

## Acculturation and Cigarette Smoking Among Korean American Men

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This study examined the prevalence and correlated factors of cigarette smoking in a cross-sectional, epidemiological survey of Korean American men living in Maryland (n=333). In this sample, 26.1% were current smokers and 42.3% were former smokers. The older age group ( $\geq 40$  years) was more likely to have quit smoking than the younger age group ( $< 40$  years). In multiple logistic regression analysis, acculturation was associated with smoking status; those who stayed more than 20 years in the U.S. were less likely to be current smokers (OR=0.32, 95% CI 0.13-0.77) than those who stayed less than 10 years. Alcohol use was associated with smoking status; those who consumed alcohol were more likely to be current smokers (OR=5.24, 95% CI 2.33-11.79) or former smokers (OR=5.45, 95% CI=2.69-11.04) than those did not. Those with hypertension were more likely to have quit smoking (OR=3.11, 95% CI=1.33-7.24). The results suggest that the role of acculturation in smoking status among Korean American men deserves further attention by researchers as well as by health professionals who develop smoking prevention and cessation programs.

**Key Words:** Cigarette smoking, Korean-American men, acculturation, alcohol use

### INTRODUCTION

Smoking, responsible for more than one of every six deaths in the U.S., continues to be the largest single preventable cause of death and disability in the U.S and is associated with a

variety of negative health outcomes such as cancer, heart and lung disease.<sup>1</sup> Tobacco use varies within and among racial/ethnic minority groups. Among adults, American Indians and Alaska Natives have the highest prevalence of tobacco use, followed by African Americans and Southeast Asian men. Asian American and Hispanic women have the lowest prevalence.<sup>2</sup>

There is a public perception that smoking is not a serious problem among Asian Americans and Pacific Islanders (AAPIs). The 1997 National Health Interview Survey data show that AAPIs are the least likely ethnic group to smoke (16.9%), compared to Hispanics (20.4%), whites (25.3%), African Americans (26.7%), and American Indians and Alaska Natives (34.1%).<sup>3</sup> However, there are significant subgroup differences in smoking prevalence among AAPIs. For example, southeast Asian men in the U.S. reported the highest cigarette smoking prevalence in the late 1980s and early 1990s when 55% of Cambodian men, 72% of Laotian men, and 56% of Vietnamese men were current smokers.<sup>4</sup> A 1990-91 California survey reported that the rate of current smoking was 35.8% for Korean American men, 24% for Filipino Americans, 20.1% for Japanese Americans, and 19.1% for Chinese Americans.<sup>2</sup> Similarly, in another study, 39% of Korean American men in Alameda County in California were current smokers.<sup>5</sup>

Recent research to improve our understanding of racial/ethnic smoking patterns and identify strategic tobacco control opportunities has focused on determining whether there is a differential risk for tobacco use among U.S. minority groups.<sup>6</sup> High risk might derive from personal characteristics, as well as from social factors such

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as migratory patterns, acculturation, and the tobacco industry's historical involvement in racial/ethnic communities.<sup>2</sup> With the higher prevalence of cigarette smoking among Korean American men, some researchers have examined the patterns of smoking and socio-demographics and acculturation related to smoking.<sup>5,7</sup>

Gathering in-depth information regarding smoking behavior of Korean Americans is an important endeavor for several reasons. First, information about specific Asian American subgroups is important to ascertain the extent to which patterns of health behavior differ between specific Asian American groups. However, a few studies have systematically compared smoking behavior among these subgroups. Such information can serve as the basis for developing effective, culturally-specific, smoking control strategies. Second, there are several difficulties in examining acculturation and smoking status among different Asian American subgroups due to their complex immigration history. Baseline data concerning smoking patterns among Koreans in their homeland is needed for a comparison of prevalence rates after immigration to the U.S. in order to learn whether the process of acculturation influences cigarette smoking. The purpose of this study was to examine the prevalence of cigarette smoking and the correlated factors of smoking among Korean American men in Maryland. In addition, we have extended our study to examine other important predictors of cigarette smoking such as health status, access to health care and alcohol use.

