step method (Van Manen, 1997, 1999). Finally, the fundamentals of this theory were reduced in a tabular format show the consistent themes that young adults' use of cigarettes or tobacco products, as well as their choices, were influenced by the messages passed on by family members and parental figures.

Questions outlined for the study also focused on young adults' perceptions of the information received from relatives in relation to smoking. The research plan concentrated on the dynamics of such communication between young adults and their parents with attention to verbal and nonverbal cues, perceptions, and behavioral cues that were consistent with the TPB (Higgins & Conner, 2003). The outcomes I found in this study may have an impact on the health of young adults by providing new perspectives concerning the role of familial communication in young adults' choices concerning the initiation of tobacco smoking. Creswell (2009) argued that the goal of a study is ultimately to achieve involvement from the participants in the compilation of various approaches, questions, and final research outcomes through the inclusion of participants in the research process, thereby supporting proactive strategies for developing useful and creative methods of communication.

According to Healthy People 2020, when a community is informed and aware of issues regarding health, the people are better equipped to make an informed decision

regarding their lives. Further, the public benefits from the outcomes and findings of research studies (Healthy People, 2011). Thus, this study is vital to the general public, including lawmakers, health care administrators and health services providers, educators, young adults, and parents. The intent of this research was to gain an in-depth understanding of the issue of the prevalence of smoking among young adults aged 18 to 26 in the community, which may aid in the reduction of smoking among the targeted group. The improvement of the health and well-being of young adults is a complex endeavor that requires the collaborative efforts of the community and all involved. Such community members include members of health services and health care administration, in collaboration with parents, families, schools, churches, local clinics, health care agencies in urban and rural areas, community youth organizations, social media, employers, and government agencies (DHS, 2014).

Definition of Terms

For the purpose of this study on perspectives on smoking held by young adults based on messages received from family members, I used the following terms:

Adolescence: This period is marked by physical, cognitive, emotional, social, and behavioral changes that take place between the onset and offset of puberty. Current knowledge of brain development indicates that brain maturation persists into the early 20s (Evans et al., 2005; King, 2012).

Habits: Automatic behaviors performed by the consumer often in a regular and repeated way (Venkatesh et al., 2012).

High-risk behaviors: These include regular smoking, regular tobacco use, and frequent alcohol use. Behaviors are evaluated using criteria specified by the CDC (2004)

and as measured by the Youth Risk Behavior Scale (YRBS), which indicate that *regular tobacco use* applies to smoking at least one cigarette daily for the past 30 days.

Selfie: An image of oneself, taken using a digital camera by oneself, especially for posting on social networks.

Social influence: The perception of consumers of the benefit of the use of technology by significant others (Venkatesh et al., 2012).

Young adult: A category encompassing individuals 18 to 26 years of age (Wagenaar & Toomey, 2002).

Assumptions

Other researchers in prior studies have considered and examined the effects and deciding factors of cigarette smoking for the young adult population (Mallia & Hamilton-West, 2010). However, fewer studies have been able to link the young adult's decision to smoke with the familial communication perceived within the familial environment. Researchers have conducted studies and explored risk behaviors among adolescents and young adults ages 18 to 20 in a college setting (Garrett & Williams, 2012; Harakeh & Vollebergh, 2012).

Young adulthood is noted as a period of autonomy and independence, as well as a period of exploration and influence from peers and the familial environment that may lead to risky usage of substances, including but not limited to tobacco products (Martinasek, Gibson-Young, & Forrest, 2014; PlOS ONE Staff, 2014). As such, this Chapter presents an opportunity to examine young adults' perceptions, views, and opinions concerning the influence of familial communication on their decision to start the habit of smoking. It also represents an effort that has been made to understand this as an

important issue, created in an effort to reduce or eliminate the practice of smoking among the targeted young adult population. According to a study from the CDC (2010), individuals who start smoking in their adolescent years or around the age of 18 have the greatest risk over time of becoming pack-a-day smokers.

Scope and Delimitations

For the scope of this qualitative phenomenological descriptive study, I targeted transferability and dissemination to healthcare institutions, organizations and professionals, and families. This was achieved by dissemination of one- to two-page result summaries through medical and nursing journals, to clinics, schools, health care administrators, health agencies, and libraries as contributing research for social change related to adolescents' and young adults' health problems, with particular attention to smoking-related issues. I delimited the study by researching young adults within the northeastern region of the State of New Jersey, with the use of convenience-based sampling without restriction by ethnic group. I did not include groups such as children, pregnant women, or nonsmoker in the research study. Participant interviews were limited to a sample of 15 individuals. According to Creswell (2013), a phenomenological study should have a sample size of 5 and 25 participants to facilitate in-depth analysis and understanding of the lived experiences of the subjects.

The boundaries of this study included the following: I interviewed the participants by telephone, by Skype, or face to face. The participants were young adults 18 to 26 years of age, and I interviewed them regarding their perspectives on communication from family members regarding tobacco use (King, 2012). I randomly recruited participants

from public areas of the community such as a local libraries, convenient stores, grocery stores, and coffee shops anywhere in the northeastern region of New Jersey.

Limitations

A limitation of this study was that the sample participants were predominantly White middle-class youth, which limits the generalization or replication of results across other populations, as suggested by Garret and Williams (2012). Because the literature review indicated a lack of qualitative research on this topic on adults of different races, an examination of young adults of various ethnicities may be used to design and implement effective smoking prevention and cessation programs for this targeted population (CDC, 2010). According to a 2015 U.S. Census Bureau report, the population of northeastern New Jersey is 8.8 million, and 68% of this population is White, which posed a limitation to my research (USDOC, 2015).

Other possible limitations that applied to this descriptive phenomenological qualitative study included time, financial resources, and locale management for obtaining a representative population of young adults who used tobacco and had the habit of smoking. In addition, the convenience-based sample of 15 young adults did not consistently represent the broad spectrum of perspectives of young adults globally. Furthermore, the outcomes and data collection were subject to researcher bias (Creswell, 2009). Hence, for reasonable measures to address the identified limitations, I as the researcher adhered to the parameters identified within the scope of the study by making sure that the population sample selections for this study were not limited to White youths, but distributed among young adults of various ethnicities, including African Americans, Hispanics, Asians, and other groups.

Significance of the Study

This study was unique because it addressed the perceptions and views of young adults who started using cigarette or tobacco products based on the information provided by their family members. Further, it addressed a gap in the literature on the perceptions and views of young adults regarding the influences of family members on their decision to smoke (Gerking & Khaddaria, 2011). The imperative underlying the study was to understand the way in which communication received from family members regarding cigarettes or tobacco products influenced young adults to begin the habit of smoking (Babbitt, 2010). I also examined the ideas, behaviors, and opinions of young individuals concerning their decision to start smoking.

An additional purpose of the study was to gain knowledge of how young adults understand and interpret the information that they receive from their families. This research study may contribute to positive social change by providing insight to the public regarding the views and perspectives of young adults concerning the influence of messages generated from their familial environment relating to smoking. The findings and results of the study may thus lead to efforts to promote healthier lifestyles for young adults as the findings are disseminated to health services, health care administrators, parents, families, schools, and medical and nursing journals.

A one- to two-page summary of the findings of this study will be available to members of the public, including young adults and their family members, relatives, and friends, with dissemination occurring via email, journals, educational seminars and outreach programs for local high school seniors, colleges, churches, hospitals, libraries, and institutions such as the YMCA. According to Healthy People 2020, when the

members of a community are informed and aware of issues related to their health, they are better equipped to make informed decisions regarding their lives (Healthy People, 2011). In this way, the public benefits from the outcomes and findings generated from research studies. A goal of this research study to contribute to the body of knowledge concerning the prevalence of smoking among young adults aged 18 to 26 in the community (King, 2012).

Improvement of the health and well-being of the younger population is a complex endeavor. Progress in this area requires collaborative efforts within the community that include health providers and health care administrators, along with parents, families, schools, churches, local clinics, health care agencies in urban and rural areas, community youth organizations, social media, employers, and government agencies (DHS, 2014). Environmental and health-related illnesses caused by tobacco users and tobacco products create $96 billion in annual medical expenses and $97 billion in lost productivity (National Institutes of Health [NIH, 2014).

The types of communication regarding smoking received from family members play a significant role in an individual's decision to smoke (Colby et al., 2010). Researchers in the public health arena have conducted ongoing study of trends of smoking among youth of various ages, ethnicities, and genders (Healthy People, 2011). Therefore, awareness regarding young adults' tobacco use that is gained from this study may be leveraged to promote and encourage a healthy lifestyle, as well as provide insight within the field of health services to inform efforts and solutions to improve or eliminate the use of tobacco products. Probable benefits from this study is in modifying healthy life style choices, smoking cessation treatments and programs, and maximizing available

health resources for the public. Other benefits may include controlling healthcare expenses, decreasing insurance billing for smoking-related illnesses, saving time and energy, expediting tobacco-related treatment techniques, as well as encouraging preventative measures for health care through smoking cessation programs and lifestyle changes thereby reducing the rate of morbidity and mortality.

Summary

In this Chapter, I introduced a problem related to young adults' perspectives of messages received from their family members regarding smoking. The purpose of this qualitative research study was to investigate the perspectives of young adults aged 18 to 26 regarding communication from their family members related to smoking and tobacco use. I used the research questions to introduce and support the framework used for this study, addressing the theories that informed the study and the phenomenological nature of the study design. In this Chapter, I also provided the assumptions, scope and delimitations, limitations, as well as the significance of the research.

Implications of this study for positive social change affecting stakeholders in public and health care settings, educators, lawmakers, parents, and young adults were considered. The dissemination of the findings of the study will occur via journal articles, educational seminars, outreach programs, libraries, churches, and hospitals, with the goal of improving societal health and well-being. In Chapter 1 of this study, I outlined the background, problem statement, purpose of the study, research questions, framework, nature of the study, definitions, assumptions, scope and delimitations, limitations, and significance of the study. In Chapter 2, I present a detailed synthesis of the literature

review, which reflects gaps in research concerning young adults' perspectives on the promotion of healthy behaviors related to cigarette and tobacco use.

Chapter 2: Literature Review

Introduction

The problem and issue of smoking, including addiction to tobacco among the population of young adults, is of utmost health concern to the community, where this addiction often occurs at early ages within the younger population (Leavy, Wood, Phillips, & Rosenberg, 2010). The earlier a child starts to smoke, the less likely it is that the child will be able to quit the habit as an adult, and the more likely the child is to die from a smoking-related disease (Gordon, Mackay, & Rehfuess, 2014). In 1964 in the United States, the Surgeon General first released a report on smoking and health-related issues. Yet 50 years of subsequent reports, mandated by Public Laws 91-222 and 99-252, have consistently documented that smoking and tobacco use have serious health consequences not limited to preventable heart and lung diseases, leading to millions of preventable deaths each year in the United States (DHS, 2014). For this study, I explored the perspectives of young adults on familial communication concerning tobacco use.

Historical Overview

Despite 50 years of health warnings, more than 3 million youths and young adults smoke cigarettes, with nearly all initial use of tobacco products occurring by the age of 18 (DHS, 2014). Some noted influential psychosocial factors, such as familial messages, messages from peers, and cigarette advertising, play a role in young adults' decisions to use tobacco products, and may increase the risk of smoking (DHSS, 2011). McCool et al. (2012) found that the prevalence of smoking peaked among young adults aged 18 to 30, many of whom believed that they were exempt from premature morbidities and mortalities associated with smoking, despite warning labels shown on tobacco products.

Environmental and health-related illnesses caused by tobacco use and tobacco products create $96 billion in annual medical expenses and $97 billion in lost productivity (NIH, 2014). This study may provide insight for those within the field of health services, informing efforts and solutions to reduce or eliminate the use of tobacco products. Consequently, the knowledge gained from this study may ultimately aid health care services and administration in maximizing available health resources, controlling expenses, reducing morbidity and mortality, decreasing insurance billing for smoking-related illnesses, saving time and energy, expediting tobacco-related treatment techniques, as well as encouraging preventative measures for health care through smoking cessation programs and lifestyle changes.

According to the CDC (2010), every day 4,000 young adults try their first cigarette, and over time, these youths run a risk of becoming pack-a-day smokers. An estimated 35% to 50% of these young adults who try even a few cigarettes become addicted to the habit in a 2- to 3-year period, with evidence of dependency and withdrawal syndrome. The prevalence of past cigarette smoking among young adults 18 to 26 years old is 39.5% (Substance Abuse and Mental Health Administration [SAMHSA], 2005).

Among such preventable diseases related to cigarette smoking is chronic obstructive pulmonary disease (COPD). This disease is characterized by progressive and potentially severe airway obstruction and is predicted to be the third leading cause of disabilities and death in the next 10 years all over the world, including the United States (Hukkinen, Korhonen, Heikkila, & Kaprio, 2012; World Health Organization [WHO], 2012a). According to the World Health Organization (2012b), the estimated costs of the

disabilities, health and disease treatments, and deaths caused by cigarettes and tobacco products amount to approximately $190 billion in the United States and $350 billion worldwide.

For the literature review conducted for this study, I read articles that included studies on familial communication, views, and perceptions in relation to young adults' risk of behaviors including cigarette smoking and tobacco use (Garrett & Williams, 2012; Glock, Muller, & Ritter, 2012; Mallia & Hamilton-West, 2010). A much wider linkage was found between late adolescents' and young adults' use of tobacco and other social problems, including alcohol use, substance use, vandalism, domestic violence, and abuse. I also investigated young adults' decision to smoke as a coping mechanism due to stress or peer pressure (Lam et al., 2014; Palamar et al., 2014).

Simons-Morton et al. (2011) found that when family members were engaged and involved positively in adolescents' or young adults' activities, the factors that influenced young people to initiate the habit of smoking or tobacco use were significantly decreased, with significant improvements noted in academic achievements for the adolescent or young adult. Based on these findings and their importance to health, the U.S. Department of Health conducts and promotes community outreach programs in an effort to improve and promote overall health of adolescents, young adults, and adults (DHS, 2014).

The above research literature supports the premise that parents' involvement in the lives of their children promotes a healthy lifestyle, in addition to supporting the recommendation for additional research. Therefore, to build upon previous studies, I extended the literature by seeking an in-depth understanding of the views and perceptions

of young adults toward the type of familial messages received from parents or guardians in relation to tobacco use or cigarette smoking.

Few studies have examined young adults' psychosocial perspectives on tobacco use, particularly the familial communication or messages that young adults receive from their families, thus creating a gap in knowledge. I have sought to contribute to filling that gap through this study, adding to the body of knowledge in an attempt to increase understanding and promote interventions involving relationships between social, environmental, and cognitive factors that may contribute to smoking among young adults. Health care administrators may use the findings of this study, as disseminated through health and medical journals, libraries, clinics, schools, or the health care industry, to increase their understanding of tobacco use by young adults, including messages young adults receive from family members.

The public's and professionals' understanding of this problem will help health care professionals in the promotion of efforts such as early intervention of negative behaviors regarding smoking communication, modification of negative life style choices, educational classes, and graphic anti tobacco public service campaigns. Interventions may involve lifestyle changes and improvements, including treatment options for the cessation of smoking and tobacco use as well as prevention for the young adult population before initiation of the habit of smoking. Furthermore, I explored the association between psychosocial perceptions and familial messages or communication that the young adult receives from family members and peers.

In Chapter 2, I describe the search strategies used for the literature review, followed by the study's theoretical foundations and prominent research concepts. The

Chapter ends with a summary. In Chapter 3, I provide details of the research methods and designs used. I provide in Chapter 4 the results of the study, and finally, I address in Chapter 5 the findings, interpretations, and recommendations for further research.

Strategy Used for Literature Review

The primary databases used for this literature reviews were Google Scholar, Academic Premier, ProQuest, CINHAL Plus with Full Text, MEDLINE with Full Text, and CDC Publications. I used keywords and phrases to locate relevant articles as well as the views and perceptions tool that pertained to the research study (Martinasek, Gibson-Young, & Forrest, 2014). Key terms used for the literature search included *smoking*, *nicotine*, *cigarettes*, *smoking initiation*, *youth smoking*, *addiction*, *young adult*, *adolescent*, *gender*, *race*, *ethnicity*, *age*, *social change*, *socio-demographic*, *perception*, and *emotional intelligence*. Other key terms were *social behavior*, *risky behavior*, *tobacco products*, *psychosocial perception*, *familial communication*, *familial messages*, *families*, *health risk perception*, *peer pressure*, *COPD*, and *lung cancer* (Afifi, Cox, & Katz, 2007; Garrett & Williams, 2012; Myung et al., 2012).

With the use of the previously mentioned databases, I reviewed 156 documents that included primary and secondary sources in qualitative and quantitative research. These documents included books, dissertations, and journal articles. Materials I collected for this study included works related to smoking and the use of tobacco products in adolescents and young adults, as well as perceptions of familial messages and communication received from family members such as parents and guardians (Garett & Williams, 2012). Although I collected and reviewed 156 documents, I used 94 of the most recent articles, five research books, and two research dissertations for this study,

with a concentration on years of publications within 5 years (2009-2015). Thirty of the articles reviewed identified links among behaviors, perceptions, and addiction to tobacco products. Insofar as consumer research studies usually focused on addiction and the behavior of adolescent smoking among different subpopulations, the authors of those studies failed to provide a precise picture of the familial messages that young adults received from their environment that initiated smoking in the first place (Young & Bruce, 2011).

Upon reviewing the research articles in further depth, I found that Stockman (2011) and Duncan et al. (2012) provided qualitative insights into adolescent smoking and addiction in relation to gender, ethnicity, and age. Used for this study were the results from 20 studies, combined with meta-analysis methods that estimated the percentages of young adults who are currently engaged in the risky behavior of cigarette smoking and tobacco use. The findings from the reviewed articles were very indicative of considerable differences in the same behavior across demographic categories, which were due to socioeconomic, ethnic, or cultural differences (Myung et al., 2012).

Although traditional qualitative reviews have been used to combine relevant information from several studies on adolescent smoking behaviors, the research has failed to explore specifically young adults' perceptions of communication from their families in relation to their decision to start the habit of smoking. Hence, I applied the meta-analysis method used by Cho and Kim (2014) for this study to provide a holistic assessment of adolescents' perceptions and behaviors regarding smoking. Therefore, the research findings I generated from this study may help in addressing the literature gap and may be disseminated among health care administrators, to possibly assist in diagnosis and

treatment, promote preventative care programs, achieve cost containment, and prompt lifestyle changes for young adults.

