Spring 5-2014

An Exploratory Study of Generational Differences in Health Information Seeking and Smoking Behaviors in Bulgaria

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AN EXPLORATORY STUDY OF GENERATIONAL DIFFERENCES IN HEALTH INFORMATION SEEKING AND SMOKING BEHAVIORS IN BULGARIA

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A Thesis Submitted to the Faculty of
Old Dominion University in Partial Fulfillment of the
Requirements for the Degree of

MASTER OF ARTS

LIFESPAN AND DIGITAL COMMUNICATION

OLD DOMINION UNIVERSITY
May 2014

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ABSTRACT

AN EXPLORATORY STUDY OF GENERATIONAL DIFFERENCES IN HEALTH INFORMATION SEEKING AND SMOKING BEHAVIORS IN BULGARIA

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Smoking is a serious global public health threat that causes more than 6 million deaths annually (WHO, 2013). Smoking is also the single, most preventable cause of death (CDC, 2014). According to a recent study, Bulgaria was ranked as one of only11 countries in the world, in which half of the adult male population smokes, as well as one of 11 countries in which more than one-quarter of the adult female population smokes. Research suggests that the most significant predictors of smoking behavior in Bulgaria were age and geographic location (Balabanova, Bobak & McKee, 1998). Contributing to these finings, generational gaps in information communication literacy and technology were also found to be a contemporary phenomenon in Bulgaria (Mihailova, 2009). The primary purpose of this thesis was to inform potential public health interventions, aiming in decreasing the high number of smokers in Bulgaria. More specifically, the goals of the study were to deepen the current understanding about generational differences in the current health information seeking behavior in Bulgaria as well as the current attitudes and cultural perception in regards to smoking. The intended audience for this analysis was public health practitioners, policy makers, interested agencies, community groups, and academic researchers.

Triangulation in data collection and data analysis was performed in order to answer eleven research questions. Findings indicated that there were statistically

significant generational differences between GEN X (1961-1981) and GEN Y (1981-2001) in: concern with quality of health and medical information online, perception of how easy it is for a person to quit smoking, perception of the health consequences of first-hand smoking, and in the attempts to quit smoking in the past year. Generational differences in cultural trends in regards to smoking were also noted in the qualitative analysis. Finally, guidelines for translating these data into an applied public health intervention in Bulgaria were discussed.

This thesis is dedicated to my parents, Diana and Tsanko Stoynevi.

ACKNOWLEDGEMENTS

First and foremost, I would like to thank my academic advisor Dr. T. Socha. I cannot thank him enough for his hard work, trust and encouragement in the process of completing this project.

I would also like to thank my sister, Ralitsa for being a phenomenal support system for me, as a best friend and colleague. Having her as a role model has taught me to never give up, and always keep improving.

Last but not least I would like to thank my family and friends, in the US and in Bulgaria, for being so supportive and loving thought-out this journey. For Matt, Claire and Ashley…it has been an absolute pleasure to be a part of the "COMMtastic 4" with you! Thank you for all the laughs, cries and good conversations.

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CHAPTER I

PROJECT FRAMEWORK

INTRODUCTION

According to the World Health Organization (WHO, 2013), every year smoking kills more than 6 million people worldwide. Approximately five million of these people die from direct use, and most of the rest are result of second-hand smoking. Around 80% of the world's smoker population lives in low- and middle-income countries (Fact sheet N°339; WHO, 2013). Tobacco smoking is considered responsible for 1 in 10 adult deaths, and is among the five greatest risk factors for mortality (CDC, 2014). Further, according to the Centers for Disease Control and Prevention (CDC, 2014), smoking harms every organ in the human body. It causes multiple health disparities and reduces overall health and wellness of individuals. According to a European Union report focused on tobacco-related public health risks, being exposed to smoke in the work place (in particular in the hospitality industry), or living with somebody who smokes, greatly increases (in some cases up to 50%) the chances of lung cancer and heart disease for non-smokers (EC, 2007). Yet, many people around the world continue to smoke (WHO, 2013).

Smoking however, is also the single, most preventable cause of death (CDC, 2014). A recent story broadcasted by National Public Radio (NPR) stated that, since the first Surgeon General's Warning about the negative health effects of tobacco was launched 50 years ago, roughly about 8 million tobacco related deaths have been prevented in the United States (Knox, 2014). A follow up article however, points out to

the fact that this decrease in smoking rates cannot be observed in the entire world. A statistical map drawn by the Health Institute for Health Metrics and Evaluation shows that, countries like Bulgaria, Macedonia and Greece are struggling with increasing rates of smoking even today (Hensley, 2014). This thesis is dedicated to exploring the state of public health communication and health information seeking behaviors across two generations in Bulgaria, with the purpose of informing a potential smoking cessation or initiation prevention campaign. The study's aim is also to capture attitudes towards smoking in the midst of current public policy change and legislative turmoil in Bulgaria in regards to smoking in enclosed public spaces.

A recent study conducted at Georgia State University titled, *The 10 Countries Where People Smoke Most*, (McIntyre, Sauter, Hess, & Weigley, 2012), Bulgaria was ranked as one of just 11 countries in the world, in which half of the adult male population smokes. It is also one of 11 countries in which more than one-quarter of the adult female population smokes. According to this research, Bulgaria's citizens, in general, are more likely to become smokers. They also tend to smoke heavily. The nation consumes the second most cigarettes per capita in the world, at 2,822 per year. Bulgaria's smoking rates on a global scale are: "Pct. [percent of] adults that smoke: 38.8%; Pct. men that smoke: 50.3% (10th highest); Pct. women that smoke: 28.2% (6th highest); per capita cigarette consumption: 2,822 cigarettes (2nd highest); Cigarette prices per pack: $3.29 (34th highest)" (McIntyre et al., 2012). In Bulgaria, 31.6% of girls between the ages of 13 and 15 smoke, which is the fourth highest worldwide (McIntyre, et.al., 2012).

In recent efforts to decrease the number of smokers in the country, on June 1, 2012, a national ban on smoking in enclosed public places in Bulgaria went into effect

(Ministry of Health, 2012). This ban was met with serious opposition by Bulgaria's hospitality industry. It has also been widely violated, according to some of the county's leading news reports from 2013 (Staff, 2013). In October of 2013, the Bulgarian government voted in a bill that actually allows smoking in some enclosed public places again (Panchev, Dubov, Mihalevski, Zahariev, Danev, et.al., 2013).This inconsistency in the messages sent out by the government, makes up for a complicated and polarized (smokers vs. non-smokers) public opinion in regards to smoking in the country. The inadequacy of governmental agencies in Bulgaria to implement long-lasting public policies about smoking appears to be a re-occurring problem with the planning of large-scale public health efforts (Anatchkova, Redding, & Rossi, 2006).

Other countries' governmental and non-governmental agencies however, such as the ones in the United States (US), have been very effective in reducing the smoking rates amongst their populations (U.S. DHHS, 2014). In the US, multilayered and longitudinal anti-tobacco campaigns have been remarkably successful in the last four decades (CDC, 1999). The reduction of smoking prevalence among adults from 42.4% in 1965 to 24.7% in 1997 has been regarded by health professionals world-wide, as a huge accomplishment (CDC, 1999). According to the latest data at the Centers for Disease Control and Prevention, only about 19% of American adults smoke today (CDC C. f., Adult Cigarette Smoking in the United States: Current Estimate, 2013). This success has been the product of multiple public health interventions, governmental regulations, and mass media influences towards smoking cessation, to name a few. The main components of these campaigns are: "Population-based community interventions, counter-marketing, program

policy/regulation, surveillance and evaluation." (CDC C. f., National Tobacco Control Program, 2012).

Information from these national initiatives and campaigns, however, does not reach all people directly. Instead, it travels mostly from intermediary opinion leaders in different peer groups and family systems, to others within the group, through interpersonal means (Southwell & Yzer, 2010). Therefore, mass media messages have mostly indirect effects, which get mediated by the interpersonal communication within the system of people who are decoding the message. This is the primary reason why the same mass media messages might have different levels of efficacy amongst different groups of people. Therefore, a key point in creating an effective public health campaign is better understanding this information flow and the intersections between mass media messages and interpersonal communication (Southwell & Yzer, 2010). In a sense, what Southwell and Yzer suggest is the importance of discovering and describing the point where the public health messages reach interpersonal conversations and become commonly held group beliefs about health behaviors. Understanding the specificities of the context in which this communicative transaction takes place, is also a key component in this process (Baxter, 2011). Within a family system for example, typically the older members of a family are serving the function of leaders in providing information that helps younger members with the development of initial attitudes about behaviors such as smoking. Research also shows that being around smokers in a family system, can be a predictor of youth smoking (U.S. Department of Health and Human Services, 1994).

The alarming statistics in regards to smoking in Bulgaria, the current, ongoing fluctuating public policy legislation, the insufficient number of public health

interventions, and the fact that the author of this project is well acquainted with the culture in Bulgaria (being a native), and the four primary reasons why this project is interested in exploring health information seeking and smoking attitudes particularly in Bulgaria. In an effort to better understand the communication environment with regards to public intervention intended to reduce smoking, this project is interested in describing communication obstacles that may reduce the effectiveness of public health campaign on tobacco cessation and tobacco initiation prevention in Bulgaria (e.g., lack of trust and lack of confidence in the quality of health information Bulgarians consume). In order to do this, this thesis has two major goals. The first one is to quantitatively determine the generational differences in health information seeking behavior and levels of trust and perceived quality of different communication sources in Bulgaria, as well as describe the generational differences in attitudes and educational level on the topic of smoking. The second goal is to determine how these generational outlines of the Bulgarian public translate into interpersonal narratives within families and close-circle peer groups. In part, this project is also interested in the process of meaning making concerning tobacco smoking, which can be detected by carefully examining the complex fabric of interpersonal dialogue on the topic. Specifically, this thesis is attempting to uncover the kinds of communication modes and means that appear to be most effective in the construction of long-lasting attitudes "pro" or "against" tobacco smoking across generations. From lifespan and family communication stand points, this project also asks a unique reversed-generational influence question: How can family members from Generation Y (1981-1994) effectively influence family members of Generation X (1961-1981), in changing their attitude towards tobacco smoking? The author is particularly

interested in exploring these dynamics through a qualitative discourse analytic method. Even though the influences GEN Y might have on GEN X, in regards to changing their smoking behavior, might not be immediate, this study is interested in exploring the variances of how GEN X reacts to different types of messages about smoking from GEN Y, since this is not a question typically researched in social influences of smoking literature. The primary reason for choosing to explore generational differences in this project is the huge socio-economic change that Bulgarians experiences after the collapse of the Soviet Union (SU) in the late 80's and early 90's. This change has created a generational gap in regards to digital literacy, technology use, networking skills (Mihailova, 2009) and potentially, health information seeking behaviors and levels of education in regards to smoking between members of GEN X and GEN Y. In addition, research suggests that, due to the large amount of smokers in the country, the most significant predictors of smoking behavior in Bulgaria are age and geographic location (Balabanova, et.al.,1998).

A "generational group" has been defined in the past as a group of people for whom particular events happened in the same point in time in relation to their date of birth (Corsten, 1999). The cohorts formed from such social division, allows researchers to distinguish certain age-related groups with similar measurable characteristics. The years chosen to form the brackets of time in which GEN X and GEN Y are defined for this study, were not arbitrary, but rather based on popular culture definition of GEN X and GEN Y on an international level (UN, 2013). Even though, the cultural definition of GEN X and GEN Y in Bulgaria will vary from the definition of GEN X and GEN Y in other countries, the significant sociopolitical events in regards to the collapse of the SU

that effected late 80's early 90's in Bulgaria, served as a catalyst for the birth of a new generation, namely GEN Y.

THEORETICAL BACKGROUND

Theories and Models of Health-Information Distribution

The Centers for Disease Control and Prevention (CDC) and the National Cancer Institute define health communication as: "*The study and use of communication strategies to inform and influence individual decisions that enhance health*" (CDC, 2011). What health communication aims to do is promote healthier lifestyles and behaviors though effective messages. Often times when it comes to strategizing the creation and dissemination of mass media messages for public health purposes, researchers and practitioners utilize ecological models of influences (Sallis, Owen, & Fisher, 2008). Ecological models, in a nutshell, propose that in order to promote a particular health-related behavior, interested parties should consider individual as well as social factors of a human's life, in order to reach optimal efficacy of intervention. However, most ecological models do not specify different levels of efficacy in the impact factors of the different layers of influence on the formation of intrapersonal attitudes. In particular, they do not put emphasis on the point in which the messages from the different layers, become part of the interpersonal communication realm. With this in mind, in order to examine the environmental influences on message dissemination and adoption in Bulgaria, the Ecological Model of Health Behavior (McLeroy, 1988) and Social Cognitive Theory (McAlister, 2008) (in particular the concepts of reciprocal

determinism) were combined into a new distilled model of communication influences on individual's health behavior. The model is utilized throughout this thesis as frameworks of thinking about what the process of mass message distribution and interpretation in Bulgaria might look like. This model will serve the purpose of answering the first sets of research questions in regards to Health Information Seeking in Bulgaria.

In order to explore the second set of research questions about the social and cultural meaning of smoking in Bulgaria, a more interpersonal communication approach was adopted. As discussed before, close peer groups and family systems play an integral role in health information distribution. Interpersonal communication and health communication have been studied together by qualitative and quantitative health communication scholars in the past. *Positive Communication and Health and Wellness* is an example of a collaborative effort in the field of positive, family and interpersonal communication to address their relationship to health and wellness outcomes (Pitts & Socha, 2013). Michelle Miller-Day is another prominent scholar in this field. She has written and edited multiple books and articles on the subject of family communication and health: *Communication among Grandmothers, Mothers and Adult Daughters; Family Communication, Connections and Health Transitions* (Miller-Day, 2004; 2011). By performing various types of discourse analyses in interpersonal settings, communication scholars hope to decode and describe complex processes of attitude formation and meaning making in human relationships and human communication. As understanding and meaning are linked to behaving, defining the communication fabric in which meaning is given to a particular behavior, such as smoking, is essential to understand how to reverse or change this behavior. As the discourse of smoking is fraught with tensions

(e.g., want to quit—can't quit), the interpersonal meaning making process will be examined through the use of Relational Dialectic Theory (RDT) (Baxter, 2011) as a framework for decoding meaning making based on current ways of talking about smoking across generations.