## MATERIALS AND METHODS

The 1998 Healthy Korean American Project collected information on health behaviors (e.g., cigarette smoking and alcohol use) in Maryland. It also collected additional information about mental health, preventive health behaviors (e.g., mammogram and Pap smear), and other issues about risk factors for cardiovascular heart disease.<sup>8,9</sup>

### Study sample

The study sample came from a community-

based population consisting of two types of sampling sites: Korean churches and Korean grocery stores. The sampling frame was the 1998 Korean Directory of Maryland, which listed 134 Korean ethnic churches and 54 Korean grocery stores. From this list, six churches and two grocery stores were randomly selected. We used a sampling frame from Korean churches because we knew from prior studies that most Korean immigrants attended church.<sup>10</sup> The bias from excluding those who do not go to church is about 15%. Thus, we added the sample from the two selected Korean grocery stores to minimize the sampling bias due to churchgoing. All Korean men and women age 18 and older were eligible to participate in the survey. Verbal consent was obtained from each respondent. The survey was approved by the Joint Committee on Clinical Investigation (JCCI) at the Johns Hopkins University School of Medicine and the Johns Hopkins Hospital.

Data was collected from October 1998 to February 1999. A total of 796 immigrant Koreans, aged 18 years and older, residing in Maryland participated in the survey. Of these, 25 were excluded from the analyses because of substantial noncompletion of items or apparent random responding (16 from churches and 9 from grocery stores). The final sample size for the analysis was 771 (333 males and 438 females), giving a response rate of 96.9%. Of the total sample, 554 (71.9%), were from churches and 217 (28.1%) were from grocery stores.

The questionnaire was self-completed by the majority of the respondents (86.5%), with the remainder completing via in-person interviews at the recruitment site. For the few who had problems reading Korean (13.5%), a one-to-one interview was conducted by bilingual Korean American graduate students who were trained and monitored by the investigators. Three-quarters of those interviewed were 60 years and older. The average length of the interview was 20 to 30 minutes.

### Data collection instruments

The survey instrument was developed in English, translated into Korean, back-translated,

and then revised. To determine if the developed survey instrument was understandable and culturally sensitive, it was pretested with ten members of a Korean senior citizen center in Baltimore and appropriate revisions were made. The questionnaire asked about socio-demographic indicators, acculturation, hypertension screening (blood pressure check), breast and cervical cancer screening behaviors, substance use, health care access, and other health behaviors. The Korean language instrument was used since nearly all participants were Korean-born immigrants.

#### *Measures*

The dependent variables measured the respondents' self-reported smoking behavior. The classification of smoking status was based on the items used in the National Health and Nutrition Examination Survey.<sup>11</sup> The respondents were asked, "Have you smoked 100 cigarettes in your lifetime?" Those who responded 'no' were classified as never smokers, and those who responded 'yes' were further asked if they currently smoked; those who responded affirmatively were classified as current smokers and those who responded negatively were classified as former smokers.

#### *Independent Variables*

**Family Background:** Age, educational attainment, marital status, and employment were included as measures of family background. For the analysis, age was dichotomized as less than 50 and 50 and above. Education was dichotomized as high school graduate or lower (0-12 years of schooling) and more than high school graduate (13 years or more). Marital status was dichotomized as married and not married. Employment was categorized as employed and unemployed.

**Acculturation:** The proxy measure of acculturation was the length of stay in America. The respondents were asked how long they had been in the U.S. The length of stay was categorized as: 1) less than 10 years; 2) 11-19 years; and 3) more than 20 years.

**Health status** was assessed by asking the respondents whether they had a chronic condition

such as history of hypertension (no=0, yes=1).

Access to health care included insurance status and routine checkups. For insurance status, the respondents were asked two questions: 1) whether they have private insurance; and 2) whether they receive medical assistance (i.e., Medicare/edicaid). Based on these two questions, three categories of insurance status were created: 1) no insurance; 2) medical assistance only; and 3) private insurance. In the analysis, insurance status was dichotomized as having insurance and no insurance. The routine checkup was dichotomized as yes and no.

Alcohol use was included to examine the comorbidity of cigarette smoking (no=0, yes=1).

#### *Analysis*

Logistic regression analyses were used to examine the bivariate and multivariate relationships of smoking status to each factor. Factors assessed for associations with cigarette smoking were age, educational attainment, marital status, employment status, length of stay in the U.S., history of hypertension, having health insurance, regular checkup, and alcohol use.