Theoretical Foundation

The theoretical foundation I used for this study provided the concepts of social and learned behavioral patterns in young adults. Bandura (1986) initially developed social learning theory (SLT) in 1977, and updated it in 1986. With SLT, I established that parents, teachers, and society positively influence children through social contexts of observation, learning, monitoring, and interacting. SLT, which was consistent with the findings of researchers Sherman and Primack (2009) as well as Garrett and Williams (2012), corroborated the notion that a young adult's choice for the use of cigarettes usually occurs through learned behavior, as evidenced by messages received from family members. Consequently, the application of SLT confirmed the idea that individuals develop a smoking habit by watching and imitating the people who surround them, such as their family members and peers (Bandura, 1977, 1986).

I also used the theory of planned behavior (TPB) for this study. Researchers Higgins and Conner (2003) applied TPB in prior investigations. The logical connection of TPB to this study resided in its strength in identifying young adults' cigarette use and behaviors that they exhibit as the "intentions to engage in the behavior and the perceived behavioral control of the behavior" (Higgins & Conner, 2003, p. 174). These theories provided for an investigation of the constructs that related to the research phenomenon and problem of this study, as well as to perspectives on familial communication of smoking-related messages generated from the young adults' homes. According to Anfara

(2010), the theoretical foundations of a research study are the base to explore a construct systematically as it relates to a research problem and phenomenon.

Theory rationale for use of both theories was in the realization that children are influenced positively or negatively by their parental figures through socialization, observation, and learned behaviors. Therefore, the role of parental figures in a young adults' life should not be undermined (Ganley & Rosario, 2013). Consequently, it was pertinent to research the regularity of the adult interaction concerning cigarette use as well as the rationale of the combination of the two components within the theoretical foundations (Hilliard et al., 2014).

For the theories used for this study, I present backgrounds from several investigations and explorations of scientific discoveries in the field of health care administration and health services. Table 1 presents the two theories, including how they relate to the research questions and constructs for this qualitative phenomenological descriptive study. The concepts and constructs of the study concerned young adults' perception, recognition, behavior, and construing of the communication received from their families in regard to smoking and tobacco use. The use of these concepts may aid in the promotion of healthy lifestyle habits and behaviors, address health concerns and issues, and clarify disparities in the family dynamic (Whittaker, Cox, Thomas, & Cocker, 2014).

Table 1

Rationale for Theoretical Foundation of the Study

Theoretical foundation	Origin	Purpose
Social learning theory (SLT)	Bandura (1977, 1986)	Parent/Family
Theory of planned behavior (TPB)	Higgins & Conner (2003)	Young adult behavior

Moran and Sussman (2014) corroborated the notion that even though there existed gaps in literature regarding perspectives of young adults toward tobacco use, there also existed enormous scale of written works of social contextual analysis of young adults' behavior and history for tobacco use including cigarette smoking. Even though researchers have used SLT to examine relationships between youth cigarette use and adult cigarette use, there remain noteworthy gaps related to interactions involved in young adults' cigarette choices. A gap was also noted in relation to verbal/nonverbal cues, or information observed from family members or parental figures, that play a role in young adults' decisions to start the habit of smoking (Dietz et al, 2013; Ennett et al., 2010; Furrukk, 2013; Haines-Saah, Oliffe, White, & Bottorff, 2013). Because the goal of this study was to explore the ideas that young individuals received and their interaction with their determination as well as their choice to use cigarettes, I used TPB in the study as well.

I explored smoking-related messages that young adults received from their family members. I also explored and examined verbal and nonverbal communication techniques, young adults' decisions, and the involvement of parents in young adults lives based on SLT (Creswell, 2009). I used this particular method to create and align the research

questions, and specifically to explore young adults' perspectives in terms of aspirations, influences, observations, ideas, and monitoring.

I use tabular, narrative, and graphical format to convey critical factors within the framework of this descriptive phenomenon qualitative research study (Miles, Huberman, & Saldana, 2014). I use narrative and tabular format to convey the concept of TPB as it relates to the research design, how I created the research questions and open-ended interview questions for the investigation process, as well as the ways in which I collected and analyzed data using Van Manen's eight-step method. I explore the fundamentals of Van Manen's theory to explain young adults' use of cigarettes or tobacco products, and I show how the choices they make are affected by the messages passed on by family members, parents, or guardians.

Table 2

Linkage of Interview Questions to the Study

Interview questions	Origin	Research question(s)	Theories
Questions a, b, c, d, and e	Bandura (1977, 1986)	RQ1, RQ2 SQ1, SQ2	SLT, TPB
Questions f, g, h, i, j, and k	Higgins & Conner (2003)	RQ1, RQ2 SQ1, SQ2	SLT, TPB

Table 2 contains information on the open-ended interview questions, which were applicable to Van Manen's eight-step method for the analysis of the data collected from the participants of this study.

Conceptual Framework

I aligned SLT and TPB with research questions (RQ1, RQ2, SQ1, and SQ2) that pertained to a behavior, the family, and the promotion of healthy habits and lifestyle.

Creswell (2009, 2013) argued that conceptual frameworks for qualitative phenomenological descriptive studies are used to investigate perceptions, beliefs, points of view, experiences, and values, which are difficult to quantify in numbers. The purpose of such research is to explore and understand the perspectives of individuals. In support of the theoretical framework I used for this study, researchers in Korea applied the same in-depth qualitative descriptive phenomenological approach, to interview and investigate sociodemographic factors related to beliefs in adults of a Korean community toward the prevention and restriction of smoking, with an intention to quit the habit (Myung et al., 2012). In another study, researchers used the same approach to investigate adolescents' and young adults' perceptions of homosexuality and related factors in three Asian cities (Feng et al., 2012).

In Chapter 3, I detailed Van Manen's eight-step methods. Goodrich (2012) used Van Manen's eight-step methods to interview, investigated, and explored lived experience of young adults in college in comparison to how transsexuality affected their education and consequently determined the need for clinical practice and future research to help with discomfort, social support, and academic achievement. In addition, Voss (2012) used Van Manen's eight-step methods for the reduction of gaming and texting activity among young adults that improved learning in college technology. In addition, Davey, Asprey, Carter, and Campbell (2013) utilized it to investigated trust, negotiation, and communication among young adults and their experiences for treatment at primary care services. Subsequently, I used this same contextual approach for investigating and exploring the young adults' perceptions of familial communication received from their families in regards to smoking and tobacco use.

Prominent Research Concepts

Prominent research concepts and variables reviewed in the literature review included: smoking communication and young adult perceptions, family influence, merits to health benefit from smoking cessation, demerits of smoking, methodology rationale, and research rationale.

Smoking Communication and Young Adult Perceptions

The issue of smoking derived from familial communication was a problem that linked to other problems when the individual started smoking from adolescence into adulthood. Studies have shown that the adolescent or young adult who attended college, and were out of their familial environment, smoked fewer cigarettes than the students who were at home, or are high school drop-outs, or only graduated from high school (Cosh et al., 2014; Dirtu & Soponarru, 2014; Garrett & Williams, 2012). However, according to studies conducted by Kear (2012) and Delorme, Kreshel, and Reid (2013), found that individuals who smoked in their early adolescences years, were more likely to continue smoking if they attended college. As such, there was a likelihood of as nearly as two-third of these young adults who smoked, became lifelong smokers regardless of what environment they came from (Klein, Sterk, & Elifson, 2013). I vastly explored the issues of family influence on the young adult smoker in terms of familial communication and messages.

Family Influence

Young adults are prone to be influenced by their thought processes, behaviors, actions, or aspirations by several factors including their family members, and one such influence was the habit of cigarette smoking (Urberg, Qing, & Deginmencioglu, 2013).

Family influences on the young adult were significant with weight management and healthier diet, sleep habit, and exercise routines (Heskey et al., 2014). In addition, family influence on the young adult noted to reduce homelessness and violent behaviors because of multiple personality traits (Furnham & Christoforou, 2012).

Furthermore, positive family influences decreased domestic and family violence, which led to incarceration and criminal activity among young adults (Winters, Clift, & Dutton, 2014). Moreover, according to Kear (2012), positive family influences improved mental health diseases such as depression, anxiety, panic attacks, and suicide in the young adult population (Fino et al., 2014; Trosclair & Dube, 2010). In a recent study, parental influence in promoting, motivating positive role modeling and investing time to promote healthy lifestyles changes were factors involved in a child's decisions and choices that promoted healthier lifestyles among adolescents (Genuneit et al., 2010; Pocock et al., 2010; Yokotani, 2012).

To corroborate the issue of family influences, researchers conducted a study from northeastern school districts, and found that parental demoralization and support at home affected and benefited improved health habits on the adolescent youth (Okado, Bierman, & Welsh, 2014). Finally, other studies conducted among Newark teenagers, and African American Young Adults revealed that family or parental intervention strategies and influences promoted abstinence from underage drinking, substance use, smoking and tobacco usage, premarital sex, effective communication skills, and positive influential outcome among peers (Cheney & Mansker, 2014; Ross, Baird, & Porter, 2014). Consequently, the results of what I found from this study may help improve smoking cessation among the young adult population by being aware of the subtle signs and

behaviors of family members in regards to tobacco use, as well as recognizing and perceiving the positive messages and communication from their familial environment.

Merits to Health Benefit From Smoking Cessation

The issue of smoking among the people in the United States has been an increasing public and governmental concern regarding the health of the community, especially the adolescents and young adults. Information are available, and researchers documented many benefits from data generated from applicable public service campaign programs and other smoking prevention, cessation, and treatments centers made available to smokers who wanted to quit the habit (CDC, 2014). The mortality rate for cancer death decreased 1.5 million since 1991 from smoking cessation programs with better detection and treatment programs implemented for the communities, showed the overall mortality decreased from 215 per 100,000 people in 1991 to 169 per 100,000 in 2011 (American Cancer Society [ACS], 2011; National Cancer Institute [NCI], 2011).

According to the data generated by researchers from a BREATHE study, other health benefits from smoking cessation apart from the decreased death rates were including but not limited to: healthy lifestyle living, decrease in morbidities from heart and lung diseases such as COPD, emphysema, strokes. The authors found improved respiratory conditions that led to full and active life, with 83.2% of the 2,187 respondents reported treatment satisfaction of the program and health advice from their physicians, including the benefits generated in regards to smoking cessation (Abdullah et al., 2012; Genuneit et al., 2010). Therefore, both environmental and financial benefits may be enjoyed by the United States population, as well as by public health administrators, caregivers, patients, pharmaceutical companies, and government health agencies, due to

decreased in the risk of second hand smoke in public places such as buildings, offices, restaurants, parks, and libraries (Genuneit et al., 2010). These benefits are feasible through community resources from treatment programs, prevention and rehabilitation support groups from smoking cessation programs and management care centers. They are available in the local communities, with emphasis on the targeted population of the adolescents and young adults aged 18 to 26 years, including promotion of anti-smoking graphic campaign outreach programs (Blanton, Synder, Strauts, & Larson, 2014).

Demerits of Smoking

Smoking and tobacco products are major causes of diseases not limited to: cancers, lung cancers, cardiovascular diseases including ischemic, strokes, COPD, premature aging, premature and stillbirths, suicidal behaviors, leading to morbidities and mortalities among smokers and non-smokers alike (Covey, Berlin, Hu, & Hakes, 2012; Genuneit et al., 2010; Hbejan, 2011; Ohgami & Kato, 2010; Sultan & Elkind, 2012; Timothy & Nneli, 2010; WHO, 2014). Other determinants of smoking linked to risk-taking behaviors, depression, conflicts with self-efficacy among young adults during the inhalation and maintenance phases of smoking (Kear, 2012; Trosclair & Dube, 2010). Multiple risk factors had also been associated with the issue of smoking among this targeted young population such as anti-social characteristics and behavioral issues of disruptive and rebellious episodes among peers and families.

The effects of smoking and other related substance dependence, including nicotine, and secondhand smoke exposure are also added risk experienced by the age of 21 (Duncan, Lessov-Schlaggar, Sartor, & Bucholz, 2012; Harakeh et al., 2008; Malarcher et al., 2010). One solemn additional problem that was address by the researchers of such

studies of adolescent smoking involved the onset of nicotine dependence and secondhand smoke exposure. The researchers concluded that such dependency generally develop between 1 to 3 years after the initial onset of smoking (Duncan, Lessov-Schlaggar, Sartor, & Bucholz, 2012; Malarcher et al., 2010; Strong et al., 2007).

Methodology Rationale

To determine the perception of a young adult of the prevalence of an initial inhalation of cigarettes and tobacco products practices among particular population, I used the phenomenological method for the study. The methodological rationale was that a phenomenological method may be use to combine similar studies to result in a distinct and new conclusion (Cho & Kim, 2014; Patti, 2004). Patti (2004) and most recently Cho and Kim (2014) were noted to use this method to estimate percentages of consumers who engaged in risky behaviors such as; the use of cigarettes smoking and tobacco products.

In addition, another method that was commonly used to study consumers' responses to risky behaviors is descriptive epidemiology (CDC, 2010). In 2013, the CDC conducted a study using a descriptive epidemiological method and looked at descriptive variables such as gender, age, and geographic location that examined risky behaviors of adolescent youths. The researchers in the organization, evaluated the data form their descriptive epidemiological study by utilizing frequencies and percentages of the variables, thereby concluded, and identified the variables as nominal compared to the frequencies of the risky behaviors studied (CDC, 2013b).

The relevancy of use of this descriptive method versus other statistical techniques were that, ordinal, interval and ratio variables that were studied in percentages, defined the range of values, which was the 50% percentile in a median, thereby defining the

range of 5% to 95% percentiles. Even though the distribution of the numbers among the categories were a convenient way to study the frequency distribution of the data collected, the disadvantage to the organizations' study by just using a frequency distribution was not feasible. It was difficult to compare the two distributions derived from the different samples used, and therefore, were not separated from the responses in each category (CDC, 2013b). As such, I did not use the descriptive epidemiology method for this study.

This process did not apply to the qualitative research plan. For this study, I represented an opportunity to explore familial behavior as related to risk behaviors and actions of young adults' usage of cigarette smoking (Dirtu & Spoponaru, 2014; Higgins & Conner, 2003). I also explored smoking-related messages that young adults received from their families through verbal and nonverbal cues or techniques that influenced their initiation of cigarette smoking (Bandura, 1977, 1986).

Summary and Conclusions

The period of young adulthood signified physical growth, autonomy, emancipation, and independence from the parental home. This period also meant an exploration, emotional turmoil, as well as peer influences from the community, which may lead to heightened use of tobacco products, smoking initiation, the use of alcohol, and experimentation of illicit use of substances (Moran & Sussman, 2014). The perspectives of young adults I explored included familial communication toward tobacco use from family members, such as parents, or guardians. I also investigated and examined the perception of young adults concerning cues that they received from family members

concerning high-risk behavior of smoking and the use of tobacco products that influenced them to initiate the habit of smoking?

I studied young adults who were smokers between ages 18 to 26, and resided in the community from the northeastern region of New Jersey. I selected the participants randomly from the use of a convenience-based sampling by handing out flyers to potential young adults from areas such as convenience stores, grocery stores, and coffee shops. Even though smoking and nicotine use has been studied in the adolescent and young adult population, few studies have examined the link between familial communication and young adults (Leavy et al., 2010). Few researchers studied adolescents' or young adults' perspectives from their familial environment that influenced their initial decision to start the habit of smoking, or the use of tobacco product (Bennet, Miller, & Wooddall, 2009; Leavy et al., 2010).

However, a recent study according to researchers, corroborated on a factor that young adults' initial decision to smoke, were often challenged due to the pressure to fit into a group, especially if that demand came from peers (Urberg, Qing, & Degimencioglu, 2013). Some other factors explored in the study included what played an influential role in the young adult's decision to smoke were social, economic, and environmental factors (Hans & Van Rossem, 2011; O'Loughlin et al., 2014). The findings I found from this study may serve to educate clinicians, health care administrators, in the use of prevention strategies, and development of programs to understand the perception of young adults, and the familial messages that received from families as related to cigarette and tobacco products, that may help prevent the initial use of these tobacco products.

Chapter 2 represented a detailed literature review process on the use of cigarette and tobacco products among young adults aged 18 to 26 years. The research methodology I discussed in detail in Chapter 3, focused on the targeted population, interviews, data collection, data management, and data analysis methods. In Chapter 4, I presented the setting, demographics, findings of the study, and finally in Chapter 5, I presented a detailed discussion of the results from this study, including the limitations, as well as recommendations for further research.

Chapter 3: Research Method

Introduction

As introduced in Chapter 1, the purpose of this study was to explore the perspectives of young adults on communication received from their families regarding tobacco use that played a role in their decision to begin smoking. The method I employed for this study was the use of a qualitative phenomenological descriptive approach. The young adults' family members identified for the study were parents or guardians. Young adults whom I studied for this research were between the ages of 18 and 26 years. *Perception* refers to the ability of individuals to be aware of their emotions and able to recognize the roles of familial communication and social interactions in influencing them to engage in the risky behavior of smoking and tobacco use (King, 2012).

Chapter 1 addressed the background, problem statement, research questions, framework and theoretical foundations, nature, definitions, assumptions, scope and delimitations, limitations, and significance of the study. In Chapter 2, I provide a detailed literature review addressing prominent research concepts. In Chapter 3, I describe the research methods, design, and rationale of the study; issues of trustworthiness; and ethical procedures. In Chapter 4, I present the results of the study, and finally, in Chapter 5, I address the findings, interpretations, and recommendations for further research.

Research Design and Rationale

A qualitative, phenomenological, descriptive interview style was used for this study. I used semi structured interview questions designed to invoke rich responses to examine perceptions and familial communication related to the risky behaviors of smoking and tobacco use. Morrisey (2011) stated that phenomenological methods are

used to study the lived experiences and perspectives of research participants regarding a target construct. Zenobia, Yuen-ling, and Wai-tong (2013) noted that phenomenology's hallmarks include the ability to glean the core essence of the phenomenon being studied from the viewpoint of research participants who have a shared lived experience.