Lifespan Health Communication

Lifespan communication scholars believe that communication competency and sophistication plays a significant role in maintaining good health and well-being throughout the stages of the human life-span (Pecchioni, Wright, & Nussbaum, 2006). A person's communication skills, language development, cognition, access to information, networks and socioeconomic status are all age-related variables which enable or disable effective communication. Healthcare organizations and governmental agencies who are interested in distributing health messages, can do so more effectively if they consider the developmental arch of the human lifespan and its generational differences in communication styles, dynamics, and preferences. For example, Nussbaum and colleagues (2006) discuss the importance about thinking about the individual's perception of a "physician" throughout the human lifespan. The role of a physician changes as we age, and so do the ways we communicate with them: a child sees their doctor much differently than a later-life adult (65 and older), due to the perceived role the doctor plays in their life. A child does not necessarily understand what the doctor's role is as a health provider, where as later-life adults become well acquainted with medical personnel due to the increased frequency of visits with a physician that come with this developmental stage. With this in mind, having a standardized one-size-fits-all model of physician-

patient interactions for example seems inadequate. The same concept applies for thinking about gathering information to inform the creation of public or individual smoking cession interventions. Generational differences play a key role in thinking about creating effective messages that will bring long-term behavioral change. A generational communication theory which aims to explain communication changes throughout the human lifespan is Selective Optimization with Compensation Theory (Baltes & Baltes, 1990). The theory is interested in mapping out how these changes in human development affect the individual as far as her active choices for communication engagement. The basic premise in the theory is that, depending on the life stage a person is in, she will be good at some tasks and not so good at others. For example, young adults may generally be more tech savvy then people in later life stages, therefore they can chose to selectively optimize their technological skills in communicating with others through increased use of digital technology. Also, they might have less free time than later-life adults, which means that they need to compensate for the lack of free time with optimizing their current communication skills to maintain their personal and professional life intact, through things like fast frequent messages such as texting. Similarly, later life adults might lack the particular set of skills required to maintain mediated interpersonal communication, such as texting. They might compensate for the lack of these skills by preferring calling or one-on-one interpersonal communication, which is happens less frequently but it optimizes the quality and depth of the conversation. According to the theory, these age related dynamics of optimization and compensation are in constant flux, but always dependent on one another. People compensate for the communication shortcoming of their age, by optimizing the communication strengths of their age. For the purposes of

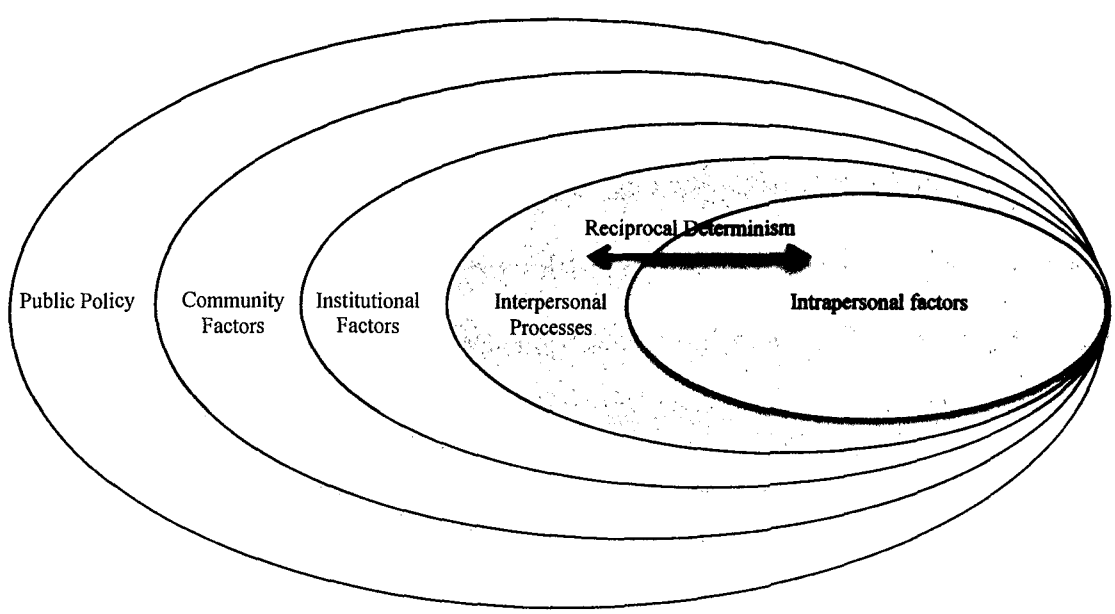
this paper, these ideas are employed in constructing the larger demographic parameters the study in interested in, namely: GEN X and GEN Y.

Ecological Model Of Health Behavior

Multiple ecological models have been used for applied health promotion throughout the years (Sallis, Owen & Fisher, 2008). Ecological models aim to employ various levels of influences in a particular process (such as attitude formation and behavioral change), while striving to make their description more comprehensive and closer to the real-life occurrence. Such models typically visualize a particular human process (behavioral, cognitive, developmental, etc.) as being influenced by multiple layers of the human experience: close family and friend's influences, socio-economic influences, media, as well as cultural and political influences. Multiple scholars have used an ecological approach: Lewin (1951), Bronfenbrenner (1979), McLeroy (1988), Stokols, (1996), Cohen at al., (2000), Fisher et al., (2005), Gass & McAtee (2006), and others. They have been preferred by large-scale influential organization such as the Centers for Disease Control and Prevention and The World Health Organization. Ecological models are particularly effective when they strive to describe a specific behavior such as smoking. They have the flexibility to describe multiple intersections and interactions between levels of influences. According to a current summary of a 2001 report from the Institute of Medicine, the use of such ecological models in the creation of public health strategies played a key role in the reduction of smoking in the US (Pellmar, Brandt, & Baird, 2002). The summary also concludes that multi-layered (ecological models) investigations of health behaviors are more promising in informing public health

promotion campaigns, which deliver long-term sustainable behavioral change (Pellmar, et al., 2002). The fundamental purpose of ecological models is to inform the development of holistic and comprehensive health interventions, while focusing on the transactions of influences between people and their environments (Sallis, Owen & Fisher, 2008). The expectations of such interventions are that people will make healthier choices if policy, societal norms and the level of education on the subject support this choice with a consistent message throughout all platforms. One of the most commonly used ecological models in health communication and health psychology is Kenneth McLeroy's Ecological Model of Health Behavior (EMHB) (McLeroy,1988). The model suggests five major sources of influence when it comes to adopting and changing a health behavior: intrapersonal factors, interpersonal processes and primary groups, institutional factors, community factors, and public policy Fig. 1 (Sallis, Owen & Fisher, 2008).

Fig. 1 *Ecological model of communication factors related to an individual's health behavior. This representation is based upon the combination and distillation of The Ecological Model of Health Behavior and the Social Cognitive Theory.*



The different layers of influences act upon specific health behaviors with different strengths and at different times. For a full description of a health behavior such as smoking, all of them should be taken in consideration. This project is interested in describing all of the layers of influence in the ecological model when it comes to health information seeking and smoking in Bulgaria. However, emphasis will be put on describing the interactions between the interpersonal and intrapersonal layers, or in other words, the process of meaning making.

Social Cognitive Theory and Relational Dialectic Theory

In order to understand the communication interactions between the intrapersonal (the decoder and final meaning making) and interpersonal factors (as the encoder and closest environmental influence for the process of meaning making) of attitude formation, some of the concepts of social cognitive theory were employed. The theory was originally known as Social Learning Theory (Bandura, 1977). It was renamed to Social Cognitive Theory during the time when social scientists were rethinking the concepts of cognition and information processing (McAlister, Perry & Parcel, 2008). Social Cognitive Theory postulates that the human behavior is shaped by a constant dynamic of different environmental influences, which in return change based on human interaction with them, or based on positive or negative outcomes that come from performing a particular behavior. If the person gets positive rewards from a behavior, they are more likely to continue doing it, but that is dependent on the reaction of the environment towards that behavior. In a sense, the person and her immediate environment are in a

constant state of *reciprocal determinism*[1] (McAlister, Perry & Parcel, 2008). These assumptions of SCT fit well with the conceptual definitions of the health behavioral influences described by the EMHB. A key component of SCT is the process of observational learning. This process suggests that family and close peer groups are the first and most influential information providers for a person, due to the fact that the access to information coming from such sources is convenient and often unchallenged at the point of receiving it. The strength of impact these factors have on a human's behavior changes across the human lifespan (e.g., children and adolescence don't have as strong of an opinion on subjects like smoking, as do adults due to the fact that topics of interest vary in the different life-stages) (Erikson, 1993). These changes will be later discussed in the Generational Health Communication section of this thesis.

Another theory that deals with interpersonal influences on attitude formation and meaning makings is Relational Dialectic Theory (RDT). Baxter and Montgomery (Baxter & Montgomery, 1996) first introduced RDT in 1996. In 2011, Baxter appropriated the theory one more. The theory focuses on the exploration of relational meaning making through interpersonal communication. In other words, it is interested in decoding how meanings and opinions people hold are constructed based on their immediate surroundings (family and close peers). It is derived from the writing of the Russian philosopher, linguist and critic Mikhail Bakhtin's ideas of dialogism (Baxter, 2011). According to Baxter, Bakhtin believes that a dialogue is "a process in which unity and difference, in some form, are at play, both with and against one another" (Baxter, 2011,

[1] For the purposes of this thesis, the term determinism will not be used in its traditional sense of assuming a necessary causal relationship between two variables, but more so will describe a process of constant reciprocal interaction between two variables.

p.32). The conceptual definition of this theory holds that meanings emerge from the constant struggle for "meaning dominance" from discourses that are often contradictory (e.g., smoking kills people vs. not all smokers die young) (Baxter, 2011). An important component of the theory is the *utterance chain.* According to the theory, an utterance chain is a social phenomenon in which the words somebody choses to use in a given moment respond to previous utterances already spoken as well as to future utterances which are anticipated by the words chosen in the moment of delivery (Baxter, 2011). In a sense, what is envisioned in this theory is that every single conversation is a part of a larger dialogue, which includes information learned in the immediate and far past and information about anticipated outcomes in the immediate and far future. The theory does not fit with typical scientific approaches that assume an objective reality, which is to be studied through the ways people talk about it, but rather it is interested in exploring the subjective realities people create for themselves on a daily basis through constantly describing and redefining meanings.

This is especially true when it comes to exploring cultural variations in social constructs, communication and meaning making through story-telling, rituals and everyday activities in family systems (Baxter, 2011). The method through which these patterns of tensions get recognized and analyzed is called Contrapuntal Analysis (CA). CA is a particular kind of discourse analysis. The main question that the method is asking is: "What are the competing discourses in a particular text and how is meaning constructed through their interplay" (Baxter, 2011, p. 152).

Baxter 2011, suggests that this process of attitude formation can be described through the way people talk about a particular problem, such as smoking. She is

interested in the relational influences on talking about a problem, assuming that meaning gets constantly re-negotiated through relational narratives with family and friends. The communication factors in the development of attitudes towards a health behavior, such as smoking, are something that, according to reciprocal determinism, has effects both ways: from a person to her environment and vice versa, or from a smoker to a non-smoker and from a non-smoker to smoker. At the point of discourse, one can note influences not only at the present, but also influences from the past, as well as anticipated influences. Baxter calls these relational dimensions: Distal Already Spoken, Distal Not-Yet-Spoken, Proximal Already-Spoken and Proximal Not-Yet-Spoken (Baxter, 2011, p.51). For example, if a person is expressing their opinion about smoking at a particular time, their expressed opinion could be formed based on their past experiences, their present situation, as well as the anticipated reaction to their opinion, again based on the environment the people they are around. According to RDT, an utterance within a narrative is always dependent on the given state of the tensions between these four dimensions. For example, in a simple case of a communication system with only two people, the encoding and decoding process of message exchange is dependent on each preceding message acts as an immediate proximal influence on the next message within that conversation. According to the theory, what a person will say is dependent on what has already been said within the immediate conversation (Proximal Already-Spoken) as well as within the broader context of the conversation (Distal Already-Spoken).

Framing multi-method analyses around these three theories allows for researchers to combine ecological models that are typically associated with quantitative data analysis, with discourse analyses in answering the same questions. In the case of this study, RDT

fits well with both the ecological model of health behavior and the social cognitive theory due to the fact that it is interested in exploring multiple layers of communication influences (proximal and distal), which ultimately lead to meaning making, attitude formation and behaviors. This approach hopes to inform the process of how competing discourses and family rituals, as an extension to the public health messages and the collective intelligence about smoking in Bulgaria, influence decisions such as smoking initiation and smoking attrition across GEN X and GEN Y.

LITERATURE REVIEW

> According to the World Health Organization, "public health" is defined as: "All organized measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole. Its activities aim to provide conditions in which people can be healthy and focus on entire populations, not on individual patients or diseases. Thus, public health is concerned with the total system and not only the eradication of a particular disease" (WHO, 2013).

The primary purpose of this chapter is to create an overall view of the state of public health in Bulgaria. It does so by describing aspects of what is already known about the tobacco related policies, community factors and institutional factors (as they are defined by the Ecological Model of Communication Influences on Health Behavior) in Bulgaria. Those factors are concentrated in 5 main sections: global influences; health-care, public policy, community and institutional factors; Internet and media use; and family dynamics.

Global Influences on Health Communication in Bulgaria

Aside from the generational differences in communication, cultural differences play a role in the effectiveness process of encoding and decoding of a particular health message. Cultural variances in communication styles and functions are important to understand and account for when it comes to relaying health messages effectively in the ever-growing globalization environment we are currently in. According to the World Health Organization, the term "global public health" acknowledges that: "...as a result of globalization, forces that affect public health can and do come from outside state boundaries and that responding to public health issues now requires attention to cross-border health risks, including access to dangerous products and environmental change" (WHO, 2013).

Bulgaria has always been a country of origin and transit migrants (IOM, 2013). This trend is particularly noticeable in the past seven years after the country became an EU member. In addition to the fact that Bulgarian citizens were allowed to travel to Western Europe without restrictions after 2007, the country became a desirable destination for immigrants due to its geographic location and its EU member status (IOM, 2013). This migration dynamic affects the ways people perceive the act of smoking. For example, when Bulgarians migrate to Western Europe where smoking is not as common, and smoking in public is strictly regulated, this introduces new way in which Bulgarians perceive smoking. This is particularly true with younger generations of people, whose attitudes and behaviors might be more susceptible to change then older generations. Conversely, people who migrate to Bulgaria from other countries, often the Middle East (IOM, 2013), might have cultural or religiously based attitudes toward tobacco, which

they bring with them within the context of Bulgaria. These attitudes might also play a role in the way Bulgarians in Bulgaria understand smoking.