## RESULTS

The cohort consisted of 771 participants (333 males and 438 females) who provided complete data (43% men and 57% women). Age ranged from 18 to 89 years, with a mean of 50.5 years, and was more weighted toward middle-aged adults with roughly 50% of the respondents aged between 40 and 59 years. Men tended to be economically better off than women, as men were more likely to be married (92% vs. 80%), had more high school education (63% vs. 44%), and were more often fully employed (86% vs. 67%). Men also had a longer duration of residence in the United States; about 30% of men and 24% of women had stayed in the U.S. more than 20 years. About 39% of men and 61% of women reported that they could speak only a little or no English. More than 40% of the respondents had no form of health insurance (see Table 1 for sample characteristics).

**Table 1.** Characteristics of Korean Americans (n=771) in Maryland, 1998-1999

| Variable                 | Men (n=333)<br>N (%) | Women (n=438)<br>N (%) | p-value<br>(Chi-square) |
|--------------------------|----------------------|------------------------|-------------------------|
| Age (yr, range)          | 50.5 ± 13.78 (18-89) |                        |                         |
| Marital Status           |                      |                        |                         |
| Married                  | 307 (92.2)           | 352 (80.4)             | <.01                    |
| Not married              | 26 (7.8)             | 86 (19.6)              |                         |
| Education                |                      |                        |                         |
| ≤ High School Graduate   | 121 (36.7)           | 234 (55.7)             | <.01                    |
| > High School Graduate   | 209 (63.3)           | 186 (44.3)             |                         |
| Employment Status        |                      |                        |                         |
| Employed                 | 285 (86.1)           | 289 (66.6)             | <.01                    |
| Unemployed               | 46 (13.9)            | 145 (33.4)             |                         |
| Length of Stay in the US |                      |                        |                         |
| Less than 10 years       | 112 (34.0)           | 160 (36.5)             | .052                    |
| 11 - 19 years            | 117 (35.6)           | 166 (37.8)             |                         |
| More than 20 years       | 100 (30.4)           | 101 (23.7)             |                         |
| Speaking English         |                      |                        |                         |
| None/little              | 129 (39.1)           | 268 (61.2)             | <.01                    |
| Some                     | 117 (35.5)           | 104 (23.7)             |                         |
| Well/Fluently            | 84 (25.5)            | 66 (15.1)              |                         |
| Health Insurance         |                      |                        |                         |
| Uninsured                | 140 (42.2)           | 195 (44.5)             | .371                    |
| Medicaid/Medicare only   | 22 ( 6.6)            | 28 (6.4)               |                         |
| Private Insurance        | 170 (51.2)           | 215 (49.1)             |                         |
| Place of Interview       |                      |                        |                         |
| Churches                 | 232 (69.7)           | 322 (73.5)             | .125                    |
| Grocery                  | 101 (30.3)           | 116 (26.5)             |                         |

The overall prevalence of current smoking among this population was 13.4%, and another 21.7% were former smokers. There were significant gender differences in smoking status ( $\chi^2=288.2$ ,  $p<.001$ ), with men being far more likely than women to be current smokers (26.1% vs. 3.7%). This gender difference was also consistent for former smokers: 42.3% of men and 5.9% of women were former smokers. In this analysis, the female respondents were excluded from the present study because their smoking prevalence was very low.

Table 2 shows that age was associated with smoking status ( $\chi^2=9.58$ ,  $p<.05$ ), with younger men being most likely to be current smokers,

compared to any other age group (33.8% for < 40 years old, 27.2% for age 40-59, 19.6% for ≥ 60 years old). Older men (≥ 40 years of age) were more likely to be former smokers than the younger age groups (46.7% vs. 29.2%).

Table 3 shows the results of the bivariate and the multivariate logistic regression analyses.

#### *Predictors of current smoking*

The length of stay in the U.S. and alcohol use were significantly associated with current smoking status at the bivariate level and remained significant even after adjustment for other variables. Men who had a longer duration of residence in the U.S. were less likely to be current

**Table 2.** Age and Smoking Status among Korean Males (n=326)

| Age (yr) | Never (n=102)<br>N (%) | Former smoker (n=138)<br>N (%) | Current smoker (n=86)<br>N (%) |
|----------|------------------------|--------------------------------|--------------------------------|
| <40      | 24 (36.9)              | 19 (29.2)                      | 22 (33.8)                      |
| 40-59    | 44 (26.0)              | 79 (46.7)                      | 46 (27.2)                      |
| 60+      | 34 (37.0)              | 40 (43.5)                      | 18 (19.6)                      |
| total    | 102 (31.3)             | 138 (42.3)                     | 86 (26.4)                      |

Note. Chi-square=9.58 (4 df),  $p<.05$ .