Therefore, I used a phenomenological approach for this study. Following the statements of Creswell (2013), I concluded that young adults' perceptions and lived experiences in their familial environment regarding the issue of smoking cannot be quantified. This research design and rationale made it necessary to gain an in-depth understanding of the social phenomenon and thoughts of the individuals whom I directly studied.

In order to achieve efficiently the purpose of this study, I randomly recruited 20 young adult participants from locations such as convenience stores, grocery stores, coffee shops, and public libraries in the northeastern region of New Jersey. A researcher using a phenomenological approach should consider a small sample size between 5 and 25 participants for an in-depth investigation and exploration of participants' viewpoints during the data collection and analysis phases (Creswell, 2013). Mason (2010) asserted that a small sample size and saturation will enable a new researcher to handle the demands of data collection for a qualitative approach, preventing the researcher from becoming overwhelmed by the demands and details of a broad sample. From the 20 young adults randomly recruited, I interviewed 15 participants by using a semi structured questions protocol. I provide in Chapter 3 of this study a description of the research process, including the design of the study, the sample participants, data collection method, data analysis, ethical considerations, and protection of the rights of participants.

The following research questions (RQ) directed the study:

Research Question 1: What are young adults' perceptions of the information or behaviors they receive from family members regarding smoking?

Research Question 2: What are some perceived smoking-related communications or behaviors from family members that influence a young adult's decision to start smoking?

Subquestion 1: What do young adults perceive to be facilitators to start smoking?

Subquestion 2: What do young adults perceive to be barriers to start smoking?

Open-ended interview questions were used for the data collection stage, as described by Creswell (2009), who noted that open-ended interview formats are used to obtain in-depth qualitative perspective responses from participants based on their perceptions, points of view, and lived experiences. Therefore, the use of a phenomenological descriptive method supported the generation and development of in-depth descriptive responses from the participants. Moreover, the use of Van Manen's eight-step method was best suited to address the research questions, as this same procedure was applied with favorable results for the reduction of gaming and texting activity among young adults to improve learning in college technology (Voss, 2012).

I explain qualitative research concerning social learning theory and the theory of planned behavior, including the method used for this study. Finally, Chapter 3 closes with a summary of the analytical process and methods used. I report the findings of the study in Chapter 4, and in Chapter 5, I present the interpretations of the findings and recommendations for further research.

Role of the Researcher

My primary function as the researcher in the study involved conducting this qualitative research using a phenomenological approach to collect data. I used a convenience-based sampling technique to gather 15 volunteer participants for face-to-face, telephone, or Skype interviews. I conducted face-to-face interviews in a comfortable and unhostile environment: a private conference room at a local library. A couple of participants preferred Skype, and I conducted their interviews in private rooms. I did not carry out any interview at a workplace for the benefit of this research study.

I used digital recordings and took detailed notes and journal entries during the interviewing process. During data collection, my role as the researcher was to ensure and validate the quality and reliability of the collected data. As such, I did not have any existing professional or personal relationships with any of the participants, including supervisory or instructor relationships that could impose power differentials over the participants. I scheduled the interview to last 30 to 40 minutes; with 5 to 10 minutes for follow-up if needed for further clarification of respondents' responses also known as *member checking* (Mason, 2010). For the privacy and protection of human subjects, I successfully completed the National Institutes of Health's human research training on March 3, 2012 (Appendix D).

The semi structured interview questions were not intrusive, nor did I anticipate that my study would bring about any ethical dilemmas, violations, emotional concerns, or responses from participants. However, I provided participants with references to free counseling and options for smoking cessation programs in the event that they experienced emotional issues or were interested in exploring available resources regarding smoking

(Appendix E). I made participants aware of information on the study, and the requirement that participants be 18 to 26 years of age was included in the flyer as well as the screening questions. I selected individuals randomly from the local community in public places within the northeastern region of New Jersey.

Notable sites of participant recruitment were a local library, convenience stores, coffee shops, and grocery stores. As recommended by Creswell (2013), an interview protocol should include an introduction; a heading; the interviewer's instructions; informed consent; the research questions; probing, open-ended questions; and opportunities to listen and pause to record or takes notes on participants' responses. Finally, per Walden University's Institutional Review Board (IRB), thank you gifts of no more than $5 are appropriate for research participants (personal communication, September 12, 2014). I provided each participant with a thank-you statement, leaving room for future clarification of answers, issues, or concerns if needed.

The interview protocol used for this study is located in Appendix C of this paper. A licensed health care professional with a PhD in Behavioral Health reviewed, verified, and validated the interview protocol. The licensed health care professional's expertise was also in terms of the scope and content of the research. The list of interview questions, which was replicated and modified from previous studies (Schutte et al., 2007; WHO, 2012), was sent to the IRB for approval, which was granted on January 28, 2016, with approval number 01-28-16-0169469 that expires on January 27, 2017. I used the validated interview protocol for this research study after approval from IRB. Lastly, the research study commenced after the recruitment of participants upon receipt of approval to conduct research from Walden IRB on January 28, 2016.

Another role as the researcher was to increase the reliability and the accuracy of the qualitative data collected. Creswell (2009) argued that in order to achieve this important task for a research study, an accurate transcription of the data verified and obtained by comparing the audiotaped interview responses against the notes taken by the researcher during the interview, and with the coded data collected. I triangulated data by the means of member checking, and by comparing the data to transcribed notes and the current literature available on the research topic. I taped recorded all interviews as a backup for verification and accurate transcription of the participants' responses. When needed, I conducted a follow-up 5 to 10 minute interview for clarification purposes that are also known as member checking, and participants were aware of this process if needed.

According to Creswell (2013), the rationale is in order to increase the trustworthiness of qualitative research data. As such, I used this technique during the data collection analysis phase. I verified notes with digital recordings of the interview using NVivo 10 software, and coded data for cross-referencing. I also analyzed the data collected with Van Manen's eight-step methods, and all data generated were stored and secured in a locked cabinet with password protected in my home office where I will maintain them for 5 years. After 5 years, I will destroy all transcribed data by fire and all electronic data completely deleted from the hard drive (Walden, 2014).

Researchers must be mindful and sensitive to bias, limiting judgements, views, opinions, and values (Creswell, 2010). Data collected are maintained in a good condition and be free of any type of damages including but not limited to: environmental, fire, water, or time passage, and having the data stored in an external storage device for

backup in case of unforeseen circumstances or events that might breach the data. The external storage backup was password protected and accessible only by me.

I avoided all ethical issues, such as recruiting personal family members or friends for the study. This was to eliminate any issues of conflict of interest. I did not conduct any interview in the work place, and I did not promise any extravagant gifts or money to any participant. It eliminated the risk of participants' pressure and thinking that they had to partake in the research study. All interviews occurred in a mutually agreed upon environment and time that was feasible for the participants. According to the ethical rules and standards of Walden IRB policy, a token gift may be acceptable and provided to the participants as a "thank you". Therefore, I awarded a $5 gift card from Starbucks to each participant for their time in participating for the study (Walden, 2012).

A participant was not required to return the gift card if he or she withdrew or did not complete participation in the study. I was to manage issues voiced by any participant immediately as it occurred, but no issue or concern was voiced. If I had mistakenly recruited a relative or friend for the study, I was to excuse the participant immediately from participation in the study and all data collected from that individual immediately destroyed, and another participant recruited to replace the excused individual, but no relative or friend participated in this study. Finally, I provided additional details on ethical procedures and trustworthiness later in this Chapter 3.

Methodology

Participants' Selection Logic

The selected participants utilized for this study were young adults who smoked, 18 to 26 years of age from the northeastern region of New Jersey. I used a convenience-

based sampling strategy, with justification that the location for the data collection area was feasible and affordable. According to Mason (2010), convenience-based sampling is conducive to achieve a study's goals, as well as cost effectiveness; but Mason further argued that a possible demerit for a convenience-based sampling data collection method is a misrepresentation of the viewpoint of the entire participant pool (2010). However, phenomenological research studies are specific to individuals who had experienced the same phenomenon of a research investigation. Therefore, my staying alert to the possibility of misrepresentation, and making sure that each participant's viewpoint was accurately represented and checking and crosschecking responses for accuracies was imperative.

The young adult population chosen for this study was significant and justified for the exploration of the missing gap in the literature reviewed in Chapter 2. For this study, I dealt with the perceptions, viewpoints, and lived experiences of the effect of smoking-related messages that the young adult received from their families that played a role in their decision to smoke. The data collection approach, criteria, and sampling strategy used for this study was the semi structured interview questions, and the targeted population of 15 to 20 young adult participants who smoked. The rationale I used for the small sampling was to gain an in-depth analysis, knowledge, and understanding of the viewpoints of study participants analyzed and managed effectively by the use of semi structured open-ended interview questions techniques.

A descriptive phenomenological qualitative study should consider a sample size of 5 and 25, to allow for in-depth analysis and critical attention to the interviewing process and data collected (Creswell, 2013). I screened the potential participants and

asked for their age that fitted the inclusion criteria, if they spoke fluent English, and gave verbal and signed informed consent as indicated in Appendix B of this study. I randomly selected participants from local public settings such as convenience stores, grocery stores, coffee shops and the local library in the community. Participation for this study was voluntary.

I handed out flyers to potential young adults, and posted more flyers on stores bulletin boards with store manager's approval. I also provided flyers to the individuals who may know other persons who met the criteria for the study for recruitment of participants (See Appendix A). Participants contacted me from the information from flyer. I asked participants to complete and sign the Informed Consent (See Appendix B). An interview protocol was used for the study (See Appendix C), and My NIH card was made available for participants' viewing (See Appendix D). The 15-sample size of young adults was an appropriate size to reach saturation as recommended by Creswell (2013). Therefore, as corroborated by Mason (2010), this study was within the scope and standard to assure saturation, or new pertinent information found.

Population

The population of interest for this study was young adults. There were no specifications if they were college students or not, as much of the existing literature related to risk behaviors and perceptions that pertained to adolescence in general. This study therefore, encompassed an overlap period between late adolescence 18 years of age, and young adulthood age 26. For clarification purposes, the distinctions between these lifespan-periods are under the definition of terms (King, 2012).

In this study, there existed several potential forms of bias. One such bias that existed was response bias. This was because the participants of the study during the interviewing process with the semi structured questions protocol may have answered questions with what they thought the interviewer wanted to hear rather than with what was the reality of the behavior. As such, it may lead to underreporting of high-risk behaviors, which may result in the wrong perception documented and thereby affected the findings of the study. Another type of bias was recall bias, and it may have existed based on what the participants remembered at the time of the interview (CDC, 2010).

Questions I asked from the interview protocol required the respondent to remember the first time they smoked a cigarette or used tobacco products, and when the behavior became a habit. They were also questioned how many cigarettes they smoked in the past seven days and in some cases the past thirty days. The random type of a convenience-based population sampling technique selected consumers or participants for the study.

I collected, transcribed, and analyzed the data generated from the participants. I was mindful not to draw any conclusion for a cause and effect outcome at the data collection and interpretation phases, which limited researcher bias (Creswell, 2007). Patton (2002) also argued that qualitative research approaches were usually difficult to replicate when utilizing the interviewing technique and that the findings for generalizations were limited. Therefore, personal views and opinions while interpreting participants' responses were not of any interest nor considered because the findings of the study maybe altered.

A best practice I used was to prepare the location or site for the research, maintained eye contact with the participants when I asked questions and listened to their answers. I also probed for more information when needed and most of all; I respected and appreciated the participants for their time. Patton (2002) stated that although there are various techniques in the interviewing process, the best way to generate valuable and authentic information from participants is achieve when the participants are comfortable. Patton (2002) further corroborated that the members needed to feel that the sessions were not like a test subject or an interrogation session but instead, more like a conversation. This way, having a conversational like course proved more relaxing and comfortable for both the interviewee and the interviewer.

Population Sample

The population sample used for this study was the convenience-based sampling. The sample population was restricted to young adults 18 to 26 years old, who smoked and not associated with any particular college. Participants' solicitations were random in public areas of the northeastern region of New Jersey, in areas such as local public libraries, convenience stores, grocery stores, and coffee shops. Therefore, there were no foreseen issues of obtaining approval for research from the Internal Review Board (IRB) as detailed in the Research Ethics Review (Walden, 2014).

As indicated in the limitations section of Chapter 2, a possible limitation for the utilization of convenience-based sampling for data collection may not represent the perspectives and viewpoints of the entire targeted population (Mason, 2010). As such, this restriction posed some limitations in this study because it was only restricted to the northeastern region of New Jersey, as related to the generalization of its findings to other

cohorts including similar populations in other States of the country. Despite the constraints, the importance of the health-related issue in this community provided the critical need for psychosocial research.

Data Collection and Instrumentation

In a qualitative research study, the selected approach was what determined the purpose of the study. The approach also determined the methodology, the data collection process, the analysis of the study, and finally, the role of the researchers conducting the study (Web Center for Social Research Methods, 2006). The primary instrument for data collection on this study was I as the sole researcher and the semi structured interview questions protocol tool I used (Appendix C). Participant recruitment commenced once I received approval for participants' research from IRB on January 28, 2016. I solicited research participants randomly from local public areas of the community such as local convenient stores, grocery stores, coffee shops, and libraries in the northeastern region of New Jersey with the utilization of convenience-based sampling technique and recruitment flyers were prepared solely for this study (Appendix A).

I used internet-based social media sites to advertise the research study after I obtained permission from administrators of the site. I also handed out flyers to individuals who may know potential participants that fitted the study criteria. Qualitative research approaches afford the researcher the opportunity and ease for data collection from few participants, who provided thick data for analysis (Patton, 2002). I recruited 20 participants for the study, the qualitative approach of one-on-one interviewing process, and the used semi structured questions protocol to conduct the interviews.

I used the selected interview mode made by the participant for comfort, ability, and accessibility. Duration of the interviewing process was 30 to 40 minutes, which was at the convenience of the participant, and was the best method for data collection for the research. I conducted one interview session per participant and if there was a need for clarification of an answer, I contacted the participant for a 5 to 10 minutes follow-up interview for correct representation of data collected. I based the research on the views, experiences, and perspectives of young adult ages 18 to 26 years old who smoked. I established rapport with participants by using multiple parts of the interview guide to obtain in-depth and full disclosure of the participants' lived experiences.

The qualitative data I collected were hand coded through the NVivo software application for trends and themes. I analyzed the data collected using Van Manen's eight-step methods (Van Manen, 1997, 1999). These data analysis approaches enabled the organization of the interview data, semi structured questions, and participants' feedback into themes and trends that are synthesize for the possible dissemination of the findings of this study (Bazeley, 2007). The diffusion of the results was available to the members of the public. These included; family members, relatives, friends, particularly the young adults, health care administrators, physicians, nurses, caregivers, members of the public and private sectors via; emails, journals, educational seminars and outreach programs for local high school seniors, colleges, churches, hospitals and clinics, libraries, and local young organizational institutions such as the YMCA.

I used NVivo 10 software to transcribed, reviewed, and managed the data collected during the interview. I crosschecked all data for accuracy, and placed into a report for participants to review for correct representation of their responses, also known

as member checking (Creswell, 2009). Multiple, password protected data storage devices was also used to store and protect the data collected to protect against unforeseen events such as fire, flood, or hardware damage. I took field notes to obtain information from participants in case the recording device broke or malfunctioned during the interview. The use of these backup strategies enabled me to collect rich and detailed data in the utilization of a strategic, systemic process (Creswell, 2009).

I recruited more participants from other local libraries and public places in the instance that I was unable to meet my targeted numbers of 15 to 20 participants. I gathered data by the use of interviews, semi structured questions protocol, and Skype. Creswell (2013) argued that there should be utilization of multiple strategies for the data collection so that there is noted evidence of member checks performed during this phase and the information collected were crossed checked too by me. Creswell (2007) stated, the reliability of any data is crucial, and obtained by the process of interviewing, notes taking, record taking, coding, transcripts, and institutional review board methods. Finally, I thanked the participants for their time, and offered the token "thank you" gift of $5 Starbucks gift card. If participants did not complete the interview or withdrew from the study, they were not required to return the gift card (Appendix C).

A licensed health care professional with PhD in Behavioral Health reviewed, verified, and validated the interview protocol used for the study (Appendix C). The licensed professional expertise was within the scope and content of the research, used to investigate and explore the young adults' perspectives of familial communication received from families related to their decision to smoke. The list of interview questions were replicated and modified from previous studies (Schutte et al., 2007) and (WHO,

2012), and was sent to the IRB for approval. Table 2 provided the rationale for the purpose of each interview question in relation to the research questions, as well as the theories associated with this study in the investigation and exploration of the young adults' perspectives to smoking-related familial communications.

Procedures for Recruitment, Participation, and Data Collection

The participants spoke and understood the English language. This criterion was to reduce or eliminate confusion; and to promote an understanding of what the expected questions and responses were from the interview. Participants who did not provide informed consent were not included in this study. Research findings were not in general to every young adult who did not have similar selection criteria from this study. Most importantly, I excluded friends and family members from participating as respondents, to eliminate bias.

Overlooking the issue and potential for bias in a study is a major concern. Patton (2002) stated that the qualitative research methods and strategy used for the study based on views, intent, depth, comprehension, experiences, and beliefs may contain tainted or biased beliefs by the researcher's views and opinions. Creswell (2007) argued that even though contamination of a study occurred by the researcher's influence on this type of research, the researcher must exercise careful consideration as to the methods and ways that data was being collected, so as not to create bias or taint the data. Recommendations suggested that researchers should utilize some strategic awareness in their research study. One recommended strategy I used was to have an awareness of bias, and assured that the study was entirely free of bias or at best reduced to a minimum amount.

Other recommendations was that the researcher must adopt ways to minimize the risk of bias, and that it was very important for a researcher to develop and maintain a risk assessment tool in the initial stages of a research study. Creswell (2013) continued that the researcher should develop a research plan that focuses, and foresees any type of ethical issues or concerns that may arose in a study. Maxwell (2005) corroborated that there were varied opinions as well as to the strategies that a researcher uses to contribute strength and quality to a qualitative research study. Patton (2002) concluded that there were several methods and strategies used in any type of research, but that the main purpose of research is to be accurate, credible, dependable, high quality; and made sure that attention to issues regarding ethics is of utmost priority. As such for this study, data collection was accurate, credible dependable, and maintained at a high level of quality to assure all ethics and privacy standards were maintained.