Migration is part of globalization. However, globalization is a hard process to conceptualize and define (Rowson et al., 2012). There are multiple problems with defining such a large social phenomenon for a variety of political, economic, cultural and historical reasons. Rowson and colleagues believe that in order to study or teach the subject of global health, the subject of values should be extracted from all definitions of the field. Their rationale is that the inclusions of values such as achieving "equality" carry significant amount of ideological connotation and it raises issues of political economy between the different parts of the world (Rowson et al., 2012). In the case of smoking, this means that smoking in a diverse cultural environment, should be defined as an act that has negative health outcomes to all human beings, and deter from the insertion of cultural and ethnic values in arguments against smoking. Concurrent with this line of thought, this thesis will not be looking at the field of global health communication as a way to reason the necessity to "equalize" the type of public health communication strategies in Bulgaria with other countries (such as the US), but rather to find the strong point in the current state of public health in the country and determine possible ways to utilize them in order to reduce smoking rates, given the global context in which Bulgaria is currently in.

Globalization is an ongoing process, which, amongst economic and societal changes, affects healthcare as well. Kar and colleagues define multi-cultural community as: " a community where people from distinct cultures live, come into contact, and interact with one another to form a new way of life, both dynamic and different from

each of its parts or culture" (2001). This definition can be stretched even further into speculating that, with the increase in international travel frequencies (Risi, 2013), as well as the potency of health information sharing through the World Wide Web, the world can be viewed as a multi-cultural community. The social schemas and the social realities that guide a person's health behavior are also affected by these factors. Increases in global traveling also increase the transmission of communicable diseases form one country to another (Freedman, 2013). Smoking is a socially contagious behavior, which spreads amongst close and distant social ties and networks (Christakis & Fowler, 2008). In addition, migrating smokers, as a population with higher chances of chronic disease, cancer and cardiovascular issues, might be more prone to get hospitalized or in need of medical treatments throughout their travels or immigration. These, amongst others, are the reasons why recent health communication scholarship is interested in global public health factors and immigrant populations.

Healthcare, Public Policy, Community and Institutional Factors in Bulgarian Healthcare and Public Policy

According to the latest population count taken by the World Bank, there are 7.305 million people who live in Bulgaria currently. The country has a GPD of 51.3 billion USD, a population growth rate of -0.6 % and a life expectancy of 74.16 years (The World Bank, 2012). Until 1989, Bulgaria provided universal health care, free at the point of receiving (Dimitrov, 2010). During the country's transition from communism, large-scale economic crisis and macroeconomic restructuring drained the governmental resources, which left a minimal budget for health care. Even though, after 1990 the healthcare

systems shifted towards payroll contributions with the establishment of the National Health Insurance Fund (Dimitrov, 2010), there is still a sizable lack of financing which translates into overall poor quality of health services (Balabanova & McKee, 2012). A recent study done by Balabanova and McKee shows that the post-transitional state of health care in Bulgaria is very complex. According to their work on the current state of the post-transitional health care of the country, the apparent universal healthcare has major weaknesses and flaws such as hidden bureaucratic barriers to access, bribing, and seeking connections to private treatment for those who can afford it (Balabanova and McKee, 2012). These factors ultimately created a deep class separation when it came to the quality of health care people received, based on their socio-economic status. In 2007, after the country became a European Union member, it started to adopt some of the EU's health care legislation (Dimitrov, 2010). However, the country has not yet been able to reach the socio-economic level as the rest of the countries in the EU. The entire healthcare system is experiencing severe fund shortages, on top of nationwide physicians and medical personal strikes. The Ministry of Health is also constantly undergoing staff changes, while disregarding aching issues with staggering inequality of health care access (Loubeau, 2012).

Eradicating smoking is one of the priorities for the European Commission's public health policy (EC, 2007). Reports show that longitudinal progress within the EU has been achieved through legislation, health education promotion and public policy mandates. However, the extend to which legislation and public health programs have effected the smoking rates varies greatly between member states within the EU (Joossens & Raw, 2007). Overall, the majority of the EU citizens have adopted the smoke-free

policies, for enclosed public places, implemented in their countries. In particular, citizens in countries that have completely banned smoking in public, including hospitality venues, report overall more negative attitudes towards smoking, and smoking in public (EC, 2007). This suggests that public support of smoke-free policies increases during and after the implementation of a particular policy. As mentioned before, these influences and policies from the EU, indirectly affect the issue of smoking in Bulgaria. However, health reforms in relation to smoking have been moving slow, due to the multiple socio-economic and financial problems the country is dealing with. The general dilemma in anti-tobacco policy-making, has been balancing revenue loss concerns with public health goals of eradicating smoking (Loubeau, 2012).

In 2012, a nation-wide ban was placed in Bulgaria forbidding smoking in all public places (Ministry of Health, 2012). In October of 2013 however, a new clause was placed by the Bulgarian government, which again allowed smoking in multiple hospitality venues (Panchev et al., 2013). The rationale provided by the committee in the motives section of the new clause, was that the smoking ban has been detrimental to the hospitality industry in the country. Combined with the financial crisis of the country, the government decided that it would be an economically sound decision to allow smoking in some hospitality venues.

A recent positive step towards reducing smoking rates in Bulgaria, on a governmental level, suggested that from 2007 to 2010, 1% of tobacco duties would be used towards funding national research programs on the use of tobacco, alcohol and drugs. Reliable data on how this 1% was actually spent however is unavailable (Loubeau, 2012). This uncertainty on where the country's leaders stands on the issue of smoking

regulations makes a hard case for public health interventions because the act of smoking has not been clearly defined as a major public health threat.

Community Factors in Health Communication in Bulgaria: Involvement and Social Life

Churches and church-affiliated organization have been identified as a key agent for community development and motivation for behavioral change related to health (Ayton, Carey, Joss, Keleher, & Smith, 2012). Churches have been used by various governments and institutions as a channel for promoting personal motivation for behavioral change in a less dehumanizing way then approaching the population at hand in marketing terms, as a "target group" (Sivov, 2008). Bulgaria's dominant religion is Eastern Orthodoxy. It has been the main religion in the country for about 14th centuries. Currently, the social and communal aspect of the institution of the Church is undergoing a process of "rebirth" due to its demolition during communism (Sivov, 2008). Based on limited research, in the current post-communist Bulgarian context, the Church have not been substantially involved in public health promotion such as, smoking cessation and preventing smoking initiation efforts, in an organized manner. However, it has been suggested that such collaborative efforts between governmental and non-governmental organizations and the Church would be beneficial (Ayton, et al., 2012).

Promoting collective knowledge is dependent on the role of cultural institutions as a learning environment for people from all ages. The links between social and economic changes typically work in network forms, due to the constant interaction between a person and environment - or reciprocal determinism (Fig. 1). The Bulgarian government

has been working on developing policies intended to modernize and reinforce the civic and educational functions of "*cultural clubs*". The culture club is an institution, which is very unique and indicative of Bulgaria (Blagoeva-Yarkova, 2012). In the 50's, when these clubs first started to emerge, they served the purpose of reading-rooms. With time, their role became one of a public space, where the local community would gather for educational, civic, and charitable purposes (Blagoeva-Yarkova, 2012). Today, research shows that Bulgarians describe culture clubs as: open, transparent, accommodating, friendly, effective, and efficient (Blagoeva-Yarkova, 2012). The culture clubs are still well-respected institutions with a great potential for public health message distribution, and health education interventions of a local level. The quality and impact of the interpersonal communication that takes place in these clubs seems to be ideal for community health promotion in a local level.

Internet Use in Bulgaria

According to data from the Health Information National Trend Survey in the US, the internet is, by and large, one of the first sources of information people go to when they are actively seeking health or medical information (Cohen & Adams, 2009). Since no official information on the subject is available about Bulgaria, the author speculates that this is also the case in the EU, and respectively, Bulgaria. Bulgaria is the EU member with the second largest digital divide gap (the gulf between those who have ready access to computers and the Internet, and those who do not). In Bulgaria, 46% of the population reports to have never used the Internet (Seybert, 2011). In 2011, 45% of the households reported having internet access, and 40% reported having broadband internet

connections. Bulgaria is one of the EU Member States with the lowest rates of e-shopping in 2011 (13%) with an EU average of over 55%. However, when it comes to online interactions with public authorities, Bulgaria ranks much closer to the EU average, with 40% of users obtaining public information online, 18% download form and 20% submitting completed forms over the internet (EU averages: 58%, 34% and 28%) (Seybert, 2011). Even though Bulgarians might not be in the habit of shopping online, they do use the internet as an semi-interactive media through which they communicate with public authorities, fill in forms, and obtain important information (Seybert, 2011). This suggests that the culture of using the Internet for educational purposes and local and political engagement is fairly well developed.

The generational gaps in Internet literacy and technology use in Bulgaria are especially obvious between GEN X and GEN Y (Mihailova, 2009). According to recent sociological analysis of online networking in Bulgaria, the ever-widening digital divide in GEN X and GEN Y prevents social cohesion when it comes to community involvement and online social support groups (Mihailova, 2009). The most active internet users in Bulgaria are the members of the younger generations – children and young adults (15-24 years old, followed by 25-35 years olds) (Mihailova, 2009). The majority of the older population is unable to keep up with the ever-changing digital world, due to the fact that most of them have very basic computer and technology skills. As a result of the growth of the field of communication technologies, the digital gap between digitally literate and illiterate Bulgarians, as well as the gap between those who have access to digital communicational technologies and those who don't, is sizably generational.

Other Media Use in Bulgaria

Based on a limited search, reliable information about current media use and media source preferences in Bulgaria was unavailable. The survey for this project asks questions about health information coming from media sources such as: radio, television, family members, medical personnel, newspapers etc., in order to explore these options in addition to the Internet.

Family Dynamics in Bulgaria

A study published in the *Journal of Advanced Nursing* from 2010, suggests that smoking behavior of parents, brothers, sisters, and friends was positively associated with smoking in other family members (Biraghi, E., & Tortorano, A. 2010). These findings correspond to Bronfrenbrenner's (1997) *Socio-Ecological Model*, which postulates that the closest influences of human behavioral development lay within the immediate family and friends circle. This suggests that different generations within a family system influence each other's behaviors and attitudes toward particular habits, such as smoking. Following a western model, the nuclear family is the preferred standard of a family structure in Bulgaria (Todorova, 1996; Todorova 2000; Merdjanskova and Panova 1995). The major difference between the "western nuclear" family and the Bulgarian one is that there is a prevalent theme of multigenerational households in Bulgaria. A recent study done by and Bernardi (2012), shows that for many young couples in Bulgaria, living with one set of the parents in law for the initial period of the couple's cohabitation (or longer, sometimes even permanently), is somewhat of a norm. Even though, this occurrence has been found to have deep roots in Bulgarian culture, economic uncertainly after the collapse of communism after 1989, is pointed out as the primary reason for this

family phenomenon today. Ghodsee and Bernardi also found this reoccurring theme to be a major reason why young couples in Bulgaria often hesitate to have more than one child. This household typology assumes that Bulgarians on average have more daily interactions with close family members, then Western families that can afford more privacy and individualism. In other words, in Bulgaria people often have the chance to get influenced, and influence other family member's behavior thought family communication strategies on a day-to-day basis.

Another study of Bulgarian family suggests that grandparents play a key role in moderating family discourse in multigenerational family structures (Botcheva, & Feldman2004). Later life adults play a role in softening the developmental outcomes of harsh parenting (often due to economic distress) on adolescent depression. This study shows that intergenerational family communication is indeed effective in moderating behaviors. The complexity of the amount of support family members receive in forming a particular behavior does however depend on the perceived quality of the relationship they have with the family member giving or receiving the support.

Attitudes Towards Smoking in Bulgaria

Stroke is one of the leading causes of death in northeast Bulgaria (Dokova et al., 2005). The risk of stroke increases with the number of cigarettes a person smokes a day (Wolf, D'Agostino, Kannel, Bonita, & Belanger, 1988). A recent study of the public understanding of major factors related to the causes stroke in Northeast Bulgaria, an alarmingly high percent of the participants did not perceive smoking as a major factor in the cause of stroke. Environmental factors such as poverty and stress were the two most

discussed causes for stroke amongst the participants (Dokova, et al., 2005). This study suggests that the severe gaps in the overall knowledge about the harms of smoking in this region of Bulgaria is indicative of the low levels of accurate health information amongst this population. This proposition is supported by another research, which found that Eastern European mothers are almost twice more likely to smoke around their children, compared to Western European mothers (Kovess, et.al, 2013). Tobacco control policies proved to be predictors of maternal smoking behavior in vicinity of children. In Bulgaria, 31.8% of mother and 31.3 % of fathers smoke in vicinity of their children (Kovess, et.al, 2013). Children living in countries with lax tobacco regulations (such as Bulgaria) are also more likely to get exposed to tobacco smoke.

Some of the suggested factors influencing smoking behavior in Bulgarian adolescents are: less support for smoking bans in public areas, parental smoking status (especially mothers), and older age and higher temptations to smoke (Anatchkova, Redding, & Rossi, 2006). In addition, believing that smoking is not very harmful to one's health was also a significant predictor of smoking initiation. Research in the field also discusses that due to this *low harm* perception of smoking, the dangers of smoking initiation amongst adolescence is high (Anatchkova, et.al., 2006). The same study suggests that the amounts of public health interventions that are currently taking place in Bulgaria are insufficient in making a substantial change in smoking behavior amongst Bulgarians. Taking this in consideration, an ecologic intervention approach (such as the ones carried out by the CDC in the US), which would focus on increasing efforts to promote smoking cessation in parents in combination with a public health message in support of the ban for smoking in public places, has the potential of significantly decrease

the alarmingly high smoking rates in the country. The reported findings also point out to the urgent need for education programs on the topic of the health benefits of quitting smoking as well as the health effects of long-term smoking.

Factors strongly associated with smoking in Bulgaria in the past have been age and gender (Balabanova, Bobak, McKee,1998). However, no association has been found between educational level or income in regards to smoking. Wealthy and poor people, as well as high or low educational attainment individuals were not significant predictors of smoking (Balabanova, et.al.,1998). This suggests that people all across the socio-economic-status spectrum in Bulgaria smoke. This is another reason why this thesis is focusing primarily on generational differences.