**Table 3.** Multiple Logistic Regression Models of Smoking Status: Odds Ratio and 95% Confidence Interval

|                       | Current (n=87) vs.<br>Never smoker (n=105) |                    | Former (n=141) vs.<br>Never smoker (n=105) |                    |
|-----------------------|--|--------------------|--|--------------------|
|                       | Crude OR                                   | Adjusted OR        | Crude OR                                   | Adjusted OR        |
| Age                   | 1.0  | 1.0                | 1.0  | 1.0                |
| < 40                  | 1.14 (.56-2.32)                            | 1.53 (.68-3.45)    | 2.27 (1.12-4.59)*                          | 2.83 (1.26-6.33)*  |
| 40-59                 | 0.58 (.26-1.30)                            | 1.01 (.32-3.12)    | 1.49 (.70-3.16)                            | 3.03 (1.10-8.36)*  |
| 60+                   |  |                    |  |                    |
| Education             | 1.0  | 1.0                | 1.0  | 1.0                |
| <= high school        | 1.14 (.64-2.02)                            | 0.93 (.47-1.84)    | 1.93 (1.13-3.28)*                          | 1.87 (.99-3.50)+   |
| >high school          |  |                    |  |                    |
| Marital status        | 1.0  | 1.0                | 1.0  | 1.0                |
| No                    | 1.34 (.50-3.61)                            | 1.70 (.54-5.41)    | 1.95 (.75-5.02)                            | 1.56 (.50-4.84)    |
| Yes                   |  |                    |  |                    |
| Employment            | 1.0  | 1.0                | 1.0  | 1.0                |
| No                    | 1.68 (.76-3.72)                            | 0.78 (.28-2.18)    | 2.27 (1.09-4.71)*                          | 2.09 (.81-5.40)    |
| Yes                   |  |                    |  |                    |
| Length of stay        | 1.0  | 1.0                | 1.0  | 1.0                |
| < 10 yrs              | 0.90 (.44-1.83)                            | 0.95 (.43-2.06)    | 1.65 (.84-3.26)                            | 1.56 (.72-2.38)    |
| 10-20                 | 0.31 (.15-.66)*                            | 0.32 (.13-.77)*    | 0.98 (.51-1.88)                            | 0.75 (.33-1.66)    |
| 20+                   |  |                    |  |                    |
| Having hypertension   | 1.0  | 1.0                | 1.0  | 1.0                |
| No                    | 1.24 (.53-2.92)                            | 1.31 (.46-3.67)    | 2.46 (1.21-5.03)*                          | 3.11 (1.33-7.24)*  |
| Yes                   |  |                    |  |                    |
| Having annual checkup | 1.0  | 1.0                | 1.0  | 1.0                |
| No                    | 1.20 (.73-1.97)                            | 1.26 (.70-2.24)    | 0.74 (.47-1.16)                            | 0.90 (.53-1.52)    |
| Yes                   |  |                    |  |                    |
| Alcohol use           | 1.0  | 1.0                | 1.0  | 1.0                |
| No                    | 5.39 (2.57-11.30)*                         | 5.24 (2.33-11.79)* | 6.09 (3.19-11.64)*                         | 5.45 (2.69-11.04)* |
| Yes                   |  |                    |  |                    |

Note. + $p<.10$ ; \* $p<.05$ . Adjusted all other variables shown.

smokers than those with a shorter stay (OR=0.32, 95% CI 0.13-0.77). Those who consumed were more likely to be current smokers than those who never drank alcohol (OR=5.24, 95% CI 2.33-11.79).

#### *Predictors of smoking cessation*

Bivariate analysis indicated that age, educational attainment, employment, having hypertension, and alcohol use were all associated with

smoking cessation. When all the variables were entered into the model, age, education, having hypertension and alcohol use still remained significant, but employment became non-significant. Those  $\geq 40$  years of age were about 3 times more likely to have stopped smoking than those  $< 40$  years of age. Those who reported having hypertension were more likely to have stopped smoking than those who did not have hypertension (OR=3.11, 95% CI=1.33 - 7.24). Alcohol use was another important predictor of smoking cessation, with those who used to smoke being more likely to have drunk alcohol than non-smokers (OR=.45, CI=2.69 - 11.04). Educational attainment was marginally significant ( $p=.051$ ), with those with higher education being more likely to have stopped smoking than those with lower education.