Standards for qualitative findings were upheld, and mindful of the issue of bias. There was limited bias by awareness of personal views and opinions. Knowing this helped insured me that personal views and opinions did not play any role in, nor interfered with findings in the research, as well as with the responses of the participants. Therefore as the researcher for this study, I was not judgmental or imposed my personal views or opinions on any participants.

I did not discuss any personal questions or invited any participant out for social activities. I conducted and upheld myself in a professional manner at all times. I did not interview any family, friends, or colleagues for this study. I collected data on young adults aged 18 to 26 and used the qualitative interviewing approach with a convenience-

based sampling method for data collection from volunteer participants who resided in the northeastern region of New Jersey.

The recruitment process for participants commenced after the Walden IRB approved the requested IRB application for conduction of human research on January 28, 2016, with an approval number 01-28-16-0169469 and expired January 27, 2017. The mode of the interview was audio recorded via face-to-face interview, or the internet medium Skype, with priority for participants' preference. I took notes as well for backup purposes in case the recorded device failed. Another alternative method for the interviewing process I used was by phone recording if the participant did not have access to the internet. The site and location for the interview was calm and comfortable for the participant, and I did not conduct any interview in a workplace.

When I was unable to meet the targeted recruitment number of 15 and 20 participants, more flyers were distributed and handed out to the targeted population in the northeastern region of New Jersey to recruit more participants. I solicited respondents from the local community libraries, grocery and drug stores, or other public places and I met the targeted sampled numbers for this study. Participation in the study was voluntary, and participants were free to vacate the study at any time, before, during, and were not obligated to finish the study.

If a participant withdrew from the study, solicitation for a replacement to fill that vacancy if necessary occurred. Necessity for a replacement participant ended when saturation occurred, which was when no new information germane to the study was uncovered. I handed out a $5 Starbucks gift card to each participant for taking time to

participate in the study. Individuals were not required to return the card if they did not complete the study.

Participants were required to read and sign an Informed Consent before I collected any data. Finally, I arranged with study participants for a 5 to 10 minutes follow-up interview if necessary for clarification, if questions arose, or if I needed further information regarding the study. I informed participants of the one to two page brief summaries I provided to them as well as the period when the study may publish and were welcomed to review the study upon publication.

Data Analysis Plan

For this study, Van Manen's eight-step methods of analysis were used (Davey et al., 2013; Goodrich, 2012; Voss, 2012). According to Van Manen (1997, 1999), the aspects for lived experience for interest of phenomenology included lived space, body, time, and human relations. In addition, this method previously used by researchers proved helpful with formulation of meaning of health, stress, bereavement, and quality of life (Davey et al., 2013; Goodrich, 2012; Voss, 2012). As such, this method was germane to the study regarding familial communication, as well as death and cancer related to tobacco use.

Focus of the study was on the living arrangements of young adults in correlation with familial communication with respect to their health and human body. The eight-steps for data analysis included: (1) reading interview transcriptions of young adults for overall understanding; (2) writing interpretive summaries of each young adult summary; (3) analyzing the transcribed interviews from young adults using NVivo to assure confidentiality of data collected; (4) confirming and resolving any disagreements or

interpretations by reviewing young adults transcriptions again; (5) identifying common meanings and shared practices by contrasting and comparing the transcriptions from young adults; (6) identifying relationships among the data from young adults that emerge; (7) preparing a draft of themes and exemplars from the data from young adults to discuss with my supervisory dissertation committee team; and (8) incorporating a summary result within the final report. Table 3 below listed the alignment of Van Manen's eight-step methods for utilization in the data analysis of the study.

Table 3

Alignment of Van Manen's Eight-Step Data Analysis Methods to the Study

Step	Action	Data analysis process
1	Read	Read all interview transcriptions of young adults for overall understanding.
2	Interpret	Write interpretive summaries of each young adult summary.
3	Transcribe	Analyze the transcribed interviews from participants using NVivo to assure confidentiality of data collected.
4	Confirm	Confirm and resolve any disagreements or interpretation by reviewing young adult transcriptions again.
5	Compare	Identify common meanings and shared practices by contrasting and comparing the transcriptions from young adults.
6	Identify	Identify relationships among the data from young adults that emerge.
7	Draft	Prepare a draft of themes and exemplars from the data from young adults to discuss with dissertation committee team.
8	Results	Incorporate a summary with final report.

I used NVivo 10 software for data analysis to organize the data collected during the interview process into themes and trends for in-depth understanding of the primary phenomena, possible synthesis, and the core essence of the participants' lived experiences. I hand coded and established triangulation of the interview data collected in cases of discrepancy. Walden University IRB and the health expert validated the

participants' questions and protocols. After permission for research with approval number 01-28-16-0169469 and expiration date January 27, 2017, I would have made a request to IRB for revalidation and revision of participants' questions in the event any discrepant case occurred during my research. No discrepant case occurred during this research study.

Issues of Trustworthiness

The qualitative research plan focused on the issue of smoking among the young adult population, and their perspectives of familial communication received from their families regarding smoking. Lincoln and Guba (1985), as asserted by Patton (1990), some criteria of trustworthiness are credibility, dependability, and quality. In order to assure and ensure quality, credibility, and trustworthiness, all preconceived notions, assumptions, notations, or ideas were set aside to eliminate bias and gained the trust of participants.

Credibility is the confidence of the researcher that there was truth or accuracy from the research participants (Polit & Hungler, 1995). Therefore, in order to gain trust, I engaged the participants and not rushed them with their responses. I established confirmability and reliability through data triangulation (Polit & Hunger, 1995). I crossed-checked the data collected by using member checking for clarification of information, inaccuracies, and distortions. I hand-coded and entered the data into NVivo 10 software for content analysis and Van Manen's eight-step methods of organizing data into trends and themes offered in-depth understanding of participant's lived experiences and viewpoints.

I provided participants my identification data, a brief written explanation of what the study entailed, and a written documentation of informed consent. A valid National Institute of Health (NIH) research card was offered for identification of my certified researcher status for human participants (Appendix D), including a written and assured confidentiality agreement. Finally, participants were informed that they were not obligated to participate, or continued participation in the research, and that they may withdraw from the study at any time without penalty.

I provided participants with information about free personal and family smoking counseling (Appendix E). I informed potential participants that participation was strictly voluntary. I offered a nominal "thank you" gift of a $5 Starbucks gift card to each participant as an appreciation for the participants' time and if anyone dropped out of the study without completion, he or she did not need to return the gift card.

The participants and I voluntarily exchanged telephone numbers, skype, and email addresses and I as a form of member checking, I provided interview transcripts to explain any information or responses, or for clarification. The technique of member checking allowed for verification of collected data for improved credibility (Creswell, 2013; Polit & Hungler, 1995). Patton (2002) argued that the validity of a research study is of paramount importance. As such, the validation of the quality of my research study occurred by working with and consulting with the participants throughout the study by the above-mentioned medium of communication, otherwise known as member checking. I employed such extra quality procedure to ensure that the data generated was as accurate and reflective of what the participants said during the interviewing and data collection phase.

Other ways to establish dependability with the research was to make use of journal entries and audit trail of respondents' answers to interview questions, to note thoughts and ideas (Creswell, 2013). Qualitative research must be stable over time, must be in good condition, and must maintain its relevancy with the findings based on the literature review (Creswell, 2013; Polit & Hungler, 1995). The hope for this study was that through interviews, I gained rich, relevant information from participants about smoking habits, peers, and parental influences related to smoking. Open-ended type of questions provided a final research outcome relevant to the literature (Patton, 2002). Finally, I contacted scholastic peer review and colleagues, I also contacted participants to review the interpretations of their responses to assured credibility and add to the validity of my research findings.

Ethical Procedures

It was imperative to discuss the measures taken to protect the participants' rights, privacies, and confidentialities. Participants were between the ages of 18 and 26 young adults from the community; as such, I did not recruit anyone under the age of 18. As asserted by Creswell (2009), research participants must be aware of their rights and other information regarding their participation in a study. I gave to all the participants, detailed information about the research topic, procedures such as the interviewing techniques and the use of the data generated. Before any interview, I informed the participants about the benefits and risks of participating in the study, as well as their confidential rights in a consent letter (Appendix B).

I provided biographic, educational, demographic, or any other information for the study to participants in a flyer form (Appendix A). I informed participants prior to the

study, both verbally and in the consent letter (Appendix B) that they had a right to refuse to answer any questions, stopped the interview at any time, or refused to participate in the study without penalty. As such, I obtained all appropriate and necessary documentation and signed informed consent forms prior to the start of the research.

Additionally, I treated all participants with respect, professionalism and assured them of confidentiality and if any participant raised any concerns or issues, I immediately addressed with honesty and respect. To my knowledge, no participant raised any such concern. I completed the necessary IRB application in accordance with the Institutional Review Board (IRB) guidelines, and the ethical regulations and directives of Title 45 of the Codes of Federal Regulations Part 46, Protection of Human Subjects (Title 45 CFR Part 46). I received approval with authorization granted by the board before I conducted research or collected data will be for this study. IRB granted approval on January 28, 2016 with approval number 01-28-16-0169469 and expires January 27, 2017.

In preparation for the IRB process, I generated an initial Form A: IRB Pre-application form and pre-telephone conference held this past fall 2014, with a representative of the IRB for any issues and or concern regarding my study. I used my approved prospectus and sent it to the IRB representative, and no issues or ethical concerns identified with my draft research (personal communication, September 12, 2014). There are no partnerships with any organization concerning participants, the provision of data, or space used for this research.

According to the CDC (2013a), no personal information of the participants must be recorded as such I did not link any participants' answers to any identifying characteristics that could associate their responses to them (Walden, 2014). I did not use

identifiers, such as names, addresses, or social security numbers instead codes and numbers such as PP1, PP2, and PP3 labeled participants. Participant's telephone numbers and email addresses were confidential, used only for the need to clarify or address any issue, question, or concern pertained to the study. I accessed participants' contact information by using a password-protected computer, and all data I collected was stored in a secure manner in a locked cabinet in a home office.

I coded the data so that there were no identity breeches and I assured anonymity and confidentiality. I recruited participants randomly from the local community public library, convenience stores, grocery stores, coffee shops in the northeastern region of New Jersey. Any participant may refuse to participate, or withdrew early from the study. Any participant who withdrew retained the $5 Starbucks gift card. After 5 years, I will shred all paper media I collected and all electronic media pertained to the study permanently deleted from the hard drive.

Giving of a gift card is common for research studies (Laureate, 2010). Ethics regulations and standards of the Institutional Review Board (IRB), and the National Institute of Health Research (NIH) did not frown on such gestures, as long as it was not an extravagant gift, but nominal and appropriate (Walden, 2012). Therefore, a Starbucks $5 gift card was not unethical, extravagant, or inappropriate, but instead considered nominal and appropriate according to the standards of ethics (Walden, 2012).

Creswell (2013) stated that a human research subject must not be coerced, threatened, or bought with any form of an extravagant gift or promise. He further asserted that such extravagance would taint the findings of a research study, already causing biases. As recommended by Creswell (2009), and Laureate Education Inc. (2010), I

informed participants that there was high possibilities that the research data collected from the interviews may be publish for public viewing, but that their identities are protected and safeguarded. I also advised them that they had a right to obtain study results once I completed analyzing the data. Finally, I did not conduct a pilot study for this research.

Summary

In Chapter 3, I included the methodology and the data collection procedures used to explore the perceptions of study participants that includes young adults aged 18 to 26 concerning their perspective on tobacco use and communication they received from their families related to their decision to start smoking. In addition, I addressed in details in this Chapter the issues of ethical considerations and trustworthiness that included the thick descriptive and selection processes of the research participants and the locality of recruitment from community public places such as the library, which were applicable to a convenient-based sampling used in a qualitative research study. The types of interviewing techniques such as a face-to-face, or telephone, or Skype used for this study were discussed, as well as how the participants were contacted via email, phone, or in person to review and signed the informed consent before participating in the research. Paramount to the discourse in Chapter 3 was the issues of confidentiality, including the role of the researcher that I discussed.

The processes of data analysis through the Van Manen's eight-step methods and NVivo 10 software, as well as hand-coding for cross reference to establish triangulation, coupled with the procedures for data storage, security, dissemination, and disposition of the information was discussed in this Chapter as well. In Chapter 4, l included the

demographic summaries, data collection and analysis, evidence of trustworthiness, as well as the results of the research. For the final Chapter 5, I discussed the study findings and recommendations for future research.

Chapter 4: Results

Introduction

The purpose of this descriptive, qualitative, phenomenological study was to explore, investigate, and gain in-depth understanding of the views and perspectives that young adults have regarding the use of tobacco. I explored the viewpoints, understanding, and lived experiences of young adults concerning information or behaviors presented by their parents or guardians in relation to smoking. The targeted population consisted of young adults aged 18 to 26 in the northeastern region of New Jersey.

I derived the following two research questions and two subquestions for the study:

Research Question 1: What are young adults' perceptions of the information or behaviors they receive from family members regarding smoking?

Research Question 2: What are some perceived smoking-related communications or behaviors from family members that influence a young adult's decision to start smoking?

Subquestion 1: What do young adults perceive to be facilitators to start smoking?

Subquestion 2: What do young adults perceive to be barriers to start smoking?

For Chapter 4, I provide a description of the research setting, demographics, data collection, data analysis, evidence of trustworthiness, as well as the results. I also provide an overview of the results concerning the perspectives of young adults toward tobacco use, which leads to the conclusions in Chapter 5 as well as the final discussion, interpretations, findings, further recommendations, and conclusions of this research.

Research Setting

As the primary researcher, I conducted this study using a descriptive, phenomenological, qualitative approach. I conducted the study in February 2016 and interviewed 15 volunteer participants who were young adults between the ages of 18 and 26. I wrote down their responses to the open-ended interview questions and voice recorded the interviews to make sure that I did not miss any information that the participants provided. I received initial contact from 30 individuals who were interested in participating in the study; 20 agreed to scheduled dates and times, but 15 showed up for interviews. I received consent from all 15 participants. I conducted 12 of the interviews in a private conference room at a local library and three at private rooms at the participants' location and my home office using Skype.

The participants all verbalized being comfortable and provided consent before interviews were conducted. The interview sessions lasted between 30 and 40 minutes each. The young adults were from the northeastern region of New Jersey. In Figure 1, I illustrate the region in the State of New Jersey from which I recruited the 20 volunteer participants with the use of convenient based sampling and where I interviewed 15 of the participants.

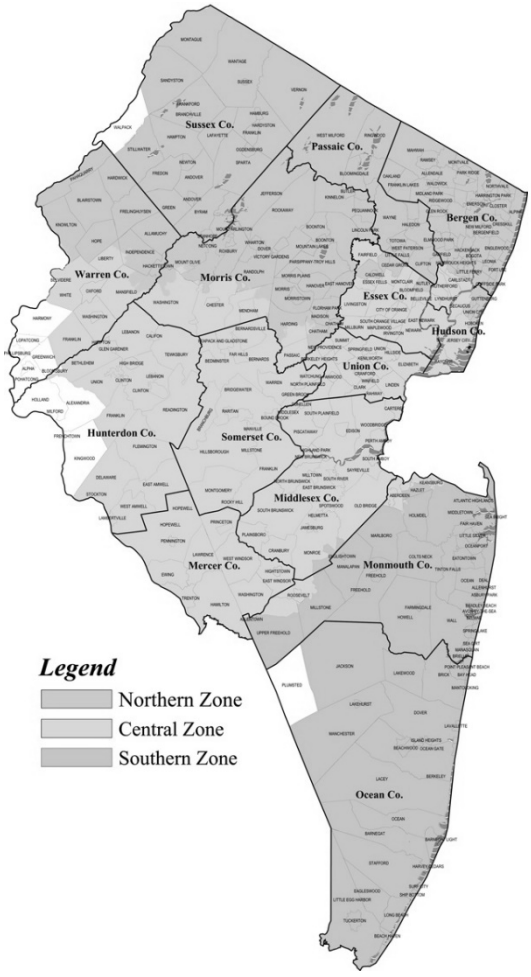

Figure 1. Demographic setting of the research study.

The local library was a convenient location for the volunteer participants to meet me for interview sessions. I conducted person-to-person interviews over a 2-week period. All participants agreed to audio recordings, but only a few agreed to video recordings. As such, in order to be consistent with the interview pattern and avoid any discrepancies within the study results, I conducted all interviews consistently in person and audio recorded the sessions so as not to miss any information that any participants might give. I also took detailed written notes as a backup in the instance that my recording device failed.

I retained an interview log of dates, times, as well as contact information for the participants. In order to preserve confidentiality for my study subjects, the information log used first names only, as well as 3-digit identifiers (e.g., PP1 for Participant 1). At the time of the study, no other personal or organizational conditions influenced the participants that might have, in turn, influenced the results or the interpretation of the study. Although 20 participants agreed to participate, 15 actually showed up at their appointed date and time. I made a confirmation call the day prior to each scheduled interview to remind the participant of the interview session. All 15 participants continued with the study; no main participant withdrew.

Demographics

Relevant characteristics and demographics of the 15 participants living in the northeastern region of New Jersey included age, smoking habit, race, occupation, educational status, family type, number of family members, and income class. Each of these characteristics is presented in Table 4.

Table 4

Characteristics of Participants in the State of New Jersey

#	Age	Race	Smoking habit	Occupation	Education status	Family type	Family size	Income class
PP1	22	White	Daily	Dental asst.	High sch.	Bio. P.	5	Middle
PP2	24	White	Daily	Clerk	High sch.	Adp. P.	3	Low
PP3	19	White	Daily	Unemployed	GED	Stp. F.	6	Low
PP4	20	Hspn	3X/Wk	Student	College	Bio. P.	6	Low
PP5	19	White	3X/Wk	Student	High sch.	Sgl. P. M.	2	Middle
PP6	24	Black	Daily	Trucker	Midd sch.	M. & G.F.	4	Low
PP7	22	White	3X/Wk	Student	College	Bio. P.	5	Middle
PP8	23	White	3X/Wk	Asst. mgr.	High sch.	Bio. P.	3	Middle
PP9	20	White	Daily	Unemployed	High sch.	Bio. P.	5	Middle
PP10	20	Black	Daily	Waitress	High sch.	Sgl. P. M.	2	Middle
PP11	21	Asian	Weekly	Student	College	Guardians	4	Middle
PP12	23	White	Daily	Student	College	F. & Stp. M.	4	Middle
PP13	23	White	Weekly	Nurse asst.	High sch.	Bio. P; G.P	6	Middle
PP14	25	Hspn	Weekly	Cust. serv.	High sch.	Bio. P; ExF	7	Low
PP15	25	White	Daily	Retail mgr.	College	Bio. P.	5	Middle

Note. Hspn = Hispanic; Bio. P. = Biological Parents; Adp. P. = Adoptive Parents; Stp. M = Stepmother; Stp. F. = Stepfather; M. = Mother; F. = Father; Sgl. P. = Single Parent; G.F. = Grandfather; G. P. = Grandparents; Ex F. = Extended family.