CHAPTER II

METHODS

TRIANGULATION AND RESEARCH QUESTIONS

Triangulation in data collection was used in order to address a series of eleven research questions pertaining to generational communication differences, health information seeking, and attitudes towards smoking in Bulgaria. This exploratory study was interested in determining numerical indicators of health information seeking behavior in Bulgaria, as well as indicating the cultural and relational meanings associated with smoking, in a systematic way. The primary purpose of collecting qualitative data for this project was to explore the cultural aspects of smoking as well as the intergenerational family discourse on the topic, since such literature did not exist based upon my search. The *Good Reporting of a Mixed Methods Study* (GRAMMS) guidelines were applied to the result section in order to systematically conduct and report the findings from both the survey and the interviews (Cameron, Trudy, Scott, Ezaz, & Aswini, 2013).

GRAMMS guidelines:

1. Describe the justification for using a mixed methods approach to the research question.
2. Describe the design in terms of the purpose, priority and sequence methods.
3. Describe each method in term of sampling, data collection and analysis.
4. Describe where integration has occurred, how it has occurred and who has participated in it.

5. Describe limitation of one method associated with the presence of the other method.
6. Describe any insights gained from mixing or integrating methods.

Mass media campaigns are intended to serve mass audiences, and as such, they are greatly dependent on the current most prominent channel/s for mass communication dissemination. The characteristics that define such channels are: availability, popularity, usability and trustworthiness according to the user population. The Health Information National Trend Survey (HINTS) was partially created to ask these questions about modern day health information sources and their prominence and utility amongst different populations (Nelson, Kreps, Hesse, Croyle, Willis, 2004). HINTS data collection project was created in order to better understand and monitor the constantly changing health communication world and it's relationship to health behaviors, attitudes and beliefs (Nelson, et.al., 2004). The survey was originally designed in order to help collect national representative data of the American public's needs and preferences for health related information. Since its creation, it has been translated for use in foreign cultural contexts such as the ones in Puerto Rico as well as in China. This cross-cultural flexibility of the HINTS questionnaire made it an appropriate tool for the purposes of this project. The survey was independently translated in Bulgarian by the author of this thesis (a native Bulgarian speaker) as well as another native Bulgarian speaker who is fluent in English. The translations were compared in order to minimize errors in translation. The questions this thesis was interested in answering through the survey are as follows:

RQ1: In Bulgaria, are there differences in the ways people from GEN Y (those born in 1982-2004) and GEN X (those born in 1960-1980) seek health information?

RQ2a: What health-related sources do members of GEN X currently consult?

RQ2b: What health-related sources do members of GEN Y currently consult?

RQ3: Are there differences in the levels of concern with the quality of health-related information received by the most preferred source between Bulgarians of GEN X and GEN Y?

RQ4: Do members of GEN X and GEN Y in Bulgaria place different levels of trust in the health-related information received by the most preferred source, as well as by all other sources?

RQ5: Do members of GEN X and GEN Y in Bulgaria differ in their perception of how easy it is for a smoker to quit?

RQ6: Do members of GEN X and GEN Y in Bulgaria differ in their perception of the potential health consequences of first and second-hand smoking?

In the second stage of the data collection, interviews of Bulgarians representing GEN X and GEN Y were collected. The research questions were framed using Baxter's Relational Dialectic Theory (2011), which states that within relationships, attitudes are a constantly shaped by a tension of contradictions in personal opinions, or by an unceasing interplay between contrary or opposing tendencies. I chose to survey both smokers and non-smokers, due to the fact that in family systems, discourses about smoking happen between smokers and non-smokers. A working assumption behind the question was also

that smokers-non-smoker discourses would be contradictory and filled with tensions on both sides. Due to the exploratory nature of this project, the interviews were semi-structured, allowing for new questions to emerge from the dialogue. Given that what the act of smoking means to people is fraught with contradictions, here are the seven research questions that were to be addressed through the interview data:

RQ7: From a dialogic perspective, what are the competing discourses experienced by GEN X in regards to smoking?

RQ8: From a dialogic perspective, what are the competing discourses experienced by GEN Y in regards to smoking?

RQ9a: What is the broad developmental arc of the story of smoking for GEN X?

RQ9b: What is the broad developmental arc of the story of smoking for GEN Y?

RQ10a: To what extent do individuals in GEN Y perceive they are able to influence GEN X's attitudes towards smoking?

RQ10b: To what extent do individuals in GEN X perceive that individuals from GEN Y are able to influence their attitudes towards smoking?

RQ11: What are the competing discourses between smokers and non-smokers in Bulgaria?

PARTICIPANTS

Quantitative

All participants were over the age of 18. From a total of 165 surveys, 94 participants fell under the set parameters of generation X (1961-1981) and 71 participants

fell under the set parameters of generation Y (1981-1994). 106 of the participants were female and 59 were male. 71% of them have smoked 100 cigarettes through-out their life, 50.3 % still smoke every day, 9.7% smoke some days, which means that only 11% of the participants who have smoked 100 cigarettes did not become smokers or quit smoking entirely (Table 1).

Table 1. *Demographic information of survey participants N=165*

Variables	***Frequency / Percent***
Gender	
Female	106 (64.2%)
Male	59 (35.8%)
Total N	165 (100%)
Age	
GEN X	94 (57%)
GEN Y	71 (43%)
Total N	165 (100%)
Smoked at least 100 cigarettes in lifetime	
Yes	118/ (71.5%)
No	46/ (27.9%)
Missing Data	1/ (.6%)
Total N	165/ (100%)

Qualitative

Fourteen informants were used for the in-depth interviews. Nine of them were representing GEN Y and five of them were representing GEN X. Five were female and nine of them male. Four of the participants were non-smokers and ten were smokers. The participants were selected from the survey participants. They were verbally asked after filling in the survey if they would like to participate in an interview on the subject of tobacco smoking. No identifying information was collected. In order to perform

intelligible contrapuntal analysis (Baxter, 2011) of a text, the researcher should obtain supplementary information about the context in which this discourse was created. The author of this paper used her cultural knowledge about the topic of smoking in Bulgaria as additional information, which helped to identify unspoken tensions exhibited during the interviews. For the purposes of gaining familiarity and intimacy with the participants, the author of this thesis (a native Bulgarian) was a participant observer in the process of data collection. All interviews were informal and conducted in natural communication environments such as coffee shops and home settings. The author maintained moderate participation, while being mindful of balancing the roles of an "insider" and an "outsider".

PROCEDURES

Surveys

IRB approval for data collection was granted to the author of this thesis on 05/20/2013 (# 12-046). A total of 200 surveys were distributed in the South-West region of Bulgaria, in Kustendinl and Sofia counties. Only 165 of the surveys were included within this analysis due to issue of incomplete surveys. They were selected as a non-random sample through a snowball effect. The surveys included a combination of two of the HINTS subscales, as well as basic demographic information such as sex and age of the participants. The surveys was completely confidential and of no danger to the privacy of the participants. An email for contact with the researcher was provided at the end of the survey for debriefing purposes.

The Bulgarian version of the questionnaire was a combination between a sub-scale in HINTS 4 cycle 1 and cycle 2 surveys. The reason for this combination is that the cycle 1 version of the survey does not contain smoking subscale and cycle 2 versions does not include health information seeking subscale. In order to answer the research questions this study is interested in, the author combined both subscales into one. Some questions were omitted from the original HINTS subscales, due to their inapplicability in Bulgaria. In addition, 5 questions were added to the survey in order to measure variables important to this research that were not available in the HINTS questioners (Appendix B). The data from the paper surveys were double coded by the author of this study and a colleague of hers (second year PhD student in Applied Experimental Psychology) who is also a CITI certified graduate student.

Interviews

The participants were not asked to provide any identifying information, in order to protect their privacy. The interview process was approximately 15–20 minutes per participant. All participants were provided information about the purposes of the study and about their rights as a participant. Ten of the interviews were conducted in person and 4 were conducted via internet (Skype). All interviews were transcribed with any and all inadvertent identifiers removed. The audio recordings and the paper transcriptions were destroyed after the completion of the project. The interviews were transcribed and translated by two native Bulgarian speakers, independently of each other, for the purpose of reliability in the translation. Edits were made accordingly until the necessary level of agreement was achieved. Baxter (2011) does not require inter-rater reliability for this

type of analysis.

The questions aimed at unveiling the process of attitude formation about smoking in Bulgaria, smoker/non-smoker dialectic tensions, as well as the inter-generational communication about smoking in close interpersonal settings. Some examples of the questions were: "What does smoking mean to you today?; Can you remember the first time you were a part of a conversation about smoking?; Has your attitude towards smoking changed with time?; Have you had conversations about smoking with younger and older people in your family and friends circles?; What do non-smokers in Bulgaria think about smoking?

ANALYTICAL STRATEGY

Surveys

I began by examining the descriptive statistics for all variables, screening for skewness and kurtosis, while assuring that all missing data was properly coded for analyses. The data was normally distributed. All analyses were conducted using the default handling of missing values in IBM's SPSS statistics software - listwise deletion. Missingness is reported in the results section. Multiple statistical methods were used in the analyses, based on the type of scale that the DV was represented through. The author used Multivariate Analyses of Variance (MANOVA) in order to check for between group generational differences in regards to the research questions. In the cases where the DV was not an appropriate level of measurement for Analysis of Variance (ANOVA), Chi-

square tests were performed. The IV was always the same binary variable: GEN X=1, GEN Y =2.

Interviews

For the qualitative examinations, the researcher utilized contrapuntal analysis as an analytical framework. Contrapuntal analysis aims to interpret communication text as an utterance chain (Baxter, 2011). Recognizing different tensions and struggles within a particular text varies from text to text. According to Baxter, relational communication always represents culture. The way people talk about a particular topic mirrors the culture this topic exists in. According to Baxter, Contrapuntal Analysis (CA) should be purely inductive: meaning the researcher should let the analysis emerge from multiple readings of the text and multiple distillations of themes, in order to provide the reader with exemplars from the text that answer the research questions most objectively and most accurately (taking in consideration knowledge of particular culture, and the ability to notice unspoken utterances within the discourses). This is precisely where CA differs from other forms of content analysis. CA is interested in a more holistic understanding of a discourse, past the literal meanings that can be extracted. This is why reliability is hard to measure in this type of analysis—it is rather impossible to have another coder who will have the same knowledge about the culture in order to be able to "read between the lines". However, for the sake of reaching maximum objectivity, the text and the results were additionally assessed for accuracy by a communication expert (thesis advisor), thus receiving expert validity. Following the systematic guidelines for *Doing Contrapuntal Analysis*, provided in Baxter (2011,chapter 6) initial coding categories were created,

followed by identifying and defining themes, and finally providing textual examples of the emerged themes form within the text. The requirement for cultural familiarity (Baxter, 2011) was met both because the researcher was a participant observer in the interviews, and because she is a native Bulgarian. The general steps of analysis went as follow:

1. Becoming familiar with the entire data set
2. Generating initial categories
3. Generating themes
4. Review themes
5. Define/name themes
6. Locate examples
7. Identify completing discourses

CHAPTER III

RESULTS

SURVEYS

RQ1: In Bulgaria, do members of GEN Y (those born in 1982-2004) seek out more health-related information than members of GEN X (those born in 1960-1980)?

First, I examined the differences between initiating health information seeking in the two generations- 1= GEN X 2= GEN Y. For GEN X (N= 94) the results show that 87.2% sought information and 12.8% did not. There was no missing data for this group. For GEN Y (N=71), 97.2% sought information and 2.8% did not. Then, I asked the participants who have looked for health information, if they have looked at more then one source at the time they last looked for information. This is how active seeking was measured. There was also no missing data on this variable. In order to assess generational differences in more active health information-seeking behavior, a Chi-square test was performed in order to assess distribution differences between categorical variables. There was no significant differences between the two generations: $c^2(1, N = 149) = 0.24, p = .37$.

Fig 2. *Generational differences in people who have ever looked for health or medical information.*

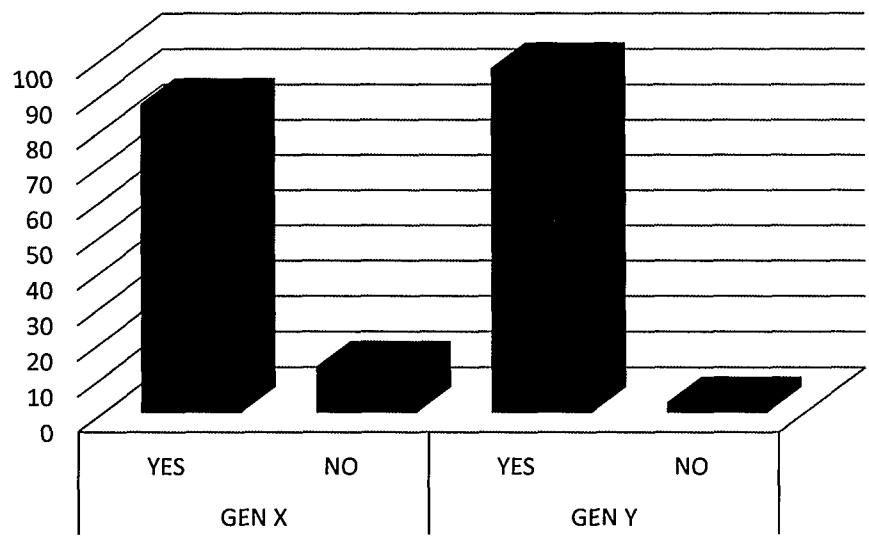
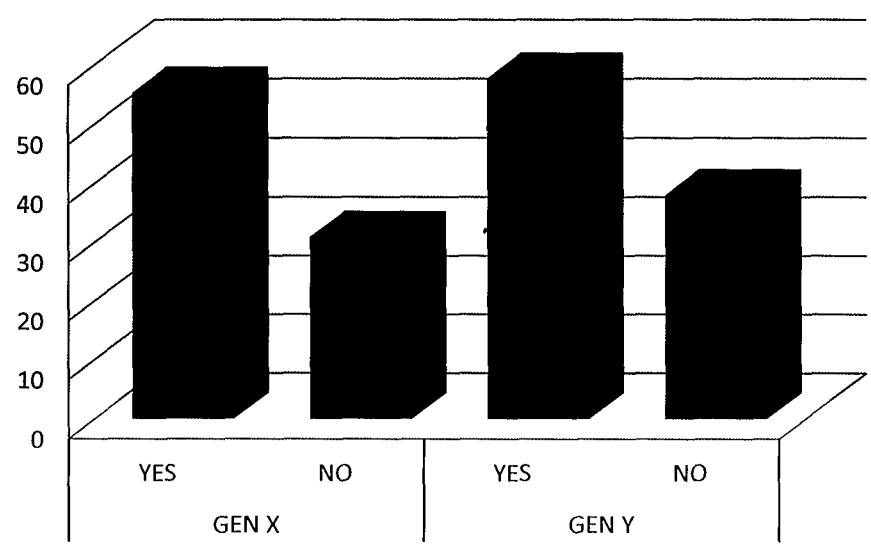
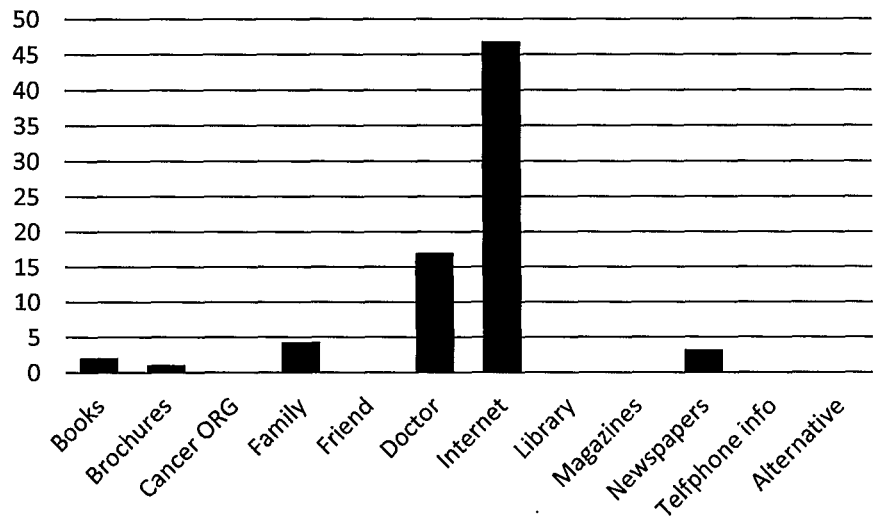


