K. A Comparison of Psychosocial Factors and Tobacco Use Among Arab and Arab-American Adolescents: Preliminary Findings

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Objective

The purpose of this presentation is to compare psychosocial and tobacco use factors in Arab (Middle-Eastern born) and Arab-American (American-born) adolescents (14–18 years of age) who attended a suburban community teen health center near a midwestern city. The teen clinic services almost 2,500 youth visits each year. The majority of the clients that utilize clinic services are poor, undereducated, live in extended families of 3–5 adults, are immigrants, and speak Arabic as their first language. Those who self-identified as either Arab or Arab-American and who had smoked at least one cigarette in the past 30 days were recruited to participate in the testing of a culturally tailored smoking cessation/prevention intervention. Only descriptive information of the sample will be presented here.

Background

In Michigan, the smoking ratio for high school seniors is approximately 38%; for teenagers 14 to 18 years of age, the cigarette use ratio is approximately 28%.[1] A 1998 Wayne County Teen Health Needs Assessment Survey found overall tobacco use to be 28%; the smoking ratio for Arab-American youths was 34.3%.[2] State of Michigan smoking data for youths with an Arab or Arab-American identity are not available.

Since smoking ratios in Arab/Arab-American adults are among the highest in this nation and in the world, and survey data suggest relatively high tobacco use in teens, determining their definitive tobacco use patterns is important. Identifying factors that contribute to tobacco use in this rapidly growing young population is also necessary.[3]

The Adolescent Tobacco Use Model (ATUM) directed this evaluation.[4] It identifies moderating and mediating forces found to influence tobacco use in adolescents. Components are personal, sociocultural, and environmental. Personal factors include demographics (age, sex, socioeconomic status), tobacco use behavior (intention to use tobacco, tobacco use history, stage of change, strength of addiction), school grades, non-classroom activities, stress, self-esteem, self-efficacy, perceived health, and barriers to not using tobacco. Sociocultural influences are country of origin, family and peer tobacco use and pressure, and social support. Environmental conditions are availability of and advertising exposure to tobacco products.

Methods

Sample Adjusted

A total of 312 teen clinic adolescents (14–18 years of age) participated in the survey. Of these, approximately 80% were born outside the United States. Almost 61% were male.

Procedure

All teens between 14 and 18 years were asked to participate and to sign an

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approved informed consent and then to complete the study measures described in the introduction. It took adolescents 40 to 45 minutes to complete all of the scales. Each participant was given two theater ticket vouchers for their time.

RESULTS

Data analysis showed that Arab-American youths were: 1) significantly older (P=04); 2) more likely to have brothers (P=.04) and friends that smoked (P=.01); 3) more likely to have offers of tobacco each week from friends and family (P=.01); and 4) more likely to have tobacco products sent to them (P=.001) than Middle Eastern-born teens. Arab-American mothers were more likely to be born in the United States (P=.02), and the family income was significantly higher (P=.01) for Arab Americans. No differences were found for: 1) sisters who smoked; 2) number of smokers in the home; 3) hours of exposure to environmental tobacco smoke; 4) narghile use; or 5) levels of reported stress and health. Arab Americans were more likely to have smoked in the past 30 days (P=.01) and to have used the narghile.

Self-esteem scores for Arab-born and American-born youths were submitted to a t test. The results showed Arab-born participants (M=29.15) had lower self esteem scores than the American born (M=32.55), [t=−2.606, P<.01]. Depression scores were evaluated by the t test, with the same groups as before. This analysis showed that those born outside the United States had higher depression scores than those born in the United States [t=2.809, P=.05].

DISCUSSION

Arab Americans smoked more in the last 30 days than Arabs in the Middle East and more had used the narghile. This finding might be due to more exposure to tobacco products and advertisements while living in the United States. Arab Americans have higher incomes than Arabs, which means they could purchase tobacco more easily, and they were more likely to have older brothers and friends who smoked.

LIMITATIONS

Our sample was very small, with 63 Arab Americans and 249 Arabs. In addition, the Arab-American youth using the teen health clinic may have had more health problems related to smoking than the Arabs using the clinic because of their low incomes. Further research is needed to study both groups of Arab youths and compare them with non-Arab youths.

CONCLUSIONS

Arabs may be more prone to develop future smoking habits because they appear to be more depressed and to have lower self-esteem. Our goal was to study closely the difference between Arab-born and Arab-American adolescents and be able to develop the right interventions to decrease tobacco use in both groups. Our findings were surprising—Arabs were assumed to have higher smoking rates than Arab Americans, since several studies show that Arab countries have high smoking rates. In future studies, the danger of narghile use should be targeted; it is uncommon in the United States, but its use is growing.

IMPLICATIONS

Research results should be shared with physicians, mental health providers, and health educators to be able to address and correct Arab youth health problems.

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REFERENCES

1. Hammad A, Drzal N, El-Haj J, Abdulrahim S. *Arab Community Center for Economic Social Service Teen Health Needs Assessment Survey: An Arab Community-Based Approach.* Lansing, Mich: Michigan Department of Community Health; 1998.
2. *Michigan's Behavioral Risk Factor Survey.* Lansing, Mich: Michigan Department of Community Health; 1994.
3. Rice VH, Templin T, Kulwicki A. Arab-American adolescent tobacco use: four pilot studies. *Prev Med.* 2003;37:492–498.
4. Houston T, et al. Guidelines for diagnosis and treatment of nicotine dependency. Chicago: American Medical Association. *Am J Public Health.* 1994;77:1435–1438.