Data Collection

Interviews

For this study, I collected data from 15 young adults who smoked and resided in the northeastern region of New Jersey. I interviewed the research participants who contacted me from the flyers I handed out and posted on bulletin boards. The interviews lasted 30 and 40 minutes and when necessary, I followed up with a 5 to 10 minutes interview for clarification of responses and accurate transcription and triangulation of the interview data. I used the semi structured interview question protocol tool (Appendix C) to conduct interviews in private conference rooms at a local community library.

A licensed health care professional with a PhD in Behavioral Health reviewed, validated, and verified the interview questions used for this study. The health care expertise was within the scope, content, and subject matter of the research, used to investigate and explore the young adults' perspectives of familial communication received from families related to their decision to smoke. There were no unusual incidents or circumstances involved with any participant during data collection, and no participant voiced any issues or concerns.

Data Masking

For the protection of all participants in this study, I masked all identifiable characters and information of all participants. I used letter and numbers such as PP1 and PP2 at random to identify the source of data collected. I informed all participants about strict confidentiality and privacy of the information provided, with accordance of Walden University ethics for human research. I included all the information in the required consent form for all participants to read and sign (Appendix B). I taped recorded all

interview sessions and took written notes as well. I stored all data collected on my computer with secured password to ensure strict privacy.

I as the sole researcher had the only access code to my computer. I locked all written, transcribed, and audio tapes data in a file cabinet in my home office and I was the sole custodian of the keys to my office and the cabinet. I also masked faces of participants with big black block who individually on their own volition at different times took pictures of selfies on my cell phone holding up the flyer. My cell phone was also password protected and the participants gave permission and authorization for me to keep the selfies. I will destroy all data including the pictures after 5 years. In Table 4, I provided the unique alphabetic and numeric identifiers for each participant.

Profiles

Profile information and other characteristics emerged during the data collection and interview processes. I provided below in a narrative format, the background and context of the participants interviewed with summaries of participants unique number identifiers in accordance to information reported by each participant. Included in the narrative format were, participants' age, race, smoking habit, occupation, education status, family type, number of family members, and income class. The study is not gender specific and I selected participants randomly by using a convenience-based type of sampling method.

Participant 1, #PP1, was a 22-year-old young adult, high school graduate and had attended a vocational school to become a dental assistant. PPI identified as a White female residing in the northeastern regional community of New Jersey. PP1 reported having both biological parents at home and a family size of five from a middle-class

socio economic status. PP1 reported a smoking habit of 15 cigarettes to a pack of cigarettes per day, started smoking at the age of 18, and has been smoking for 4 years. PP1 reported feeling stressed at home and job and mother was a smoker.

Participant 2, #PP2, was a 24-year-old young adult, a high school graduate and did not attend college or vocational school. PP2 worked at a local mall as a store clerk. PP2 identified as a White female residing in the northeastern region of New Jersey. PP2 reported adopted since birth and a family size of three from a low-class socio economic status. PP2 reported smoked her first cigarette from the age of 17 and has been a pack-a-day smoker. PP2 has been smoking for 5 years and reported no pressure at home but always wandered about her biological parents and takes cigarettes breaks frequently. PP2 reported being loved and does not lack anything at home but reported her adoptive father as a smoker.

Participant 3, #PP3, was a 19-year-old young adult and a high school dropout. PP3 reported completion of middle school, but studied and passed his General Education Diploma (GED) afterwards at 19 years of age. PP3 identified as a White male residing in the northeastern region of New Jersey. PP3 reported living with his biological mother and a stepfather since the age of nine along with three other siblings, two older stepbrothers and one biological younger sister from his mother and stepfather, total of family size of six and low-class socio economic status. PP3 reported starting his first cigarette at aged 16 with about 5 to 10 cigarettes per day, and has been smoking for 3 years. PP3 reported his two older brothers smoked cigarettes as well. PP3 did not disclose any problems at his home environment.

Participant 4, #PP4, was a 20-year old young adult enrolled full time in the local County's' community college in pursuit of an Associate Degree and planned to attend a four year college for his Bachelors' Degree. PP4 reported working part time as a waiter as well. PP4 identified as a Hispanic male immigrant from South America and arrived in the United States at the age of two. PP4 resides in the northeastern region of New Jersey and reported both biological parents, and three other siblings; two older brothers and one younger sister born in the US. PP4 reported a family size of six and from a low-class socio economic status and he is the first in his family to attend college. PP4 reported starting his first cigarette at the age of 15, smokes about 3 times a week of about 10 cigarettes and has been a smoker for 5 years. PP4 reported his two brothers' smokes, as well as his father. PP4 reported that it was common for men to smoke in his ancestry of South America. PP4 reported close family dynamic at home but did not volunteer any further information regarding his home environment, but stated that he left loved and always listened to his family.

Participant 5, #PP5, was a 19-year-old young adult newly graduated from high school and gained a college admission for fall 2016. PP5 identified as a White female residing in the northeastern region of New Jersey and reported living with her mother; a single parent of middle-class socio economic status. PP5 reported father was deceased due to a result of a motor vehicle accident when she was 15 and her mother has since not remarried. PP5 reported starting her first cigarette at age 15 as a result of the tragic death of her father and smokes about 3 to 4 times a week of 6 to 10 cigarettes. PP5 reported her mother smokes as well and thinks that the habit helps both of them cope with the loss. PP5 reported loved by both parents and loved smoking with her mother and spending

time with her as according to PP5 “We are all we’ve got … Just my mom and me.” PP5 stated she is happy and sad to go off to college, leaving her mother.

Participant 6, #PP6, was a 24-year-old young adult and a high school dropout. PP6 reported working at a local community fair park as a coordinator. PP6 identified as a Black male residing with his mother, grandmother, and he is the oldest of four other siblings. PP6 reported not knowing the where about of his father, and has a family size of seven from a low-class socio economic status. PP6 reported smoking his first cigarette at the age of 13 and has been a smoker for 11 years. PP6 reported smoking a pack-a-day that he gradually ended with. PP6 reported both mother and grandmother smoked cigarette but his mother stopped a few years ago. PP6 reported feeling stressed about money issues and the expenses of cigarettes are of concern to him and his mother.

Participant 7, #PP7, was a 22-year old young adult, and a full time under graduate junior student in college. PP7 identified as a White male residing in the northeastern region of New Jersey, with both his biological parents and another twin brother and sister in high school. PP7 reported commuting to college from home. PP7 reported a family size of five and from a middle-class socio economic status. PP7 reported smoking his first cigarette at the age of 14 has been smoking for 8 years and smokes about a pack of cigarettes per week. PP7 reported smoking 3 to 4 times weekly and shares cigarettes with both twin siblings who smokes. PP7 reported no issues at home, feels loved, and loved all his family.

Participants 8, #PP8, was a 23 year-old young adult, high school graduated and works with father landscaping and masonry business as assistant manager. PP8 identified as a White male residing in northeastern region of New Jersey and lives in the basement

of both biological parents single family home. PP8 reported a family size of three and middle-class socio economic status. PP8 reported smoked his first cigarette at age 18 and has been smoking for 5 years. PP8 added that he smokes about 10 to 15 cigarettes per week and reported father smokes. PP8 did not disclose any issues at home, enjoys staying in his private quarters in the basement apartment, as well as enjoys having meals with his parents in the family kitchen, most especially on Sundays.

Participant 9, #PP9, was a 20-year old young adult just graduated from high school. PP9 reported a late graduation due to a repeated grade in middle school. PP9 was unemployed, helped her family with household chores, and hoped to have a career in fashion. PP9 identified as a White female residing in the northeastern regional community of New Jersey. PP9 reported being a middle child from a family size of five with both biological parents from a middle-class socio economic status. PP9 stated both parents and older brother smoke. PP9 reported smoking habit started one year ago on her nineteenth birthday. PP9 smoked up to 10 cigarettes daily and enjoyed the habit as she gets to be more creative in fashion ideas when smoking a cigarette. PP9 did not disclose any further information regarding her creative ideas, PP9 reported feeling loved at home and enjoys spending time with family and friends.

Participant 10, #PP10, was a 20-year young adult, is a high school graduate and worked at a local restaurant as a waiter. PP10 identified as a Black female residing with her mother who is a single parent in the northeastern region of New Jersey. PP10 reported her official family size as two, but stated relatives are frequent quests at their home in a middle-class suburban-gated community. PP10 reported started the habit of smoking at age 18 and has been smoking for 2 years. PP10 stated her mother smoked cigarette and

weed, but she had tried weed, did not like the feeling and stuck to cigarette instead. PP10 smoked up to 10 cigarettes daily. PP10 worries about money but felt loved at home. PP10 reported cigarettes are becoming too expensive and was seriously considering quitting the habit. PP10 voluntarily reported her decision to quit smoking after reading the information I provided to all participants located in Appendix E.

Participant 11, #PP11, was a 21-year old young adult enrolled as a senior in the county community college and looking to transfer to a four-year college in the fall of 2016. PP11 worked part-time at a nursing home in New Jersey. PP11 identified as an Asian female residing with her guardian aunt, uncle, and a niece in the northeastern regional community of the State of New Jersey. PP11 reported a household of four family members from a middle-class socio economic status. PP11 reported starting the habit of smoking at the age of 18, smoked 10 to 20 cigarettes weekly, and have been smoking for 3 years. PP11 reported her niece also smoked. PP11 did not disclose any issues at home, reported loved, and loved her family.

Participant 12, #PP12, was a 23 year-old young adult enrolled in a New Jersey State's college and loved to sing with a college band for local area bars during non-college hours. PP12 identified as a White female residing with her father and stepmother in the northeastern region of New Jersey. PP12 reported a family size of four from a middle-class socio economic status. PP12 reported smoking her first cigarette at the age of 22, has been smoking for one year, and enjoys the habit and social life with it. PP12 reported a loving family structure and stepmother smoked. PP12 reported interest in singing and acting and supported by her family in whatever career path she wanted to pursue.

Participant 13, #PP13, was a 23-year-old young adult, high school graduate and worked at a nursing home in the business office department. PPI disclosed his grandfather newly admitted into the nursing home. PP13 identified as a White male residing in northeastern region of New Jersey. PP13 disclosed a family size of six that included biological parents, grandmother, a sibling, and grandfather who newly admitted to a long-term care facility. PP13 reported a middle-class socio economic status and disclosed grandfather-smoked cigarettes. PP13 reported starting the habit of cigarette when he was 22 and has been smoking about 8 to 10 cigarettes weekly for one year but hoped to quit the habit soon. PP13 reported the declined health of his grandfather and the subsequent admittance into a nursing home created issues and stress in this family. Nevertheless, that all the family members pulled through the health problems and felt loved and support at home.

Participant 14, #PP14, was a 25-year old young adult, high school graduate and worked as a customer service representative at a local electronic chain store. PP14 identified as a White male residing in the northeastern region of New Jersey with a family size of seven including biological parents, an uncle, and three other siblings from a low-class socio economic status. PP14 reported a 4-year habit of smoking since age 21 and smoked about 6 to 10 cigarettes weekly. PP14 reported money being tight and would have progressed to daily smoking but due to the increased cost of cigarette, was unable to do so. PP14 added his father and uncle smoked daily, and apart from the chaotic noisy environment at home, he does not stress much and that his family loved each other.

Participant 15, #PP15, was a 25 year-old young adult, a college graduate and worked as a retail manager. PP15 identified as a White male residing with his biological

parent, his girlfriend, and younger sister in his parents' home located in the northeastern region of New Jersey. PP15 reported a family of five from a middle-class socio economic status. PP15 and his girlfriend occupied the basement apartment but share meals in the family eat-in kitchen. PP15 stated he was 20 years old when he started the habit of smoking with his girlfriend whom he had been dating for 5 years, and had been smoking for 5 years as well. PP15 reported smoking a pack of cigarette daily. PP15 reported his father and girlfriend smoked. PP15 did not disclosed any problems or stress at home and stated his appreciation to his parents to let him and his girlfriend live in the house in order for them to save for their wedding and eventually purchasing their own home. PP15 felt loved and supported by his girlfriend and his family.

Data Analysis

I used Van Manen's eight-step methods of data analysis to analyze my data collected for this study. I outlined in Table 3 the eight-steps of analysis aligning the data first to; read, interpret, transcribe, confirm, compare, identify, draft and finally the results of the data collected. In addition, for data analysis, I used NVivo software, as well as hand coding methods to enable organization of the interviews into common themes and trends for possible synthesis and in-depth of the core essence and phenomena of the participant's perspectives and lived experiences.

For movement of data inductively from coded units to larger representation of categories and themes, I analyzed the data within the blended theory of the social learning theory (SLT) and the theory of planned behavior (TPB) illustrated in the theoretical foundation of Table 1 and aligned the research questions to the conceptual framework as illustrated in Table 2. The framework of this study was designed to

investigate and explore young adults' perception of cigarette smoking, based on the familial communication received from their families. I bracketed the results of the data collected in this study by constructs aligned with both theories (SLT and TPB) and coded the data by the 11 categories within the interview questions and reported common themes and clusters that emerged during the interview process with the participants.

The specific codes, trends, categories, and themes used, I formulated from the two research questions, the two sub research questions, and the 11 interview questions as outlined in the linkage of the blended theoretical foundation in Table 2 and included:

- Bandura's (1977, 1986) SLT was linked and aligned with research questions, the sub research questions as well as the 11 interview questions that all dealt with the construct and concept of social learning.
- Higgins & Conner (2003) TPB was link and aligned with the research questions, the sub research questions, and the 11 interview questions that dealt with the construct and concept of planned behavior.

Evidence of Trustworthiness

Credibility

I conducted one last interview after the completion of the data collection for this study. This was to review and verify the credibility of the literature gap and recent publications as pertained to young adults' perspectives towards tobacco use. I did not find any new information on the topic of study. I applied all trustworthiness training learned from my courses in Walden University, my affirmation of oath in my Institutional Review Board (IRB) application, as well as the training techniques learned from the National Institute of Health Office of Extramural Research to protect human research

participants (Appendix D). Finally, I assured trustworthiness in this research without threats that jeopardized the quality of the study or the research participants and asked for permission and approval before conducting any audio recording of the interview.

I maintained credibility by conducting myself in an utmost professional manner and treated every participant with dignity and respect. I provided enough time of 30 to 40 minutes for the interview but was available for 20 minutes before the interview to prepare the private room and after the interview for about 20 minutes per participant to reset the room and chairs or for any further questions, concerns, or issues that a participant may have. I also worked in a timely and diligent manner with the staff of the local library that provided the private room for my interviews to ensure that all schedules kept.

According to Patton (2002) as cited in Mason (2010), contact of approximately 60 minutes were provided to interview and answer all questions to each participant to assure detailed, thick, and rich responses were collected. I limited participants sampling to 15 to limit saturation to the point of no new or relevant information. After the interview as a form of member checking, I provided participants individual transcription of each person's interview and confirmed information and responses are correct.

Transferability

I established transferability protocol within this study to the degree that other researchers may be able to research and conduct more studies to investigate and explore young adults' perspectives towards tobacco use among other regions of New Jersey and perhaps other States in the U.S. I established results summary table for possible dissemination on this study to health services, health care administrators, parents, young adults, families, schools, medical and nursing journals with examples of young adults'

viewpoint to promote the cessation of smoking and techniques to seek counseling from health professionals before or during initiation of the habit of smoking. In addition, I collected detailed, rich, and thick data by utilizing open-ended questions interview technique to capture and gain an in-depth perspectives, viewpoints, and experiences from the young adult participants of this study.

Dependability

I attained dependability by the use of triangulation and through establishing an audit trail. I audio recorded the interview and complied the data analysis to justify the conclusions of the result. I used triangulation in the data analysis process with Van Manen's eight-step methods and NVivo software to enable an organized collection of interviews into themes and trends for possible synthesis and interpretation of the data.

Confirmability

I achieved confirmability and reliability of this study by checking and rechecking of data collected with member checking, and throughout the research process. I used the eight-step methods of Van Manen to; read, interpret, transcribe, confirm, compare, identify, draft and the results of the data collected contributed to all trustworthiness principles (Goodrich (2012).

Results of the Study

The results of the study, as illustrated in Figure 2, were organized and reported based upon the alignment of the research questions and the sub questions established within the blended theoretical foundation that included the SLT and TPB.