Fig 3. *Generational differences in people who looked at more than one source last time they searched for health or medical information.*



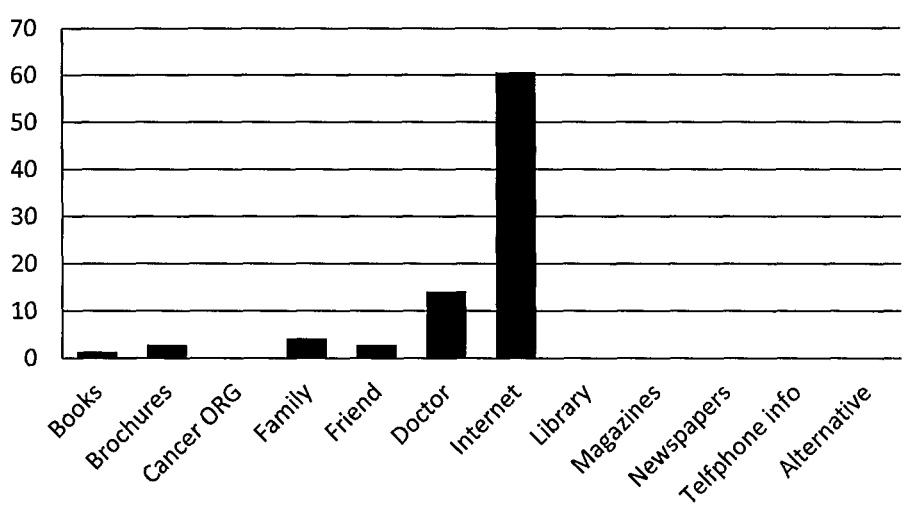
RQ2a: What health-related sources do members of GEN X currently consult?

Fig 4. *Preferred health and medical information sources for GEN X.*



RQ2b: What health-related sources do members of GEN Y currently consult?

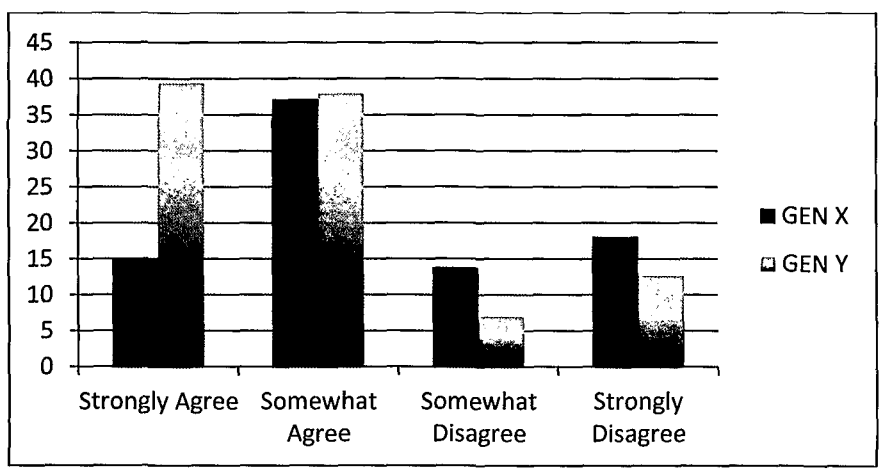
Fig 5. *Preferred health and medical information sources for GEN Y.*



RQ3: Are there differences in the levels of concern with the quality of health-related information received by preferred sources between Bulgarians of GEN X and GEN Y?

This question was interested in exploring generational differences in the concern with quality of health information by the number one preferred source of health and medical information, which was unknown until this data was analyzed. Since the majority of participants listed the Internet as their number one choice of health related information source, the author was interested in possible generational differences with the perceived quality of information people were receiving from the source. The results of the MANOVA showed that there was a significant main effect for treatment, $F\ (1,164) = 8.62, p = .004$.

Fig 6. *Generational differences in answers to: "Last time I looked for health or medical information, I was concerned with the quality of information."*



RQ4: Do members of GEN X and GEN Y in Bulgaria place different levels of trust in the health-related information received by the most preferred source, as well as all other sources?

In order to answer this question, the author created a "Total Trust" measure that aimed at assessing overall trust in all health information sources listed in the survey. The measure grouped all of the nine information sources items in one variable and combined their 4-point Likert-type scale scores in one item intended to measure overall trust in health information sources. Even though the measure proved to be consistent ($\alpha = .973$), the results from the MANOVA were not significant: $F(1, 164) = 2.96$, $p = .088$. There were also issues with significant homogeneity of variance within the sample. For the purposes of informing a potential public health intervention in Bulgarian however, it is important to know the sources that people overall trust more when it comes to health or medical advice. A distribution graph was created for both GEN X and GEN Y in order to describe the levels of trust the two generations place in information coming from different sources. Doctors, the Internet and Family and Friends were the top tree information sources for both age groups. Additional graphs of generation differences in trust towards health sources were created in order to illustrate where the greatest discrepancy in trust between GEN X and GEN Y's might be. It can be inferred that some of the observed effect can be accounted for by age group effects, rather then generational differences.

Fig 7. *GEN X Trust distribution across different sources.*

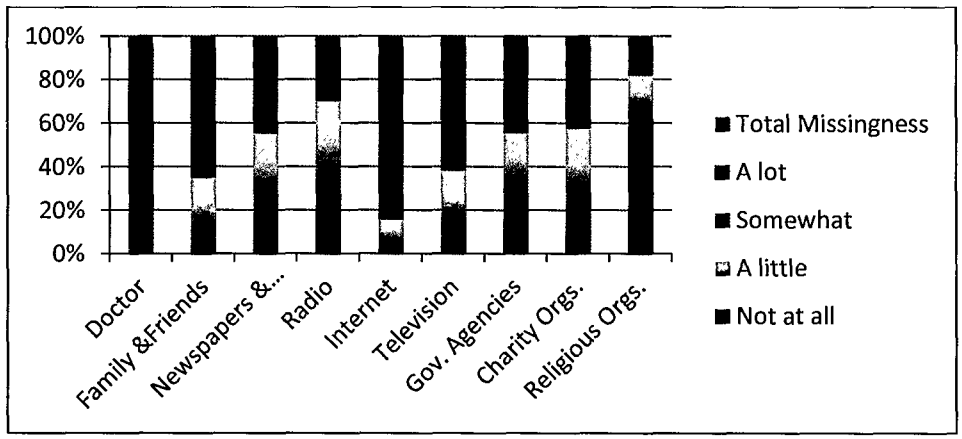


Fig 8. *GEN Y Trust distribution across different sources.*

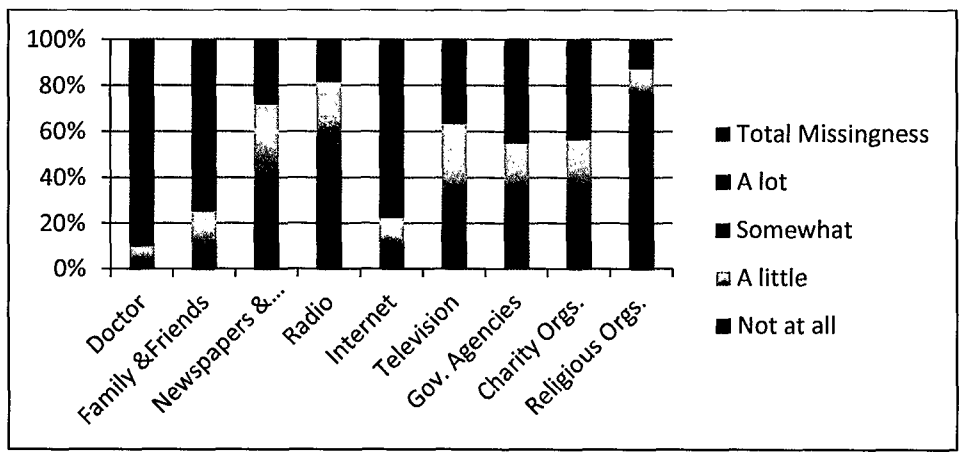


Fig 9. *Generational comparison on trust towards information from family and friends.*

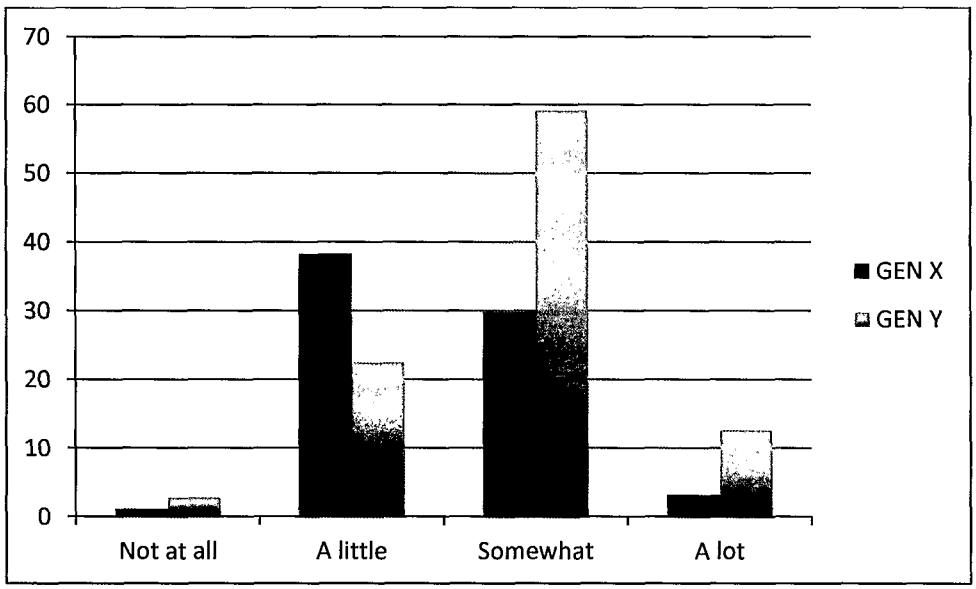


Fig 10. *Generational comparison on trust towards information from radio.*

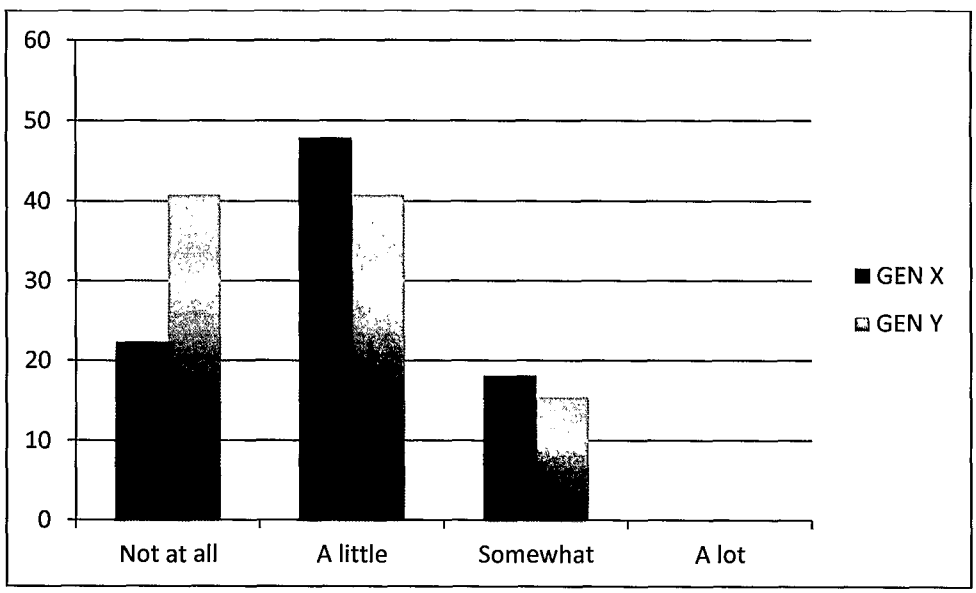
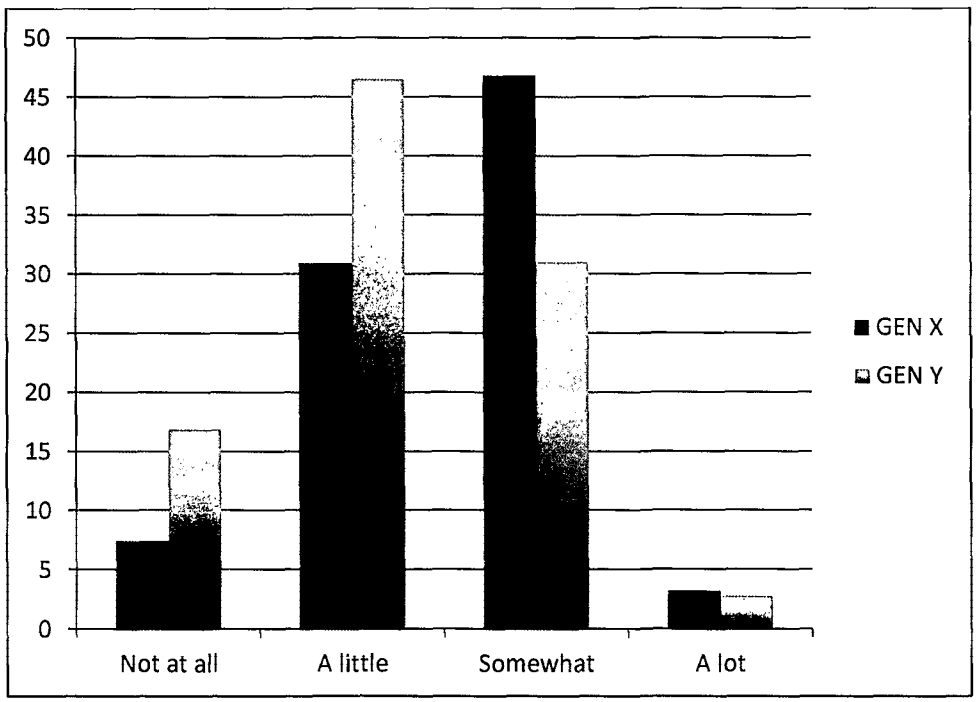


Fig 11. *Generational comparison on trust towards information from television.*



RQ5: Do members of GEN X and GEN Y in Bulgaria differ in their perception of how easy it is for a smoker to quit?