## DISCUSSION

The primary purposes of this study were to estimate the prevalence of smoking among Korean American men in Maryland and to examine the factors associated with smoking. The current smoking prevalence among Korean American men reported in this study (26.1%) was similar to that observed for U.S. men from the Behavioral Risk Factor Surveillance System in 1996 (23.4%).<sup>12</sup> However, current smoking prevalence was much lower than that of male Koreans in their homeland (26.1% vs. 53.9%), while the prevalence of former smoking in this study of Korean American men is much higher than that of Korean men in their homeland (42.3% vs. 23.3%).<sup>13,14</sup>

The proxy measure of acculturation in this study (i.e., the length of stay in the U.S.) was an important correlate of current smoking status. Those Korean men living longer in the U.S. were less likely to be current smokers. One possible explanation is that living in the U.S. affects Korean American men's smoking status in a positive way. It appears that acculturation as a protective factor may motivate Korean American men's decision to stop smoking. The same result was observed in another study among Korean Americans 8 and other Asian adults.<sup>4,15,16</sup> This result suggests further study is needed to explore

the important role of acculturation on smoking status in a large representative sample of Korean Americans. Moreover, we need to use other acculturation variables that measure attitudes towards traditional family and that influence adopting new cultural values.

Alcohol use was associated with both current and former smoking. This finding is consistent with previous studies of the interrelationship between concurrent consumption of alcohol and tobacco. A strong, positive relationship between tobacco use and alcohol consumption has been reported by many researchers.<sup>17,18</sup> Results indicate that alcohol is one of the important threats to maintaining abstinence in smoking cessation programs.

Consistent with the findings of previous studies, age was associated with smoking status. We found that the older age group ( $\geq 40$  years) was more likely to have quit smoking than the younger age group ( $< 40$  years). Advancing age has been previously shown to increase the likelihood of smoking cessation.<sup>19,20</sup> This trend may be the result of a greater frequency of comorbid conditions in the older group.<sup>20</sup> For example, older individuals experience higher rates of chronic illness such as hypertension. We also found that the diagnosis of hypertension increased smokers' desire to quit smoking. The result of this study suggests that the diagnosis of hypertension in older age groups may be an opportune time to initiate smoking cessation intervention. A symptom-based approach may be an efficient way for smoking cessation, as has been documented in a few previous studies.<sup>21,22</sup>

Education is marginally associated with quitting smoking, as has been observed in other studies.<sup>23</sup> This suggests that men with higher education may learn about the harmful effects of smoking on their own health as well as on their family members, so they start to consider stopping smoking.

Our study had several limitations. We used a sampling frame from Korean churches because most of the Korean immigrants attended church. To minimize the sampling bias due to the exclusion of those who do not go to church, we also selected Korean grocery stores. However, we could not quantify the magnitude of the bias from excluding those who neither go to church nor go

to grocery stores, because their percentages and characteristics are unknown. Second, measurement error may have occurred from using self-reports of cigarette smoking. Those who completed the survey at church may have underreported their smoking status since pastors discourage smoking. Finally, many other variables not measured in this study may influence cigarette smoking and cessation. Therefore, future studies of refined measures of acculturation, knowledge of the harmful effects of smoking, health risks related to smoking, and attitudes toward secondhand smoke may lead to a better understanding of the relationship between these predictors and cigarette smoking in such a population of Korean American men.

Despite these limitations, this study presents several important implications for understanding tobacco use patterns among Korean American men. First, as manifested by the significant association between length of residence and smoking status, anti-smoking education targeting recent Korean immigrants may be the most efficient way to approach this population. Many recent Korean immigrants do not follow smoke-free policies at home or in public places, which is a new societal norm toward smoking among those recent immigrants. For example, Korean men in general are less sensitive to smoking issues such as restrictions in environmental smoking, so they tend to hold more permissive views toward smoking in public places, even in the U.S. While researchers seem to agree that the relationships are complex and multidimensional, future research is needed on the effects of acculturation in other health dimensions such as diet, exercise, drinking, cancer screening, mental health, etc. Second, chronic illness has been found to be independent of the natural age effect, so we suggest further in-depth study to determine whether or not close follow-up by health care providers has an impact on people's smoking behavior and their heightened attention to more healthy behavior due to the diagnosis. Finally, a clear understanding of patterns of tobacco use and cessation among Korean Americans is essential for the development of culturally-integrated, community-based programs to address the factors involved.

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