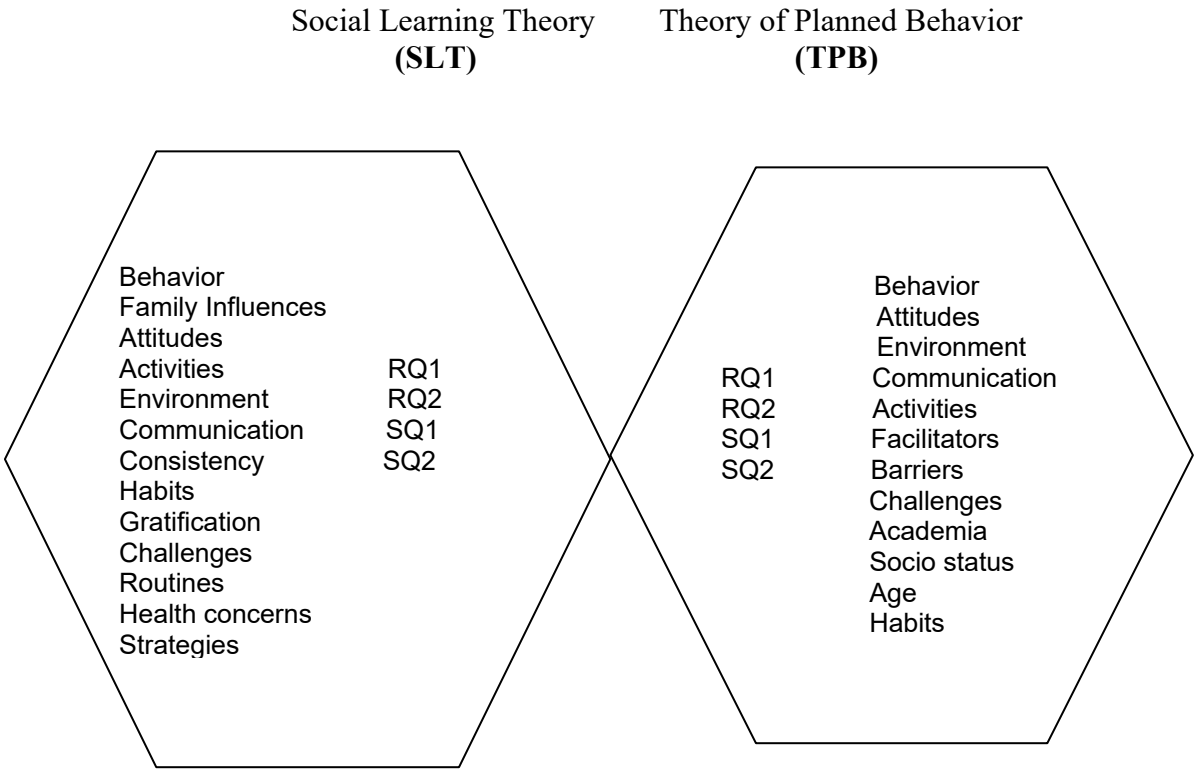

Figure 2. Results of the study.

As illustrated in Figure 2, the results of the study are organized within the blended theoretical foundation and framework related to the SLT and TPB as evidenced by; family influences, daily behaviors, attitude, strategies, activities, environment, communication, consistency, academia, habits, gratification, routines, barriers, facilitators, and health concerns. In the upcoming sections, I expanded upon the results, clustered the results, and reported the top five themes that emerged from each interview question. Finally, I provided full detailed quotes and responses from each interview questions located in tables in the appendices that included common themes, trends, clusters, and frequencies reported by the participants.

Social Learning Theory (SLT)

Bandura's (1977, 1986) SLT established that parents, teachers, and society positively influence children through social contexts of observation, learning, monitoring, and interacting. The SLT corroborated that a young adult's choice for the use of cigarettes or tobacco products are usually by learned behavior, as evidenced by the familiar messages received from their family members. Furthermore the SLT provided rationalization that these groups of individuals' developed this type of habit by watching, imitating, and molding of the people that surround them, such as their families (Bandura, 1977, 1986). In Figure 3, I depicted how the social learning theory concepts aligned with the RQ1, RQ2, SQ1, and SQ2 to relate to how young adults are positively influenced and to recognize the unhealthy smoking habits of familial communication from their parents or guardian in their home environment. As noted in Table 2, the 11 interview questions (IQ's) were formulated to answer the research questions (RQ) and the sub questions (SQ) to explore perceptions, lived experiences, behaviors, and social learning.

With IQ1 to IQ5 aligned to RQ1, RQ2, SQ1, and SQ2, I investigated and explored young adults' first use of the product, the numbers of cigarettes smoked, including the frequency of such habit. I further investigated the family behavior at home related to smoking, as well as young adults' lived experiences and perspective related to familial communication that played an influence to start the habit. Young adults interviewed reported the following top five results:

- family members who smoked (15 of 15 [100%]);
- smoking-related behaviors and familial communication (15 of 15 [100%]);

- influenced habit forming (14 of 15 [93%]);
- daily habit of ten or more cigarettes (12 of 15 [80%]); and
- started smoking in teenage years (11 of 15 [73%]).

A complete listing of all common themes, trends, and clusters that emerged related to young adults' perspectives and experiences on tobacco use and significant quotes listed in Appendices G; H; I; J; and K.

With IQ6 to IQ11 aligned to RQ1, RQ2, SQ1, and SQ2, I investigated, examined, and explored factors, gratifications, effect strategies, challenges and barriers, including health concerns related to smoking and tobacco use among young adult participants who reported the following top five results:

- long-term effects and health concerns related to tobacco use (13 of 15 [87%]);
- past or current influential factors associated to smoking (12 of 15 [80%]);
- gratification of smoking and tobacco use (11 of 15 [73%]);
- challenges and barriers impeding efforts to quit the habit (10 of 15 [67%]); and
- strategies attempted for smoking cessation without success (9 of 15 [60%]).

A complete listing of all common themes, trends, and clusters that emerged to young adults' perspectives and experiences associated to smoking and tobacco use were provided in Appendices L; M; N; O; P; and Q.

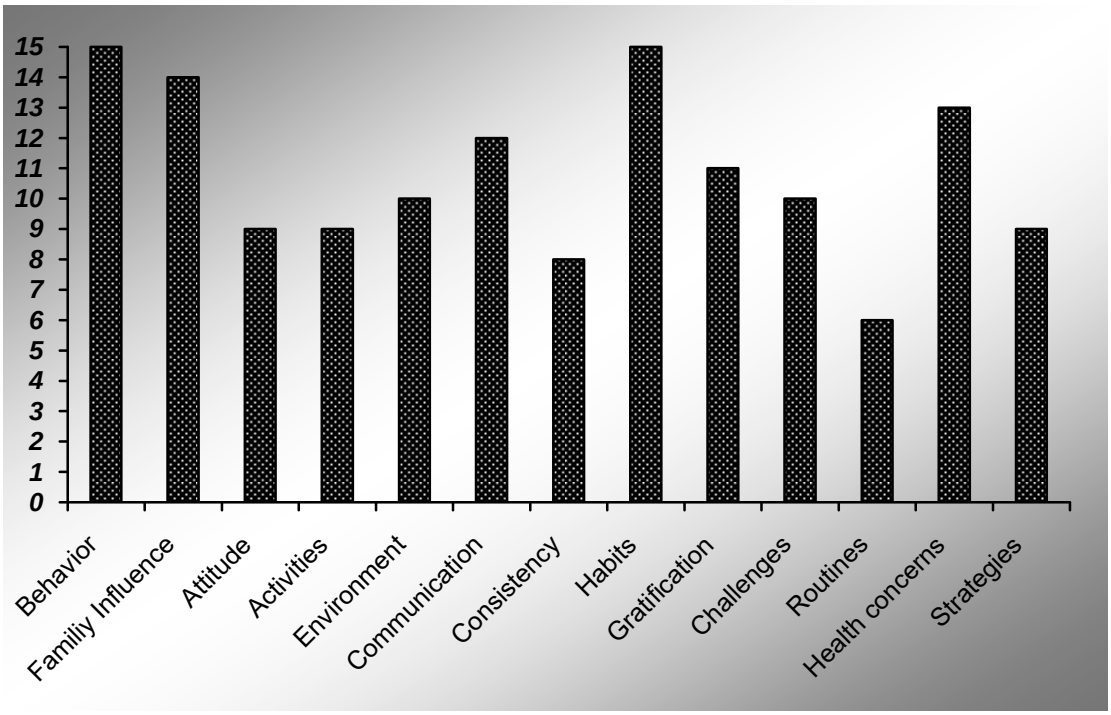

Figure 3. Findings related to SLT.

Theory of Planned Behavior (TPB)

Higgins and Conner's (2003) TPB established the core concepts and constructs of behaviors learned by example in the familial environment by identifying the young adults' intentions to engage in cigarette usage and behaviors. I used these concepts for my study to provide the investigation of the constructs that related to the research phenomenon of young adults ' perception of tobacco use based on the familial communications of smoking-related messages that are generated from young adults home. According to Anfara (2010), the theoretical foundations of a research study is the base to explore the construct systematically as related to a research problem and phenomenon. As such, the concepts and constructs of my study concerned young adults' perception, recognition, behavior, and construing of the communication received from

their families in regards to smoking and tobacco use. Furthermore, the concepts I used aided in the promotion of healthy lifestyle habits and behaviors, health concerns and issues, as well as addressed and clarified disparities among the family dynamic at home (Whittaker, Cox, Thomas, & Cocker, 2014).

In Table 2, I provided a detailed tabular format of how the TPB aligned with my research questions and sub questions related to the realization of the parental figures' position in the young adults' life that influenced the socialization and behaviors of my targeted population (Ganley & Rosario, 2013). Therefore, to answer these research questions, I formulated the 11 interview questions (IQ's) to explore and gain an in-depth understanding and knowledge of the young adult perspectives, experiences, behaviors, factors, influencers, and challenges related to smoking and tobacco use in their homes.

With IQ1 to IQ5 aligned to RQ1, RQ2, SQ1, and SQ2, I explored and investigated young adults' age of first use of cigarettes, the numbers of cigarettes smoked, including the frequency of such habit. I investigated family behaviors at home related to smoking, as well as young adults lived experiences and perspective related to familial communication that played an influence to initiate smoking or tobacco use. Young adults reported the following top five results:

- family members who smoked (15 of 15 [100%]);
- influenced habit forming (13 of 15 [87%]);
- smoking-related behaviors and familial communication (12 of 15 [80%]);
- daily habit of ten or more cigarettes (12 of 15 [80%]); and
- started smoking in teenage years (11 of 15 [73%]).

A complete listing of all common themes, trends, and clusters that emerged related to young adults' perspectives, behaviors, and experiences on smoking including significant quotes listed in Appendices G; H; I; J; and K.

With IQ6 to IQ11 aligned to RQ1, RQ2, SQ1, and SQ2, I investigated and explored past or current factors, gratifications, behaviors, strategies, challenges, and barriers, including health concerns related to smoking and tobacco use among young adult participants. The following top five results reported were:

- long-term effects and health concerns related to tobacco use (13 of 15 [87%]);
- past or current influential factors associated to smoking (12 of 15 [80%]);
- challenges and barriers impeding efforts to quit the habit (11 of 15 [73%]);
- gratification of smoking and tobacco use (11 of 15 [73%]); and
- strategies attempted for smoking cessation without success (9 of 15 [60%]).

A complete listing of all common themes, trends, and clusters that emerged to young adults' perspectives, behaviors, and experiences associated to smoking and tobacco use were provided in Appendices L; M; N; O; P; and Q.

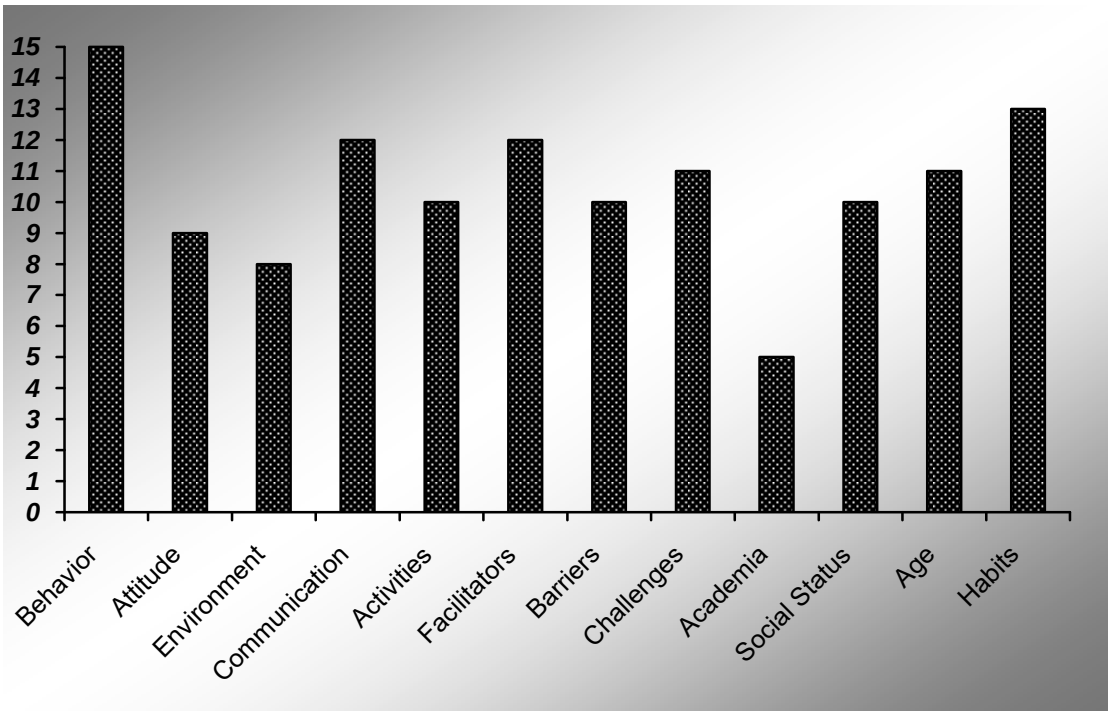

Figure 4. Findings related to TPB.

Table 5

Key Findings From the Study

Research questions	Theoretical foundations	Key findings, and concerns reported by young adult participants that played a role in their decision to smoke, and may promote healthy lifestyle choices
RQ1, RQ2 SQ1, SQ2	SLT	Daily behaviors, communications, attitudes, consistency, daily activities, family meals and meetings, activities, facilitators, barriers, academia, age, verbal and nonverbal cues, and socioeconomic status.
RQ1, RQ2 SQ1, SQ2	TPB	Family activities, behaviors, communication, attitudes, age, education, verbal and nonverbal messages, facilitators, socio status, challenges, environment, barriers, and habits

The above findings from this study as I represented in Table 5, provided an insight and significant examples, viewpoints, and understanding from young adults interviewed. The study results I found may contribute to mechanisms by which parents and guardians perceive and recognize young adults with potential unhealthy lifestyle habits generated by their familial communication. These reported lived experiences may contribute to efforts and strategies by family members to better decrease or modify information generated among adolescents and young adults in their environment to promote healthy lifestyles choices and habits.

Summary

The purpose of my descriptive phenomenological qualitative research study was to investigate and explore young adults' perspectives towards tobacco use, with primary population sample of young adults residing in the northeastern region of New Jersey. The research questions and sub questions were design to explore how young adults perceive and recognize behaviors and familial communications among their parents or guardians that played a role in their use of cigarettes. Key findings included parental behaviors and communications influences on young adults' use of tobacco during the teenage years.

For RQ1, RQ2, SQ1, and SQ2, I discovered social learning mechanisms reported by young adults to perceive and recognize parental behaviors and communications both verbal and nonverbal with potential unhealthy habits related to behaviors, consistency, daily activities, family meals and meetings, attitudes, barriers, academia, age, habits, and socio economic status. I was able to track trends and themes related to smoking and tobacco use in the home environment along with health concerns of long-term effects of smoking and provided counseling information for consult with health professionals

related to smoking cessation and the impact on health. Finally, I was able to overlap the findings with the SLT blended with the TPB related to family, environment, activities, behaviors, consistency, lifestyle changes, health professionals, and academia.

In Chapter 4, I provided an overview of the key results of young adults' perspectives towards tobacco use that led to the conclusions of this study. I described the study design, research setting, demographics and sampling, data collection and analysis, evidence of trustworthiness, and the results of the study. I provided in Chapter 5, discussions, interpretation of the findings, the study limitations and implications, conclusions, and recommendations for further research.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to investigate, explore, and gain an understanding of young adults' perspectives toward tobacco use by using a descriptive, phenomenological, qualitative approach. Using a descriptive phenomenological approach enabled me to obtain in-depth, thick, and rich details specific to the phenomena of young adults' perspectives related to their smoking habits as well as the familial influences on their initiation of the habit of tobacco use (Whittaker, Cox, Thomas, & Cocker, 2014). Prior researchers have studied and examined smoking and nicotine use in the adolescent and young adult population (Leavy et al., 2010). Few scholars have, however, examined the psychosocial perspectives of young adults regarding tobacco use, particularly the familial communication or messages that young adults receive that influence their initial decision to start the habit of smoking or the use of tobacco product (Bennet, Miller, & Wooddall, 2009; Leavy et al., 2010).

The main goal of my research was to focus on the perspectives of the young adult population related to tobacco use and the communication received from parents or guardians. Another goal of this study was to gain an understanding of the lived experiences of young adults' home environments, including how familial messages played a role in their initial decision to start the habit of smoking. Even though various treatment options and resources are available and may be sought for smoking cessation, an in-depth understanding and awareness generated from this study regarding the views and perspectives of young adults toward tobacco use, could play significant roles in minimizing or eliminating the beginning stages of the habit of cigarette smoking (Anfara,

2010; Simmon-Morton et al., 2011). With the awareness and understanding gained from the results of this study, family members, especially parents or guardians, may attempt to modify or decrease the messages that they emit to young adults.

Therefore, the adopted research design and rationale made it necessary to gain in-depth understanding through exploration of the social phenomenon and the thoughts of the individuals whom I directly studied. As stated by Cho and Kim (2014), a phenomenological method may be used to combine similar studies to result in a distinct and new conclusion. I used the design in this research due to its strength in identifying the young adults' intentions to engage in cigarette usage including the subsequent behaviors related to the habit of smoking. I also used this design in a social context because of the realization of the influence which a parental figure have in a child's life and that such position of a parent or guardian should not be underestimated (Ganley & Rosario, 2013; Higgins & Conner, 2003). The methodological rationale was that a phenomenological method may be used to combine similar studies to result in a distinct and new conclusion, as well as to estimate percentages of consumers who engage in risky behaviors such as cigarette smoking and use of tobacco products. As such, young adults' perceptions and lived experiences in their familial environment regarding the issue of smoking cannot be quantified (Cho & Kim, 2014; Patti, 2014). This adopted research design and rationale made it necessary to gain an in-depth understanding through exploration of the social phenomenon and thoughts of the individuals whom I directly studied.

The key findings I discovered from this study pertained to the perspectives and lived experiences of young adults concerning tobacco use. I interviewed 15 young adults

who resided in the northeastern region of the State of New Jersey. I used strategies included in the semi structured interview questions and generated themes reported by the participants. I recognized themes such as; behaviors, communications, daily activities, consistency, family meals, and meetings.

Other themes included attitudes, barriers, facilitators, habits, academic experiences, verbal and nonverbal cues, age, and socioeconomic status related to young adults' perspectives and viewpoints toward the unhealthy habit of smoking based on communication or messages received from their parents or guardians. The interview questions and strategies were used to explore and gain an understanding and knowledge of the influences of parents or guardians on young adults' lifestyle and choices. In investigating the types of influences that played a role in young adults' initial decision to smoke, I sought to answer the research questions and subquestions related to communication, behaviors, environment, parental influence, and barriers and facilitators for tobacco use in young adults.