In order to answer this question, I utilized the survey item: "How much do you agree or disagree with this statement: "Smoking behavior is something basic about a person that they can't change very much" as a dependent variable. The results of the MANOVA showed that there was a significant between groups main effect, $F\ (1, 161) = 7.23, p = .008$. A scatter plot of this data showed that members of GEN Y disagreed more with the statement then GEN X. The homogeneity of variance was not significant for this test. However, it must be noted that this measure is a one item measure, and thus not highly reliable.

RQ6: Do members of GEN X and GEN Y in Bulgaria differ in their perception of the health consequences of first and second-hand smoking?

The results from the MANOVA in regards to first-hand smoking health consequences, showed that there was a significant between groups main effect, $F\ (1,161) = 4.87, p = .029$. The homogeneity of variance test was again not significant. Congruent with some of the generational descriptions provided in the literature review, a scatter plot of the distribution of this data suggests that members of GEN Y perceive smoking as more dangerous when it comes to health, then members of GEN X. However, this was not true when it came to perceptions of health risks in regards to second-hand smoking, F (1,161) =.20, p = .649. According to the scatter plot of this data, members of both generations do not perceive second-hand smoking as less harmful for a person's health, compared to first-hand smoking. Homogeneity of variance for this test was again, not significant.

Fig 12. *Generational comparison in attitudes towards first-hand smoking.*

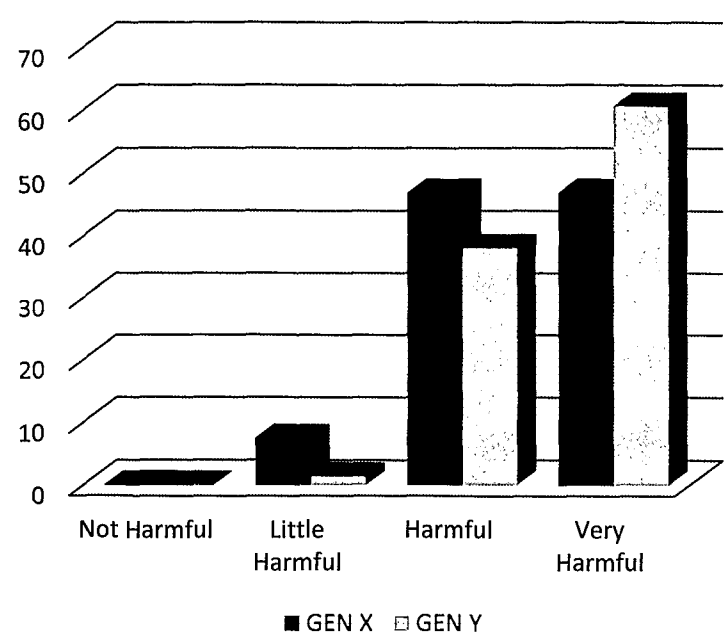
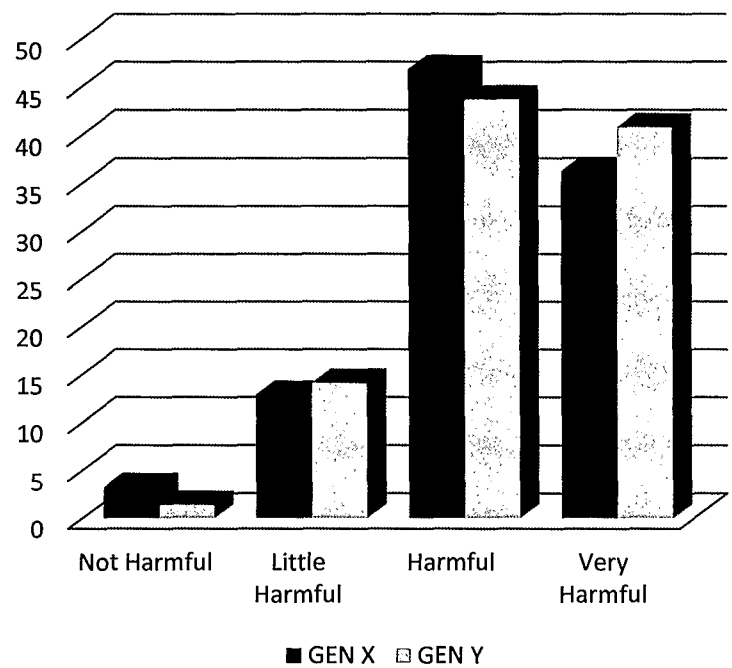


Fig 13. *Generational comparison in attitudes towards second-hand smoking.*



Post-hoc Analysis

Based on the pervious findings, a post-hoc hypothesis was developed that there is a generational difference between participant's attempts to quit smoking in the past year. It was postulated that since GEN X does not perceive smoking as easy to quit as GEN Y, they should report less attempts to quit. This hypothesis was supported by the findings of the Chi-square: $c^2(1, N = 116) = 5.57, p = .015$. Members of GEN Y are more likely to attempt quitting smoking then members of GEN X. The variation of smokers vs. non-smokers within the groups was also normally distributed.

INTERVIEWS

Generating initial coding categories and themes

The first step in analyzing this data was reading it multiple times in order to become very familiar with the text. After getting a good idea of what the text had in store across all the participants, I started distinguishing the different emerging categories. For the sake of clarity, only distilled categories and themes are reported here. None of the rough textual segments, aside from the textual examples at the end, was reported in this thesis. The first strategic reading (reading with a question in mind) was intended to answer the question: what is smoking for the participants at that very moment in time? The categories derived from the initial analysis were:

Smoking is:

- a social ritual
- a cultural practice
- a personal habit
- a harmful practice
- an emotional experience

The primary dialectical tensions were noted in the personal habit category. The habit was both described as positive-negative by both smokers and non-smokers. The positive aspects were mostly described as smoking is a subjective experience of joy, bliss and relaxation, where as the negative aspects were mostly described as a part of the aftermath of smoking: smoking is expensive, smoking is accompanied by bad odors, smoking is related to coughing, and smoking is shameful.

The second strategic reading of the text was answering the question of the developmental arc of smoking in Bulgaria. I was interested in exploring what are people's first memories of smoking, and have their attitudes about the act of smoking changed through time. In a sense, I wanted to hear their stories around smoking from the past (distal influences), the stories around smoking now (proximal influences), and the story of change in attitudes between "then" and "now", if such existed. In this reading I marked not only what was being said, but also what was being implied. These are the major findings:

Distal Influences (the story of smoking when it began)

- First memories of smoking as an act are always in regards to interpersonal relations with family and/or friends
- At an early age, smoking was perceived by the participants as a symbol of adulthood
- First smoking initiation in Bulgaria starts at an early age, roughly between 1st and 7th grade.
- Smoking initiation was reportedly a symbol of rebellion for GEN X more then GEN Y
- Smoking was an integral part of socializing during high-school years for both generations. In particular, connected with public places such as coffee shops
- Most participants reported that their parents told them that they should not smoke. However, most of the participant's parents were smokers, so their message was perceived as hypocritical. This was mostly true for members of GEN Y.

- Few participants reported initial strong negative attitudes towards smoking. Mostly, they reported that their attitudes started as either positive or neutral.

Proximal influences (the story of smoking now)

- There is no consensus amongst participants' perceptions of increase or decrease in smoking rates in Bulgaria today. No objective national data was mentioned by any of the participants.
- There are reported trends of stigmatizing smokers, and most of them are linked to the temporary "Smoking in Public" ban
- The increase in price of cigarettes was a current topic of discussion
- Participants reported distrust with the efficacy of the warning labels of cigarette packs
- The majority of participants discussed the two-sided nature of governmental involvement in regulating smoking in public (better for non-smokers, but it hurts the economy and infringes upon human rights), as well as the uncertain outcomes of these regulations.
- There was an overall mistrust with the government and it's motives behind public policy in regards to tobacco use.
- Smoking as a symbol of "Bulgarianness"
- Heavy smoking and drinking accepted as part of national character
- Discursive struggles of normative self-evaluation through comparison with the "people in Western Europe," as a group they compare with, but do not belong in (in a sense Westerners were talked about as the "other).

The third strategic reading of the text was interested in current intergenerational narratives about smoking—in particular amongst family members and close friends. I was interested in the nature of the conversations about smoking between GEN X and GEN Y, as well as how effective those conversation can be in changing attitudes towards smoking.

- Within a family system in Bulgaria, members of GEN Y report attempts to talk to members of GEN X who are smokers in regards to the negative aspects of smoking
- These conversations are perceived by members of GEN Y (smokers and non-smokers) as useless and ineffective in changing members of GEN X's attitude.
- Massages about quitting smoking by members of GEN Y are perceived by members of GEN X as nagging, annoying and having the reversed effect
- Grandparents were mentioned as active members of the family communication system
- Both generations perceive smoking is a personal problem not a societal one
- Both generations feel powerless in regards to changing other people's attitudes and smoking behaviors
- Peer influences were reported as more influential then family influences by both generations

The fourth-strategic reading was interesting in depicting current dialogical tensions and conflicting narratives between smokers and non-smokers in Bulgaria. The questions asked were interested in prompting people to talk about their experiences, with things such as smoking in public, from the stand point of smokers and non-smokers.

Smokers vs. Non-smokers collective narrative

- Congruent with the previous findings from this data, some Bulgarians feel that smoking is a personal choice and a human right. Therefore, nobody has the right to tell smokers not to smoke. However, not wanting to be around cigarette smoke was not talked about as a human right.
- Even though smoking in public is frowned upon, it is not stigmatized and criticized behavior.
- Non-smokers reported being tolerant to smoking around them as long as it is not in a very close proximity or in a very small, or poorly ventilated physical space. The tolerance level increases specifically when the smokers are family members or close friends.
- Smokers reported having hostile attitudes towards non-smokers who tell them not to smoke.
- The "smoking in public" ban was viewed by some as an infringement upon the ideology of participatory democracy.
- The government's involvement in smoking regulation was seen by most as insufficient, corrupt, and not having the interest of the public in mind.
- There are no available interventions or systematized tools and strategies that smokers can utilize in their attempts to quit smoking. There is a lack of communal and governmental support for people who are attempting to quit.
- Few people reported positive attitudes in regards to the level of education the younger generations have in regards to smoking. Trends in stigmatizations were also noted, even though there was no saturation of such narratives.

- Overall, according to the data, there is a low level caution in regards to second-hand smoking in Bulgaria.

Table 2. *Defining themes and competing visions of smoking in Bulgaria.*

Themes	Definitions
Smoking and Bulgarianness	This theme combines discourses associated with talking about smoking as something native or inherent within the Bulgarian culture and Bulgarian identity.
Smoking as habit/addiction	This theme combines discourses associated with smoking as a habit, or as something people do. It also includes the mentioning of smoking as an addiction due to the fact that they overlap as semantic expressions.
Smoking as social activity	This theme describes the different ways in which smoking is talked about as a social activity
Smoking as solitude	This theme describes the different ways in which people detach themselves from their everyday lives through smoking
Smoking as family discourse	This theme describes the narratives around smoking in the family, in particular focusing on the intergenerational aspect of this discourse.
Smoking as a personal choice or human right.	This theme describes the narratives around describing the act of smoking as a personal choice that only affects the smoker. It also includes the instances in which smoking was addressed as a human right.
Smoking as a financial issue	This theme describes the narratives around the negative aspect of the price of smoking.
Smokers vs non-smokers	This theme describes the instances in which the relationship of smokers in relation to non-smokers was described.

Locating Exemplars

In order to capture the essence of a given theme, examples within the text were identified. According to Baxter (2011), discourses are systems of meaning. The research questions in this thesis were interested in exploring discourses that are implicated in individual identity (who am I and who are the others in this relationship) as well as relational identity (who are "we" and how do we compare to "others") (Baxter, 2011). The exemplars of the systems of meaning in regards to smoking in Bulgaria are organized based on the themes defined above. The following textual examples represent possible answers to the research questions.

RQ7: From a dialogic perspective, what are the competing discourses experienced by GEN X in regards to smoking?

Smoking and Bulgarianness

- "It's just what you do, you get together with friends and you smoke. It's just how we do it here."
- "We are Bulgarians, we are "shopi" (people form low SES often talked about as stubborn and uneducated) Don't forget that the philosophy of the "shop" is that he would light up his house on fire to damage his neighbors property…Most of the time when people tell me not to smoke I smoke even more, just to prove a point."
- "Smoking was forbidden when we were young, during communism. This was the most important part. That was the biggest motivation to smoke. It meant

that you are brave, you were free, and you were hip. All the cool things that were forbidden were combined in the act of smoking. Because you can't afford anything else."

- "I lived in Western Europe for some years before I had kids, and the first thing I noticed, even back in the 80's, was that young people there don't smoke, where as all my friends here, they all smoked. There were only a few people in my school who did not smoke, and they were perceived as lame and nerds... So I think that we are getting where Western Europe was 20 years ago..."

Smoking as habit/addiction

- "To be honest with you, I think smoking is a reflex to me... I can recall a recent time when I went to a coffee shop, and somebody gave ma cigarette. I took it and at the same time I reached for my own cigarettes and lighter... I'm so used to reaching out for my cigarettes that I did it even though I had a cigarette already...It's years of me doing the same things every day."
- "Smoking means joy, pleasure. As the Russians say, "after dining you must smoke." You have to smoke after you eat."
- "As I said, when I sit down to have coffee, I have to smoke."
- "Maybe it is because it is absolutely an addiction. For me, I think that alcohol, drugs and this maybe I can put them under the same denominator. There is almost not difference between sticking yourself with a needle or cigarettes, it is the same commonality. It is just an addiction. For me it is an addiction."

- "Smoking is a necessity for me. It's an addiction. I can't go without it. I am sure everybody who smokes wants to quit, but they can't."

Smoking as solitude

- "Smoking means being alone, and time for myself. I set aside time for myself... One of the most delightful things for me is to relax, the kids are gone to bed and I go to the balcony and I smoke one cigarette... I mean these are my personal 10 minutes...they are for me."
- "Well, when he smokes a cigarette, in that short time he ....umm I can't really explain it. This time is just his...his own personal time. He is smoking in that time...just that. He is not working, he is not arguing with anybody, he is not getting aggravated by other things. He is just smoking a cigarette, and he is feeling good."

Smoking as a financial issue

- "Currently I think they connect it to money. It is very expensive to be a smoker these days. That's why people start buying illegal cigarettes, because they are cheaper. They buy tobacco and roll too I've noticed. They look like monkeys doing that. That's not normal that you should have to roll cigarettes in the 21st century. If the tobacco that's high quality in a box, yeah I get that, but to sit and roll like a loser. They buy poor quality tobacco too, it's a shame. But that's what the government did by raising the prices. The illegal cigarettes are about 50 % cheaper."

- "Yeah, we were told not to smoke, but mostly the conversation was that you are burning your money away. Not so much about the health aspect."
- "I think his motivation to quit was the money issue. He smoked like 2 packs a day, that's a lot of money. Cigarettes are very expensive."

RQ8: From a dialogic perspective, what are the competing discourses experienced by GEN Y in regards to smoking?

Smoking and Bulgarianness

- "Bulgarians are "bosses" when they sit down to drink, you know they do it all heavy and drink and smoke a lot."
- "We didn't chose to be born in this shitty country, and we also don't choose our ways of socializing. It's just how it is. Here, its ok to drink every day and drink a lot, and it's the same with smoking. Nobody cares. It's normal. You don't get to be different and not do what other people do...I mean it's how people make friends....anything else?"
- "The first thing that I can think of is that smoking is a special phenomenon in Bulgaria. Smoking is lead by... I mean many conversation start with smoking ..ummm..How to say it more accurately...Smoking is a big part of our culture."
- "Smoking has a huge cultural significance in our culture. We are a nation of smokers. Since my childhood years I can remember everybody around me smoking. In the Western world, you don't see women on the streets smoking as much as they do here. Here, you can smoke anywhere. I've even seen people

smoking on the subway… People can't help themselves, you understand? Once his work day is over, he wants to smoke 4, 5 cigarettes, in order to make up for something."

- "That's something very every-day kind of thing in Bulgaria…it's not an exceptional thing."

Smoking as habit/addiction

- "People here have too much free time. Having too much free time is the origin of all bad habits."
- Well smoking is some sort of a habit. People get used to them, and then become addicted to the habit, not the cigarette itself. They think they calm them down when they get upset, but I've read that it has been proven that they actually make you more anxious, rather then to calm you down. I connect it to habit..the cigarette.
- "I think that it's the habit, and that it calms them down and usually. You know…the situation in our country...so they say...well I can't afford so many things, now are hey going to take this away from me too? And so on…should I not have this too."
- "Well, I feel like smoking is just a habit that you acquire, unfortunately, in your young years, and then it is a hard thing to get rid of."

Smoking as social activity

- "In my opinion it is a mindless habit for most people, but it also plays a social role. At least in the environment I am in. In other words,..umm to smoke ..at work it is as a social boost. If you smoke you will have more social contact then you would it you didn't."
- "When people go out to smoke in groups, it's the same with drinking, it's not thought about as doing something bad, it's more like a social thing that we all do and its kind of like… a part of our density."

Smoking as a personal choice or human right

- "Overall I don't think that smokers get ostracized by society for smoking, it's they own choice to smoke and that's fine. Every person should be free to decide what to do you know, to smoke or not smoke."
- "I will never tell anybody what to do. It's a mater of personal choice. The only thing I'd say is if somebody is bothering me a lot with their smoke, but it would have nothing to do with how I feel about the act of smoking. I don't really get involved with people's personal choices."
- "They try to stand for some ludicrous human rights they think they have as smokers, to smoke, and smoke wherever they want because they are not harming anybody…which is not true."

Smoking as a financial issue

- "So the money they were spending on cigarettes every year was enough to buy them a car…how about that. They quit cause it got too expensive, not cause of the health issues. I'm sure of it."
- "Me as a person who has quit smoking, when I was not smoking, I can tell you that I was thinking about cigarettes, like… if I have the money, I will not worry, I will smoke. If somebody can buy me cigarettes every day, I will smoke and I would not care."
- "Well, even if cigarettes become like very expensive, we have seen that people won't stop smoking, that's pretty bad. Even the poorest didn't stop."
- "But that's the paradoxical thing isn't it. Doctors tell them that smoking is a problem, but they don't bother. People reduce smoking for financial reasons though. But then they start buying unfiltered tobacco and roll cigarettes."

RQ9a: What is the broad developmental arc of the story of smoking for GEN X?

Distal influences

Smoking as social activity

- " I started smoking in high school. I started smoking in the park, like all young people do. We sat around at the park a lot in high-school."
- "Yeah, in the neighborhood with one kid when I was very little. But we smoked sticks, like, we were pretending. Then with a friend of mine later we smoked…We wanted to be like the big guys, be grownups."

- "The very first time I tried, I was not even in school yet, before first grade. We were trying to smoke…with friends…Under the bridge, next to the river."

Smoking as family discourse

- "As a younger boy, I have a memory of people constantly sending me to the store to buy cigarettes. My grandparents smoked too, we lived with my grandparents and my parents in the same house. So I was always out to go get cigarettes. Back in the day you could buy cigarettes even before you were 18."
- "The first conversation I can remember about smoking must have been with my parents. In all cases, it was from my parents…how it was bad for you."

Proximal influences

Smoking as a habit

- "I've never had a negative attitude towards smoking. That never formed in me I don't think. I never really got addicted though, as I said I don't need them. My sister for example can't live without smoking. I'm not like that, a week a month a year, doesn't matter I don't need it I like it."
- "My opinion about smoking has always been the same. I know I shouldn't smoke, I know it's bad for me, but I feel good when I smoke. You can't put a price on feeling good."
- "Now I think about it as a necessity. In the beginning it was mostly to be different, to be free, to be an adult."

Smoking as a family discourse

- "Well, when my kids grew up, and I mean when they were 5, 6 years old and they started to understand what's going on around them. That's when my attitude towards smoking became negative. I didn't want them to smoke"
- "There is not a lot of evidence of quitting at later age. My parent's stories are much more full of nostalgia. Smoking seems to be accepted as an inherent characteristic of their generation."

RQ9b: What is the broad developmental arc of the story of smoking for GEN Y?

Distal Influences

Smoking as social activity

- "I remember in 4-th grade we were hanging out with a bunch of my friends in the near by neighborhood, and there was this one good-looking girl who was older than us, who was a smoker. We thought that if we smoked, she would like us more, and so we did."
- "I remember in first grade with my best friend we used to go in the neighborhood to hang out and he'd smoke with them. I remember him smoking clearly. And I didn't smoke. They used to try and make me smoke, but I always refused."
- "When we were little with my friends in the neighborhood, we would go to where all the young moms would hang out, and they would smoke, and we would go after they leave and pick up heir cigarette buds and hide to finish smoking them…whatever was left."

- "I had this one friend, she was older then me, and she was more mature and interested in other things, so I would follow her around… She was already a smoker, and we would go hide so she can smoke, and I was just learning how to. I would have a few drags, and then I would clean my hand with pine needles so I don't smell like smoke.… stuff like that."
- "Back in the day when we smoked, in my late teenage years… I mean 16, 17 years old, and around the prom. It was something you do to go with the masses, with your classmates. It was something you do to feel like an adult. We all smoked. In the coffee shop we used to go to during school breaks and after school, we would fill in the ashtrays all the time. But back then, I didn't care how many cigarettes I would smoke for the day. A pack, or two I didn't care."

Smoking as family discourse

- "Well, my parents figured out that we had smoked, and they sat me down to have a conversation. They told me not to do that, and so I stopped. I had only smoked a few cigarettes at the time so it's not like I was addicted yet."
- "The first memory I can recall are the soccer games we used to watch when we were little, and our parents would get around and smoke. Especially the World Cup in 94, I must have been 8 at the time. The first time I tried I was in first grade, and I almost threw up. Then my grand mom smelled me and you know what happened next (he laughs)…that's my first conscious memory of smoking."
- "Both my parents smoked a lot. I mean there was some mentioning of the fact that smoking is bad, but the fact that their behavior was different contradicted

what they were saying. When they do it, there is no point in saying anything about it."

Proximal Influences

Smoking as a social activity

- "It is much different now. In the morning I absolutely have to have a cigarette. My must-have cigarette is in the morning with my coffee. And then I can just not smoke for the whole day. Where as back in the day it wasn't like this. Back in the day you had to smoke every time you go out with friends. There was no way not to smoke."
- "When I was younger I was much more neutral towards it. I never really liked smoking, or engaged with it, but I never really cared if people around me smoked. When I became older and started going out to night-clubs and bars, my opinion changed drastically towards it being negative. I really can't stand it when people smoke in closed spaces."

Smoking as habit

- "With time, you become a grownup and now I feel it as a habit and stuff....back when I was starting to smoke I felt like, you know...everybody smokes...why not me too. I'm gonna be more interesting from curiosity, just pure curiosity and you start."

Smoking as personal choice

- "Well, lately I've been ashamed of it. I think that's a good thing. I've noticed that the instances in which I am ashamed for smoking are increasing in number. But that's only maybe but the past two months or something, it hasn't been a long time at all…maybe at the most a year."
- "Yes I can definitely say there have been changes in my opinion about cigarettes, due to the fact that I have smoked. I've had my own opinion about it, since in Bulgaria there was no control over selling tobacco when I was younger. Anybody was able to buy cigarettes. I have came to the conclusion on my own, that this is something that I have no need for, and that it is something I can get over."

RQ10a: To what extent do individuals in GEN X perceive that individuals from GEN Y are able to influence their attitudes towards smoking?

Smoking as a family discourse

- "However my kids talk to me about smoking (they are 13 and 10)…haha I actually have to hide from them now when I smoke, it's that bad. So far I'd say they really are 100% against smoking."
- "I couldn't care less really, what they young people think. Why should I care? I care about their lives as much as they should care about what I think. "
- "I don't think that telling people that smoking is bad for them has any effect what so ever. Telling somebody what to do in like talking to the radio. There is no effect."

- "My daughter won't make me quit smoking by nagging. I can't quit. I am absolutely convinced that I should quit, but I can't quit. And just talking about it annoys me. It's better not to even have the conversation, because it is pointless. The effect is that I just get annoying and light up another cigarette."

RQ10b: To what extent do individuals in GEN Y perceive they are able to influence GEN X's attitudes towards smoking?

Smoking as a family discourse

- "I have mentioned to my mom that she should stop smoking, but she says that it won't happen, so that's it. I don't try forcing her to quit by locking her up in a room and having this long speech about the harms of smoking for example. She is not little, she knows what she is doing, there is no need for me to tell her."
- "I don't think that talking to people stands a chance in changing people's smoking behavior."
- "You can get older people to quit but with too much effort and too few long term effects. It won't make sense economically."
- "I mean I've told my dad, why are you doing it? You have been poisoning yourself for a long while at this point, why are you doing it? If you don't have the will, just at least smoke less. Try to limit yourself…I've told him this, but he still smokes."
- " I tell my parents every day that they should quit…I think that older people don't even try to listen to what the younger people are telling them."

RQ11: What are the competing discourses between smokers and non-smokers in Bulgaria?

Smokers vs. non-smokers theme

- "One time she was smoking in a train for non-smokers and this one lady said something to her and she yelled back at the lady telling her it's her life and she can do whatever she wants wherever she wants. She really took her smoking seriously."
- "I've noticed people who don't smoke when we are at the coffee shop smoking, they don't want to breath in our smoke, it makes sense."
- "I don't care for the problem of smoking. If you wan to smoke, smoke. If you don't that's fine too. I really don't care. It concerns me as far as that I continue to enjoy what I enjoy and that's it."
- "Well I don't think non-smokers go to restaurants a lot, or at least very few of them do. So this smoking ban thing is hurting smokers a lot...When I was in high-school I didn't hide to smoke, now I have to go and almost hide outside or in a different room. Why? We are getting more strict then America when it comes to laws and law enforcement, which is not the point in a democracy."
- "People who don't smoke don't actually say a lot to smokers in public places. They just make facial expression and they know on the inside that they don't like it, but they don't say it a lot because there is no point in this."
- "Overall I don't think that smokers get ostracized by society for smoking, it's their own choice to smoke and that's fine. Every person should be free to

decide what to do you know, to smoke or not smoke. As long as you are not harming other people it's all good."

- "Personally, if is it me and somebody smokes around me, if they are people I care about I would not mind them smoking around me…But when there is a lot of people in a small place there is no air anyways, when you add smoke you literally can't breathe."

INTEGRATION

According to the *Good Reporting of a Mixed Methods Study* (Cameron et.al., 2013) framework, reporting the integration between both methods is a key component in reporting mixed-methods efficiently. The most important overlaps between quantitative and qualitative research were:

- Both sets of data agreed that GEN X perceives their smoking habit as something they can't change and are not trying often, where GEN Y is more positive in their perception of the necessity and possibility of quitting smoking.
- GEN X and GEN Y's attitudes towards the harms of first-hand and second-hand smoking in the surveys and interviews overlaps.
- Family is not a trusted or preferred source of health related information, or information about smoking, by both generations.

The low number of overlaps is not surprising due to the fact that only the second half of the HINTS survey deals with smoking, and none of the survey questions deal explicitly with the health information seeking behavior.