RQ1: What are young adults' perceptions of the information or behaviors they receive from family members regarding smoking?

RQ2: What are some perceived smoking-related communications or behaviors from family members that influence a young adult's decision to start smoking?

SQ1: What do young adults perceive to be facilitators to start smoking?

SQ2: What do young adults perceive to be barriers to start smoking?

A brief summary of the top five findings is as follows: In response to RQ1, demographic data showed that 100%, or 15 out of 15 participants interviewed lived with family members who smoked. For RQ2, 100% of participants maintained and reported

lived experiences of smoking-related behaviors and communication from their family members. Multifaceted themes emerged from the participants' responses to SQ1 and SQ2. I provided no background information to the participants on the interview question trends found throughout the study, yet themes identified based on the participants' responses confirmed parental influences on adolescents' and young adults' lifestyle choices.

Interpretation of the Findings

The findings I generated from this study might enable healthcare professionals and the public to have a better understanding of young adults' perspectives toward tobacco use, including cigarette smoking. This study's purpose was to support adequate resources, treatment options, and strategies to promote healthy lifestyles for adolescents and young adults that might persist into adulthood. The findings I generated from this study may provide significant viewpoints, perspectives, and examples from young adults' lived experiences with the promotion of healthy lifestyle choices as well as extend further upon information reported within the prominent themes of the study.

Research Question 1 (RQ1) sought information about young adults' perceptions of information or behaviors presented by their family members in relation to smoking. The responses from the 15 young adults randomly selected from the northeastern region of New Jersey yielded fundamental demographic data. As reported in Chapter 4, all 15 participants reported experiencing smoking-related behaviors and communications from family members. Eleven out of 15 reported smoking their first cigarette during their adolescent years (ages 13 to 19).

The demographic data for RQ1 had several commonalities with information found in the literature review. For example, the literature review indicated that young adults are prone to influences over their thought processes, behaviors, actions, or aspirations by several factors, including their family members, and one product of such influence is the habit of cigarette smoking (Urberg, Qing, & Deginmencioglu, 2013). All of the participants' responses, including 100% of the data reported for this first research question, confirmed and showed that behaviors, habits, and familial communications from adolescents' and young adults' family members, as asserted by Bandura (1977) as well as Higgins and Conner (2003), influence children, adolescents, and young adults positively or negatively in a social context.

PP3 stated, "I have two older brothers, and they smoke. I go on errands with them to buy cigarettes and watch them smoke. So I grew up thinking that it is okay to smoke." PP4 stated, "The men in our house smoke, my father, my brothers, so I smoke." PP5 stated, "I lost my dad to a motor vehicle accident. I smoke, and my mother smoke. I think cigarette helps us cope with our loss. We are all we've got … Just my mom and me." In this study, young adults were negatively influenced by their families regarding smoking and tobacco use, as evidenced by their use of cigarettes, and consequently formed the habit of smoking during their adolescent and young adult years.

This study findings expanded upon Bandura's (1977, 1986) SLT and established that parental figures, parents, and guardians positively influence children through social contexts of communication, familial messages, behaviors, habits, observation, learning, interaction, and monitoring, including verbal and nonverbal cues. Therefore, the interpretation and meaning of the findings, as evidenced by the top five Y-axis reported

frequency, is that children, adolescents, and especially young adults are influenced in a social context by the behaviors or words demonstrated by their family members, not limited to parents and guardians.

RQ2 sought information to describe the perceived smoking-related influencers from family members that played a role in the young adult to smoke. Study results for RQ2 brought forth trends and themes that addressed and confirmed that children, adolescents, and young adults are influenced by their family and environment that played a role in their habit to smoke. The themes and trends of the study findings mirrored prevalent themes found throughout the study literature. Interpretation of these findings in relation to the larger body of literature on the topic of young adults' perspectives towards smoking to include the conceptual framework for this study follows with examples in the next paragraphs.

The top five themes and trends identified by the participants were behaviors, habits, communications, family influences, and age. According to Urberg, Qing, and Deginmencioglu (2013), young adults are prone to be influenced by their thought processes, behaviors, actions, or aspirations by several factors including their family members, and one such influence was the habit of cigarette smoking. Researchers found significant percentages of consumers who engaged in behaviors such as cigarette smoking became dependent on the product by age 21 with such dependency generally developed between 1 to 3 years after the initial onset of smoking (Duncan, Lessov-Schlaggar, Sartor, & Bucholz, 2012; Harakeh et al., 2008; Malarcher et al., 2010).

PP6 stated, "I had my first cigarette when I was 13 years old, and I have been smoking for almost 11 years. Growing up, almost anyone I know smokes, my mother and

grandmother smokes. Oh! My mother stopped smoking a few years ago, but it's just what I see." PP7 stated, "I tasted my first cigarette, I think when I was 14. I have twin brother and sister and we share cigarettes. I have been smoking for 8 years, it's no big deal." The study expanded upon Higgins and Conner (2003) TPB that outlined the core concepts and scope of this research that suggested that young adults' behaviors, values, beliefs, attitudes, facilitators, and practices are emulated, learned, and influenced by their parents or guardians in their environment. All participants reported having family members who smokes. All participants reported lived experiences on smoking-related behaviors and familial communications from family members, 14 out of 15 participants reported and confirmed being influenced by family members and thereby formed the habit of smoking, with a daily consumption of 10 or more cigarettes, and 11 out of 15 participants reported starting the habit of smoking in their teenage years.

The interpretation of the top five findings to answer RQ2 found and expanded on the context that the perspectives of young adults and the dynamics of communication between young adults and their parents or guardian whether verbal and nonverbal cues, attitudes, perceptions, as well as behavioral cues are consistent with the TPB (Higgins & Conner, 2003).

The sub question 1 (SQ1) sought to introduce what young adults perceive to be facilitators to start smoking. Similar to the findings for the first and second research questions (RQ1 & RQ2), top-ranked themes for this research question aligned with prominent themes throughout the topic literature and phenomena. Gratification, environment, facilitators, social status, and activities ranked as the top five themes and trends identified and aligned with this SQ1. For example, O'Loughlin et al. (2014)

identified several factors such as social, economic, and environmental factors that played an influential role in young adults' decision to smoke (Hans & Van Rossem, 2011). The Center for Disease Control and Prevention also conducted a descriptive epidemiological study that confirmed the link of descriptive variables such as age, gender, and geographic location that played a part in adolescents' engagement in risky behaviors like smoking and alcohol products (CDC, 2010).

As discussed in this study, the conceptual framework and theoretical foundations guides the interpretation of the top five themes and trends, possible challenges, improvement and opportunities for positive social change, and integration. Twelve out of 15 participants reported facilitators played roles in their decision to smoke, 11 out of 15 participants reported personal gratification of cigarette smoking amounted to 80% and 73% respectively of the studied population. PP12 stated, "I enjoy smoking, it helps me to socialize better with friends. It keeps me calm and less moody." PP9 stated, "I like smoking, it keep me calm, it helps me make better decision, and I just personally like the nicotine rush." PP11 stated, "Smoking keeps me calm, helps me concentrate and make better decision about my school, and mostly it helps me lose weight." PP14 stated, "Cigarettes helps me reduce my stress level by being calm. My home is chaotic with noises, so I do not stress when I smoke."

The interpretation of the top five findings to answer SQ1 found and expanded on the context that young adults are positively or negatively influenced in a social context by their environment and parental figures. Such influences are on the recognition of behaviors and familial communications of both verbal and nonverbal cues that are consistent with the SLT (Bandura, 1977) and TPB (Higgins & Conner, 2003).

The sub question 2 (SQ2) sought to answer what young adults perceive to be barriers or challenges to start smoking. As was found with SQ1, the top five ranked themes and trends for SQ2 aligned well with prominent themes and trends found throughout the literature that included barriers, challenges, health concerns, social status, and activities. Thirteen out of 15 participants, which accounted for 87% of the study participants reported health concerns and long-term effects of tobacco use as a barrier to start the habit of smoking. Other challenges and barriers reported such as finances and cost quitting products, weight gain of 10 Lbs., or more, decreased participants' will power in terms of quitting as family members who still smokes at home, were reported by 10 out of 12 or 73% of the respondents.

Smoking and tobacco products are major causes of diseases and illness (CDC, 2013b). Diseases not limited to: cancers, lung cancers, cardiovascular diseases including ischemic, strokes, COPD, premature aging, premature and stillbirths, including suicidal behaviors, leading to morbidities and mortalities among smokers and nonsmokers alike (Covey, Berlin, Hu, & Hakes, 2012; Genuneit et al., 2010; Hbejan, 2011; Ohgami & Kato, 2010; Sultan & Elkind, 2012; Timothy & Nneli, 2010; WHO, 2014). PP14 stated, "Money is tight with me right now. Cigarette products and quitting products are very expensive, health insurance is expensive." PP15 stated, "I am grateful to my parents to allow me and my girlfriend to continue to live in the basement, or else I wouldn't be able to save money for my wedding. My health insurance does not cover quitting products." PP13 stated, "I am concern about health problems, I did quit smoking once, but I am hoping to quit soon. My grandfather is in a nursing home and it's got me thinking about quitting." The interpretation of the findings expanded on the construct and concept

aligned in the linkage of the blended theoretical foundation of the SLT and TPB (Bandura, 1977; Higgins & Conner, 2003).

I found as demonstrated in the Y- axis of Figure 4, factors that played significant roles that influenced young adults to engage in behaviors exhibited by their parents or guardians. I interpreted the data and found that the perspectives of young adult participants in this study are influenced by parental behaviors, communication; subtle messages including verbal and nonverbal messages, attitudes, habits, education, and socioeconomic status are factors that contributed to their choice for tobacco use. Therefore, the research findings demonstrated the affirmation, supported the analysis, and consequences resulted in negative outcomes for the young adults I directly studied. The reported influences and factors were related and aligned to the TPB as well as the promotion for better heathy lifestyle choices, habits, behaviors, and health concerns among adolescents and young adults population (Higgins & Conner, 2003).

Interpretation of qualitative data for the research questions and sub questions expanded upon Higgins and Conner (2003) TPB that outlined the core concepts and scope of this research that suggested that young adults' behaviors, values, beliefs, attitudes, facilitators, and practices are emulated, learned, and influenced by their parents or guardians in their environment. As asserted by my chosen theorist and the conceptual framework I utilized, concentrated, and guided this research study, the dynamics of communication between young adults and their parents or guardian whether verbal and nonverbal cues, attitudes, perceptions, as well as behavioral cues were consistent with the TPB.

Limitations of the Study

Several limitations pertained to this descriptive, phenomenological, qualitative study. The limitations include the use of convenience-based sampling of 15 young adults, which may not consistently represent the broad spectrum of perception of young adults globally. The sample participants were of predominately-White middle-class youth, which limited the generalization of replication of results across other populations as suggested by Garret and Williams (2012). The 2015 U.S. Census Bureau reported the demographic population of New Jersey in the northeastern region of United States was 8.8 million, and 68% were predominantly White. Among the 15 young adults who participated in this study, nine were Whites, which represented 60% of the demographic participant and posed as a limitation to my research (U.S. Department of Commerce [USDOC], 2015).

Other possible limitations of this descriptive phenomenological qualitative study included time, financial resources, and locale management for obtaining a representative population of young adults who used tobacco and had the habit of smoking. A phenomenological study is specific to a group of individuals who have experienced the same phenomenon of inquiry. Further, the outcomes and data collection are subject to the bias of the researcher (Creswell, 2009). Hence, for reasonable measures to address the identified limitations, I adhered to the parameters identified within the scope of the study and made sure that the population sample selections for this research were not limited to White youths but were distributed among young adults of various ethnicities, including African Americans, Hispanics, Asians, and other groups.

Recommendations

After interviewing, exploring, and investigating young adults' perspectives towards tobacco use among the residents of the northeastern region of New Jersey by utilizing the semi structured, open-ended interviewing techniques, my recommendations were for further expansion of this topic and study to other regions throughout the United States. Since the gaps in current and relevant qualitative research studies, including this study noted a lack of research on adults of other regions and different races, an examination of young adults of various ethnicities applies in order to design and implement effective smoking prevention and cessation programs for young adults (CDC, 2010). The exploration of young adults smoking habits versus the common trends, themes, clusters, and frequencies noted from the data collected are recommended for further research.

Implications

For this study, I focused on the perspectives of young adults towards tobacco use based on the familial communication received from their parents or guardians that played a role in their decision to smoke. The scope of the study research was also in relation to young adults' perceptions, behaviors, attitudes, and knowledge toward recognizing unhealthy lifestyle choices for enhanced and available resources of professional diagnosis and treatments options. The relevance of this study aligned with the goals of the U.S. Department of Health and Human Services (DHHS) and future goals and objectives for the improvement of adolescents and young adults' views including cessations of tobacco products, which may thereby improve young adults' health.

Potential Impact for Positive Social Change

Potential implications for positive social change from the findings of this study may provide information or impact parents or guardians to modify or decrease the messages or lifestyle behaviors emitted among adolescents and young adults which may save health care administrators and providers money, reduce time, expedite and make available treatment options and techniques for healthy living. Possible dissemination of this study included the provision of summary results to health services, health care administrators, study participants, parents, families, clinics, schools, medical, and nursing journals. Further dissemination of this study through peer-reviewed journals might extend the literature by addressing the research gap. Finally, Health care providers and professionals may advocate social change for the healthier lifestyles choices of adolescents and young adults, as the scope and context of this study were targeted for potential transferability.

Methodological, Theoretical, and/or Empirical Implications

There were no methodological, theoretical, and/or empirical implications for this study. The population I identified for this study was young adults 18 to 26 years from the northeastern region of New Jersey. The identified population was significant and justified for delving into the missing gap in literature detailed and addressed in Chapter 2 that dealt with the views and perspectives of young adults towards tobacco use and may advocate for a healthier lifestyle choices and living of young adults.

Recommendations for Practice

Recommendations for practice of this descriptive, phenomenological, qualitative study may possibly provide potential insight to the public regarding the views and

perceptions of how young adults are influenced by the messages generated from their familial environment in regards to smoking and therefore, may lead to a positive social change in healthier lifestyles of young adults. For further provision to effect positive social change, dissemination of this study's findings to the public, educators, and health practitioners may be in understanding the possible impact that family interactions have on smoking behaviors for young adults. As unfortunately, the general global population lacked awareness that family influences at home play a significant role in a young adults' lifestyle and choices (Garrett & Williams, 2012). Young adults' perspectives towards tobacco use based on the familial communications may enhance the knowledge, and understanding of past research involving adolescents and young adults health, growth, and development in the home are influenced by the family unit and dynamics (Simmon-Morton et al., 2011). In addition, healthy lifestyle choices among young adults may lead to decrease in morbidity of lung diseases, heart diseases, neurological factors, high blood pressure, and other various health comorbidities and disparities in the targeted population for this study (CDC, 2013b).

Conclusion

The findings I generated from this descriptive, phenomenological, qualitative study extended the knowledge of health professionals and families that included awareness and an in-depth understanding of the views and perceptions of young adults toward the type of familial messages received from their parents or guardians relating to tobacco or cigarettes that influenced their use of tobacco or cigarette smoking. The overarching positive insight of this study was that critical efforts might be made to modify or decrease behaviors and non-influential communication in the house among

adolescents and young adults. This might also extend the knowledge in the discipline of public health care services and administrations in the academic, clinical, and non-clinical settings.

The results I found may also aid to increase the awareness and knowledge family members attain to promote healthy habits for young adults population and to affect positively their daily behaviors especially towards smoking and tobacco use. Finally, for the health care providers and administrators, the results of this study I found may further add an insight for promotions, exploration, and conditions to understand and aid in available resources for young adults treatment options for a healthier choice and cessation of tobacco products among young adults.

By the understanding of young adults' perspectives towards tobacco use through these research findings, health care professionals may offer critical insight within the field of health services in public and private sectors. These valuable insights may contribute to the development and establishment of effective programs, treatment options, and solutions to improve young adults' health. This may thereby influence health care providers including administrators to maximize available resources, control expense, expedite treatment options and techniques, decrease health care insurance billing, as well as encourage and promote preventive measures for healthy lifestyle choices and habits for adolescents and young adults. Given these possible benefits and social implications, understanding young adults perspectives towards tobacco use as it pertains to their lived experiences and views within the family environment is an important and significant contribution to this research domain. A complete alignment matrix is provided in

Appendix R recapping the research questions, interview questions, theories, and findings of the study.

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Appendix A: Bulletin Flyer to Research Participants

Note: All photos/images taken & reprinted with permission by photographer Caroline Oluwatosin Adesanya, RN

Doctoral Research Study

Perspectives of Young Adults towards Tobacco Use

I am Caroline O Adesanya, RN, a PhD candidate in Health Services at Walden University. I am conducting a research study in the Northeast region of NJ (USA) related to the perspectives of young adults towards tobacco use.

I am seeking volunteer participants to interview either by phone, person to person, or via Skype. The interview time span may last between 30-40 min, at a conference room in an area local library of your choice. Timing is flexible, and at any time during the interview, you may withdraw if you feel uncomfortable with the content of the interview, without any penalty.

Participants Criteria for this Study are:

. Adults between 18 to 26 years old
. New Jersey Residents
. Current smoker, or smoked in the past
. Speaks English fluently
. If female, not pregnant

The Institutional Review Board (IRB) approval number from Walden University for this study is 01-28-16-0169469 and expires on January 27, 2017. If you are interested, please contact me at the information below.

Caroline Oluwatosin Adesanya, RN
PhD Health Services - Healthcare Administration Candidate
Walden University
College of Health Sciences
Caroline.adesanya@waldenu.edu

Appendix B: Informed Consent Letter

Perspectives of Young Adult towards Tobacco Use

IRB Approval Date: January 28, 2016

Dear Prospective Research Participant,

This is an informed consent letter to confirm that you are invited to participate in this research study. This study was approved to start by the Institutional Review Board (IRB) with an approval number 01-28-16-0169469. The purpose of this research study is to explore your perceptions and experiences regarding the perspectives of young adult ages 18 to 26 and the familial communication from their families towards tobacco use. Participation is voluntary, and participants should be able to speak English.

The interview may last between 30 to 40 minutes, and will be digitally recorded by phone, Skype, or face-to-face as you wish. After this interview, a follow-up interview may be needed to clarify your responses, and may take 5 to 10 minutes. The results of this interview can be published after the completion of this study, and a 1-2 pages brief summary will be provided to you of your choice either verbally, by mail, or by email.

I am not affiliated with any organization, whether government or private other than with Walden University, which is the college that I am attending to obtain my Ph.D. degree in Health Service, and the main reason for this research. There is a $5 token Starbucks gift card as a “thank you” for participation. At any time during the research study, you may withdraw if you feel uncomfortable with the content of the interview process or for no particular reason, and you do not have to return the “thank you” token $5 Starbucks gift card.

All information provided by you is confidential and guaranteed such as; I will not require or obtain any identifiable information from you. All information collected from you are placed under lock and key cabinet in my private office and password protected in my personal computer as only I, the researcher will have full access of the qualitative data generated, with exception of my Walden University professors.

There are minimal associated risks such as; fatigue, discomfort from sitting during the interview or with the research topic, or even irritability of time for participating in this study. I will try to not take too much of your time.

One of the benefits of this research is to help the community to have an understanding of young adults’ perception of familial communication from family members regarding the issue of smoking and tobacco inhalation, which will help continue with efforts to decrease the habit of smoking from the onset of adulthood.

There is no organization or company involved and there is no cost or compensation connected to me, or anyone, or the participants for this study, except for a "thank you" token $5 Starbucks gift card for each of the participants, provided by me, the researcher.

If you have any questions, issues, or concerns, please do not hesitate to contact me anytime at (xxx) xxx-xxxx or by email to caroline.adesanya@waldenu.edu. In addition, if you would like to know more about your rights as a research participant, you may contact Dr. Leilani Endicott at (612) 312-1210. The IRB approval number from Walden University for this study is 01-28-16-0169469 and expires on January 27, 2017.

If you agree that you meet the criteria listed on the flyer required for this research study, and would like to participate, please sign these two copies of consent forms by filling out the information below with the words "I consent" to confirm that you agree to participate in this study. Also for your records, please feel free to retain a copy of this informed consent letter.

Date of consent_____

Participant's Telephone Number_____

Participant's Email Address_____

Please indicate your preferred day and time to contact you for an interview

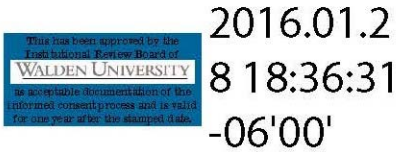
Sunday Monday Tuesday Wednesday Thursday Friday Saturday (please circle)

Time _____am_____ pm

Thank you very much.

Sincerely,

Caroline Oluwatosin Adesanya, RN
Ph.D. Candidate in Health Services
Walden University
Email: caroline.adesanya@waldenu.edu



Appendix C: Qualitative Phenomenological Interview Protocol and Questions

Perspectives of Young Adults Towards Tobacco Use

Introduction for the Interviewer: State name of the researcher, title, purpose of research, and the IRB approval number. Obtain young adult participants demographics including; age, gender, highest grade or level of education, smoking status, number of household along with gender and ages.

Informed Consent: Have participant to verbally state "I consent" to the terms outlined in the consent letter.

Finally, advice participant that interview may last 30 to 40 minutes, a 5 to 10 minutes follow-up may be needed, and reiterate that participation is voluntary and are free to terminate at any time. If necessary, administer icebreaker conversation.

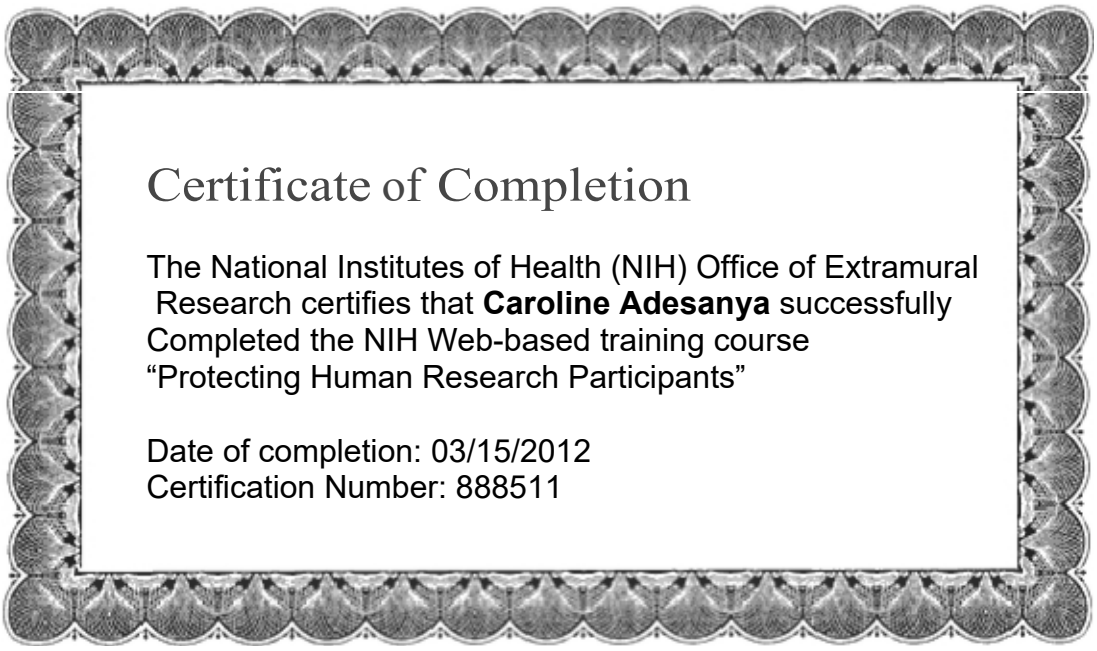
Interview Questions:

a. When was the age that you stated smoking, or first use a tobacco product? And how often do you smoke?
b. Are there any other persons who smoke in your family? If so, who and how many members smoke?
c. What type of smoking related communication or messages do you perceive or experience coming from your family members?
d. How influential were these types of messages or communication had on your decision to start smoking?
e. Does your family know that you smoke? If so, how do they feel about it?
f. What are the past or current factors within your family at home that causes you to smoke?
g. What do you derive from smoking?
h. Have you tried to quit the habit of smoking? If so, how successful did you get? What strategies did you use, and how effective were the strategies?
i. What are the challenges and/or barriers that you have experienced in your effort to quit the habit of smoking?
j. Have anyone in your family ever discussed with you the long-term effects of smoking?
k. Under what conditions and behavior do you perceive that smoking or the use of tobacco products as a health concern?

Conclusion: Thank the participant for their time, and as a special thank you gesture for the participant's help to contribute to the research data for positive social change to improve and gain more understanding for the health benefit of young adults population on the issue of smoking and tobacco products, provide the participant a token $5 Starbucks gift card. The researcher for any needed follow-up or verification may contact

participants. Finally, remind the participant of how and when the research study will be available for perusal, and how their data will be protected.

Appendix D: National Institute Research Card



Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Caroline Adesanya** successfully Completed the NIH Web-based training course "Protecting Human Research Participants"

Date of completion: 03/15/2012
Certification Number: 888511

Appendix E: Information on Free Family and Smoking Counseling

Online Help Support:

- www.TobaccoFree.org
- www.NYsmokefree.com
- www.BecomeAnEx.org
- www.quitnet.org
- www.quit4life.com
- www.questionit.com

Telephone Help Support:

- Smoke Cessation Hotline: 1800 QUIT NOW
- Nicotine Anonymous: 1-800-642-0666
- Call 311 or 1-866-NYQUITS
- In Patient Program: 1-866-359-3296

Clinic Support:

- The Mayo Clinic in Rochester, MN
- Preferred Behavioral Health, NJ (732-367-4700)
- Ocean Health Initiative, NJ (732-363-6655)
- St. Helena Hospital in Napa Valley, CA

Federal Bureau of Prisons Counseling
320 First St. NW
Washington DC, 20534
Phone: (202) 307-3198
Website: http://www.bop.gov/contact/

Note: The above reference list provides free smoking counseling and available tips and programs for any participant experiencing emotional or behavioral issues from the interviews and needing help with smoking-related problems.

Appendix F: Participant Screening Questions

Perspectives of Young Adults Towards Tobacco Use

1. Are you an adult aged 18 to 26 years?
2. Do you speak English language fluently?
3. Do you live in the State of New Jersey?
4. Do you smoke cigarettes? If so, for how long have you been a smoker?
5. Did you smoke cigarette in the past? If so, for how long did you smoke?
6. If female, are you pregnant?

Appendix G: IQ1

What was the age that you started smoking, or first use a tobacco product? And how often do you smoke?

#	Age	Common themes and clusters by young adults	Trends # of young adult smokers	Number of Cigarettes	Frequency Daily, Weekly, or Monthly
PP1	22	By age 18	4	15 -20	Daily
PP2	24	By age 17	5	20	Daily
PP3	19	By age 16	3	5 - 10	Daily
PP4	20	By age 15	5	5 - 10	3 times a week
PP5	19	By age 14	5	3 - 6	3 times a week
PP6	24	By age 13	11	20	Weekly
PP7	22	By age 14	8	20	Weekly
PP8	23	By age 18	5	10	Weekly
PP9	20	By age 19	1	10	Daily
PP10	20	By age 18	2	10	Daily
PP11	21	By age 18	5	10 - 20	Weekly
PP12	23	By age 22	1	10	Daily
PP13	23	By age 22	1	8	Weekly
PP14	25	By age 21	4	6	Weekly
PP15	25	By age 20	5	20	Daily

Appendix H: IQ2

Are there any other persons who smoke in your family? If so, who and how many members smoke?

#	Common themes and clusters reported by young adults	Trends	Frequency Smokes per day
PP1	Mother	Y	4
PP2	Adopted Father	Y	7
PP3	Step Father	Y	3
PP4	Brothers	Y	3
PP5	Mother	Y	5
PP6	Grand Mother	Y	2
PP7	Brothers & Sisters	Y	1
PP8	Father	Y	7
PP9	Mother & Father	Y	5
PP10	Mother	Y	6
PP11	Sisters	Y	2
PP12	Step Mother	Y	2
PP13	Grand Father	Y	6
PP14	Uncle & Father	Y	2
PP15	Mother & Father	Y	5

Appendix I: IQ3

What type of smoking-related communication or messages do you perceive or experience coming from your family members?

#	Common themes and clusters reported by young adults	Trends	Frequency Daily, Weekly, or Monthly
1	Smoking at home	6	Daily
2	Asked to retrieve cigarettes/lighter	6	Daily
3	Asked to retrieve cigarette from pack	5	Daily
4	Smoking in vehicle	4	Daily
5	Accompany family members on cigarette errands	4	Weekly
6	Social media	4	Daily
7	Television	3	Daily
8	Asked to lit cigarettes	3	Weekly
9	Asked to clean out ash trays	3	Weekly
10	Chewing tobacco	1	Daily
11	Observed a family member smoked while pregnant	1	2 to 3 times a Week
12	Family times	1	Weekly

Appendix J: IQ4

How influential were these types of messages or communication had on your decision to start smoking?

#	Common themes and clusters reported by young adults	Trends	Frequency by age
1	Very influential	7	18
2	Influential	5	17
3	Not influential	3	16
4	Sort of influential	2	15
5	Made no difference	4	14

Appendix K: IQ5

Does your family know that you smoke? If so, how do they feel about it?

#	Common themes and clusters reported by young adults	Trends Y N	Frequency Daily, Weekly, or Monthly
1	Family aware and approve	6	Daily
2	Family unaware	4	Daily
3	Family aware but disapprove	3	Daily
4	Family do not have a say in decision to smoke	2	Daily
5	Family aware and prohibit the habit	1	Weekly
6	Family encourages habit	1	Weekly

Appendix L: IQ6

What are the past or current factors within your family at home that causes you to smoke?

#	Common themes and clusters reported by young adults	Trends	Frequency
1	Daily smoking behaviors	6	5
2	Attitudes	5	5
3	Grocery stores trips	5	4
4	Stress & hostile communication	4	4
5	Alcoholic consumption	4	4
6	No quality family times & meetings	3	3
7	Lack of sleep	3	2
8	Electronic devices/Television	3	2
9	Boredom/Isolation	3	2
10	Holidays	2	2
11	Medications: Over the Counter & Prescriptions (OTC & Rx)	1	1
12	Sports & extracurricular activity	1	1
13	Physical abuse	0	0

Appendix M: IQ7

What do you derive from smoking?

#	Common themes and clusters reported by young adults	Trends	Frequency Days per Week
1	Addicted to the habit	13	7
2	Helps keep calm and less moody	11	7
3	Helps make better decision & focus	6	7
4	Helps with weight loss; eats less food	6	7
5	Helps reduces stress level & relaxation	5	7
6	Helps to concentrate at work/with chores	5	7
7	Reduces irritability/attitudes	5	7
8	Enjoys the feeling	5	7
9	Likes holding cigarettes	4	7
10	Likes the nicotine rush	4	7
11	Reduces anxiety/panic attack	4	4
12	Like the smell of tobacco	4	4
13	Able to socialize with confidence	3	3
14	Reduces pain such as lower back and headaches	3	3
15	Able to sleep well at night without sleeping aid of over the counter or prescriptions (OTC & Rx)	2	7
16	Able to fit among friends who smoke	2	4
17	Everyone at home smoke	2	7
18	Enjoys smoking & alcohol together	1	5
19	Like to watch TV	1	5
20	Like the smell of ash	1	5

Appendix N: IQ8

Have you tried to quit the habit of smoking? If so, how successful did you get? What strategies did you use, and how effective were the strategies?

#	Common themes and clusters reported by young adults	Trends	Frequency Days per Week
1	Sometimes - Enjoys the sensation of smoking, but unsuccessful	5	7
2	Yes - Unsuccessful. By cold turkey: Did not use any type of smoking cessation aid	7	7
3	Yes - Unsuccessful By Medications, patches, and chewing gums	4	7
4	Yes - Unsuccessful. By Hypnosis	2	7
5	Yes - Successful, but resumed again. By medications: over the counter and prescriptions (OTC & Rx)	4	7
6	On again, off again By television and media commercials.	3	7
7	Yes – Unsuccessful Due to health issues.	2	7
8	Yes – Unsuccessful Started gaining weight, so resumed smoking.	3	7
9	Yes – Unsuccessful Used e-cigarette, but no success. Like the visual effect of smoking	1	2
10	No – Not interested in quitting	1	0

Appendix O: IQ9

What are the challenges and/or barriers that you have experienced in your effort to quit the habit of smoking?

#	Common themes and clusters reported by young adults	Trends	Frequency of times attempted to quit smoking
1	Family members still smoke at home	7	5
2	Cost of quitting products not covered by health care insurance	7	4
3	Consumption of more food such as fast food	6	4
4	Consumption of more alcoholic beverage	5	3
5	Mood and attitude problems	5	3
6	Inability to stay focus	5	3
7	Experienced weight gain 10 lbs. or more	5	3
8	Insomnia	3	2
9	Quitting products not easily available as OTC	1	1
10	Not interested in quitting	1	0

Appendix P: IQ10

Have anyone in your family ever discussed with you the long-term effects of smoking?

#	Common themes and clusters reported by young adults	Trends	Frequency Times
1	Father and Mother or guardians	4	2
2	Grand Parents	4	2
3	No one in the family has had any conversation about this	4	0
4	Mother only	3	2
5	Father only	2	1
6	Siblings	2	1
7	Step-parents	1	1
8	Unable to recall any such conversation	1	0

Appendix Q: IQ11

Under what condition and behavior do you perceive that smoking or the use of tobacco products as a health concern?

#	Common themes and clusters reported by young adults	Trends	Frequency Daily, Weekly, or Monthly
1	Continued smoking for up to 30 to 40 years without quitting	6	Daily
2	Smoking of at least 2 packs a day for a long time of about 20 years	6	Daily
3	Smoking indoors and other people may be affected by second hand smoke	5	Daily
4	Smoking while pregnant	5	Daily
5	If a family have a history of lung cancer, then smoking under those conditions ae of health concerns	4	Weekly
6	Smoking and drinking alcoholic beverages at the same	3	Daily
7	Smoking itself, is a health concern and causes cancer, which causes illnesses and deaths	3	Daily
8	Smoking indoors and outdoors; pollution of the air and environment	2	Daily
9	Smoking among children	2	Daily
10	If a person is already sick and they continue to smoke, then the health conditions are exacerbated	2	Weekly
11	When the person is reaching middle age and getting older	1	Daily
12	Smoking cigarettes and mixing it with other types of herbs	1	Daily
13	Smoking and not eating	1	Daily
14	A person’s health will be declined even if the person does not smoke	1	Daily

Appendix R: Alignment of Matrix Findings

Theory	Research questions and Sub questions	Interview questions	Key findings
SLT TPB	RQ1: What are young adult's perceptions of the information or behaviors they receive from family members regarding smoking? RQ2: What are some perceived smoking-related communications or behaviors from family members that influence a young adult's decision to start smoking? SQ1: What do young adults perceive to be facilitators to start smoking? SQ2: What do young adults perceive to be barriers to start smoking?	IQ1: When was the age that you started smoking or first use a tobacco product? And how often do you smoke? IQ2: Are there any other persons who smoke in your family? If so, who and how many members smoke? IQ3: What type of smoking-related communication or messages do you perceive or experience coming from your family members? IQ4: How influential were these types of messages or communication had on your decision to start smoking? IQ5: Does your family know that you smoke? If so, how do they feel about it? IQ6: What are the past or current factors within your family at home that causes you to smoke?	SLT: • Behavior • Family Influence • Attitude • Activities • Environment • Communication • Consistency • Habits • Gratification • Challenges • Routines TPB: • Behavior • Attitude • Environment • Communication • Activities • Facilitators • Barriers • Challenges • Academia • Socio Status • Age • Habits

		IQ7: What do you derive from smoking? IQ8: Have you tried to quit the habit of smoking? If so, how successful did you get? What strategies did you use, and how effective were the strategies? IQ9: What are the challenges and/or barriers that you experienced in your effort to quit the habit of smoking? IQ10: Have anyone in your family discussed with you the long-term effects of smoking? IQ11: Under what conditions and behavior do you perceive that smoking or the use of tobacco products as a health concern?	