Insights gained from mixing methods

Part of the goal of this study was not only to describe numerically health information seeking behavior and attitudes towards smoking in Bulgaria, but also to re-tell the everyday narratives of smokers and non-smokers from GEN X and GEN Y in a systematic way, while aiming to maintain ecologic validity. Integrating multidisciplinary perspectives in designing health promotion programs by triangulating data collection methods has been suggested by previous researchers in regards to exploring a health issue in an ecological way (Stokols, 1995). The author also wanted to paint a picture of this moment in time in Bulgaria, as it is a moment of change and legislative action in regards to smoking policies. When it comes to understanding the generational differences in the culture of smoking in Bulgaria, the surveys were insufficient to provide insight into the current narratives on the topic, and the accepted culture and tensions about smoking in public. In addition, the survey did not provide questions about attitudes towards smoking in public enclosed spaces, since this is no longer an issue within the US. However, this is an important problem to be examined currently in Bulgaria. As literature points out, public opinions about smoking in public are strictly related to the percent of smokers in a country (EC, 2007).

In addition, exploring the developmental arc of attitudes towards smoking through the interviews provides more insights as to how smoking in Bulgaria starts, and what are the first memories (that are long-held) of people about the act of smoking. The answers to these questions were very homogenous for both generations. Critically, they all start in a social environment with friends—in order to mimic the actions of their role models—most often their parents. While further research is needed, these insights can be used as a

starting point for informing smoking initiation prevention campaigns. It is safe to assume that the current at-risk-generation (early adolescents) socialize and initiate smoking in a similar fashion, due to the lack of strict governmental involvement in tobacco control policies and the wide availability of cigarettes.

Even though contrapuntal analysis does not require accounting for reliability in the traditional sense, it does provide unique insights about persuasive appeals that can resonate with the public. Most importantly, it allows for the researcher to look for unspoken cues towards cultural trends—in psychological terms traces of implicit cognition. Such accounts are impossible in traditional surveys. By analyzing the way Bulgarians talk about smoking, I was able to extract themes and notions that will be familiar to them if they were to be strategically shaped as messages placed in an anti-smoking campaign.

CHAPTER IV

DISCUSSION

TRANSLATING PUBLIC HEALTH DATA INTO PUBLIC HEALTH CAMPAIGNS

The goal of this thesis was to provide an ecological analysis of the current public health communications, health-information seeking behavior, as well as attitudes towards smoking in Bulgaria. In particular, it was structured around generational differences in these regards. The intended audience for this analysis was: healthcare practitioners, policy makers, funding agencies, community groups, and academic researchers. The primary purpose of this thesis was to inform potential public health interventions, aiming in decreasing the high number of smokers in Bulgaria.

As Stokols, 1996 suggests, the most valuable aspect of an ecological approach is that it emphasizes on dynamic interactions of intrapersonal and environmental factors, and not only on direct effect of health practices such as smoking, on a person's overall health. Based on the current literature and the data presented in this study, suggestions for potential strategies of implementing public health interventions in regards to smoking in Bulgaria have been organized in six key points inspired by the guidelines provided by Stokols (1996). These points overlap with one of the primary interests of this study, namely to discover important points where public health messages can effectively reach interpersonal communication.

1. Examine the links between multiple cultural facets of smoking and the diverse conditions of the sociophysical environment.

Ecological approaches put great emphasis on distinguishing health promoting environments specific for the particular demographics or cultures at hand. According to the literature review, as far as the public policy and community involvements layers are concerned, there are no sufficient organized efforts in changing people's every-day-life environments in order to decrease the number of smokers in Bulgaria. This provides both difficulties (lack of previous structure to work with) as well as opportunities (chance to gain people's trust faster) for future smoking-related interventions in the country. According to SCT, the environments in which the meanings of smoking manifest (e.g., social meanings of places like café's and bars), should be the ones that must be adapted to prevent smoking behavior in order to reduce smoking rates. For example, the qualitative data suggests that smoking for most Bulgarians started at an early age at school, or around school, in public parks and neighborhoods. Smoking was also something that the participants started experimenting with while still being underage. What this suggests is that strict policy against smoking in near proximity to schools could be beneficial in decreasing smoking initiation rates. In addition, regulating smoking in public places, such as parks, might be an effective way to prevent children from trying to attempt smoking while trying to copy the smoking behavior of members of the adult population in those parks. Since one of the strongest facets of smoking in Bulgaria was the social one, banning smoking in all public in-closed spaces will be the most promising environmental change when it comes to changing smoking behavior at large. Furthermore, making the voice of non-smokers being heard and respected as an opposition to the currently accepted standard of smoking as a part of socializing, is also another aspect of the process of changing the relationship of the cultural themes related to

smoking (e.g., personal right) and the environment in which they manifest (e.g., bars in which non-smokers also dine and socialize).

2. Consider Joint Influences of Intrapersonal and Environmental Conditions on Individual and Community Level.

On an individual level, the relationship between environmental conditions and intrapersonal factors in relation to health behaviors has been well documented throughout the years, in particular in epidemiology research (Stokols, 1996). Intrapersonal factors exist in the person's idea of self in relation to the world around her. Considering how many times the act of smoking was mentioned in the interviews as a way to relax, a human right, a reason to take a break, and a way to isolate, it could be inferred that the perception of an overall state of well-being for some Bulgarians might also include the act of smoking. It appears that for some Bulgarians, smoking is used as a form of escape of every day troubles and hardships. These intrapersonal factors in combination with the fact that smoking behavior is not heavily regulated, and cigarette advertising is not illegal, provides for a scenario in which smoking is not scrutinized and is constantly renegotiated as a part of one's intrapersonal beliefs of self and individuality. According to the results from the interviews, smoking was in fact connected to more positive then negative social experiences. Smoking is also something that is understood as part of what I have identified as a theme of Bulgarianness- an ideology that stands for more then just a personal habit. Detaching the sense of what it means to be Bulgarian (the Bulgarianness), from the idea of smoking, might prove to be the most challenging process, due to the emotional nature of the relationships people have with their national identity. In addition, having non-smokers have to comply to the predominantly smoking social environments,

also changes non-smokers intrapersonal perceptions of self, as compared to the rest. Most people indeed report starting to smoke in order to become part of the norm. This is an example of how the normative smoking behavior changes people's understanding of self by having them initiate smoking in order to belong to a dominant group. The smoking - enabling nature of the environments in which Bulgarians live, work and socialize, prevents people from having to reconsider their smoking behaviors. Therefore, changing the public policy in regards to smoking in public, should have an effect on the intrapersonal factors and the culture of smoking in Bulgaria.

Another example of how the different layers of the ecological model interact with intrapersonal factors was evident in the narratives from Bulgarian's when it came to the talking about where they think they stood when compared to other countries. For example, competitive identities between "Us" (Bulgarians) and "Them" (Western Europe) were clearly in place during the interviews. It can be speculated that this might be one of the reasons why members of GEN Y are more willing to try and quit, or believe that they should quit, compared to members of GEN X, since their identity is reportedly closer to the European one. As a generation that has internalized the European identity as their own, members of GEN Y mimic the appropriate behavior dictated by the EU when it comes to smoking. According to the results from the interviews, smoking reminds members of GEN X of the past, which is strictly related to a USSR identity. These somewhat nostalgic narratives might be a way for members of GEN X to communicate that they are in a sense in "no man's land" - a generation that no longer identifies as a belonging to a country which is a satellite to the USSR, but is also not fully integrated in the EU.

Another intrapersonal factor that became evident from the interviews was that smoking was highly regarded as an "individual" issue or a "human right" that has negative effects only on the smoker herself. This commonly healed belief points out to an issue of a lack of support and a sense of community conscious when it comes to tackling the public health that is smoking. A sense of cohesion, belonging and community amongst people is a key in changing health behavior (Guttmacher, Kelly, & Ruiz-Janecko, 2010). In a sense, the feeling of "we are all in this together" when it comes to understanding smoking behavior, is something that was missing from the interviews both with GEN X and GEN Y. This also points out to the lack of collective conscious in Bulgarians on the harms of second-hand smoking. All of the participants, who reported that they have quit smoking, stated that they have quit for their own personal reason, not because of, or with the help of other people. As stated by the literature review, during communism, participating in non-governmental community gatherings, such as going to church in Bulgaria, were illegal. Illegal were also any formations or civil organizations or unions that were non-governmental. What this could mean is that in Bulgaria, community involvement and social support on the grassroots level, or through non-governmental institutions like the church, are not a common practice. It can be inferred that, since the collapse of the Soviet Union, Bulgarians have been mostly relying on themselves and their immediate family and friends for help and social support.

3. Envision health promotion programs that enhance the fit between people and their surroundings.

What Stokols (1996) means by enhancing the "fit" between people and their surrounding is precisely the intersection this thesis emphasized on, namely the intersection point

between the first three layers of the ecological model, and the arena of interpersonal communication. In order to be effective in convening a consistent message to the target groups, the messages should be the same on a public policy, communal involvement and institutional levels. The message should also be sent out in a way that it would reach the realm of interpersonal communication in the most optimal way for the demographic at hand. The modes of communication in this case, become a key factor in this optimization. According to the surveys, promising environments in which community based interventions can take place in Bulgaria are the cultural clubs. Based on the results from the HINTS surveys and the in-depth-interviews, Bulgarians do not place great trust or value in health information coming from governmental sources. This suggests that these interventions might be more successful if they represent grassroots efforts or local NGO's, even thought those are currently not widely available. In addition, the data from the HINTS surveys shows that the third more trusted source of information in Bulgaria is Family and Friends, which means that community promotion encouraging family groups participation might be a good way to structure the image of the intervention.

According to the data, the number one go-to source for health and medical information in Bulgaria was the internet. This suggests that an online smoking cessation support group might be a popular tool in helping people overcome their addiction. Making social support available both online and in-person should provide a variety of people from different demographics with options, as to where to seek help and support when they decide to quit smoking. Such community based interventions could improve the well-being of Bulgarians on more levels then just help them to quit smoking or

prevent them from initiating smoking. It can provide them with the sense of community necessary as a tool for long - term involvement in healthier life styles.

4. Identify high-impact leverage points.

The definition of high-impact leverage points is: reoccurring patterns of activity that influence a person's well-being (Stokols, 1996). The results from the HINTS data gathered in this study can be helpful in determining what are these points. As mentioned before, the data from the surveys shows that the internet was the number one go-to preferred source of health and medical information for both GEN X and GEN Y. Only a few of the participants consulted more then one source the last time they looked for health or medical information. The internet was also the number one trusted source of information for Bulgarians, after the doctor. This mode of communication combines a high level of preference and trust, which means that it is a key high-impact point for smoking intervention. However, there was a significant generational difference in the perceived quality of health information available on the internet, with GEN Y being less trusting then GEN X. This difference should be taken in consideration in intervention planning.

Another leverage point that emerged from the interviews is the repetitive narrative that smoking is a costly habit. Emphasizing on the amounts of money Bulgarians can save by quitting, might be used as a part of high-impact message. In addition, identifying high-impact individuals and opinion leaders in different interpersonal networks of diffusion of health information is also an important part of smoking secession and initiation prevention campaigns (Kim & Dearing, 2014). For example, celebrities that are a reoccurring character in Bulgarian's lives, and are perceived as a desirable role-model

when it comes to healthy lifestyle, should be identifies and used as anti-tobacco promotions on a mass media level. Such strategy can be effective even in remote areas in Bulgaria where local public figures with positive image, like the mayor for example, can be incorporated in some of the interventions that happen in places like the "culture clubs.

5. Address interdependencies between physical and social environment in different life domains.

The life domain on which this project was focused was the family domain. Domain is defined as an area of life, which operates by its own unique rules and systems of meanings and interaction- the family system is one such area. The author was interested in the intergenerational communication between family members in Bulgaria, and in particular if this communication is perceived as effective in changing smoking behavior. According to the qualitative data, the social environment in the Bulgarian family is not perceived as an effective or desired place to have conversations about smoking. In particular when it comes to members of GEN Y advising members of GEN X against smoking. This dynamic was described by members of GEN X as having the reversed effect of making them smoke more, instead of considering quitting. There were some instances of members of GEN Y reporting members of GEN X being highly influential in their decision weather or not to smoke. Grandparents, as an active part of many family systems in Bulgaria, were also mentioned by members of GEN Y as influential in their decision making about smoking. In addition, the data suggested that close peer group communication environments might a more conducive domain worth examining in regards to its efficacy in promoting behavioral change.

6. Integrate multidisciplinary perspectives in the design of health promotion programs and the use of multiple methods to gauge scientific and social validity of interventions.

There has been an ongoing push for interdisciplinary in health promotions and health communications in recent years (Stokols, 1996). The socio-ecological perspective of health promotion almost cannot be imagined without gathering information on a particular problem from multiple stand points. Given how complicated and not-well understood the problem with smoking in Bulgaria is, researchers from all fields related to health must gather their knowledge in a comprehensive way in order to understand the specificities of why do people smoke so much in Bulgaria. This will benefit parties interested in decreasing the number of smokers in Bulgaria, frame their messages to be as close to the Bulgarian mentality and way of life as possible. This was the underlying reason for using mixed-methods in this study as well. As described previously, in order to effectively promote anti-smoking mentality, multiple levels of a person's ecological system must represent the same solid message- namely that smoking, and in particularly smoking in public spaces, is not a socially acceptable behavior. Due to the fact that not all interventions in the different sociophysical layers of the human experience, will be under the direct control of the same program planners, it is crucial to increase communication between all disciplines which study the human life (biology, communication, medicine, psychology, public health, sociology, etc.).

LIMITATIONS AND SUGGESTIONS FOR FUTURE RESEARCH

Collecting enough data to support an ecological approach to a public health intervention is a long process that requires a team of people and a sufficient amount of funding. This project was entirely executed solely by the author of this study, and thus it lacks the necessary empirical strength and power to give concrete prescriptive ideas for strategic communication interventions. The research sample was insufficient both in size and in the fact that it was not a random sample from the entire population. Additional demographic information in regards to determining other predictors of smoking in post-hoc tests, was also unavailable. Future research should sample a larger group of people and employ probability-sampling techniques, such as the ones the National Institute of Health does with the HINTS survey in the US. Furthermore, some of the variables examined in this project were measure by a one-item measure due to the lack of reliable scales that are culturally appropriated for Bulgaria. Future research should develop scales that measure concepts such as technology mediated communication apprehension in the Bulgarian context, as well as scales that measure attitudes towards smoking. In addition, experimental studies might be beneficial in further understanding the connections between interpersonal family communication and attitude formation in regards to smoking. For example, as Cappella (1987) states: a communication effect from person B to person A can be recognized when person A's behavior is expressing behavior that is way beyond the one that a baseline data for this person would have predicted without person B. In the case of this study, the author was unable to convey baseline research in a tightly controlled setting.

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APPENDIX A

HINTS QUESTIONNAIRE

Health Communication in Bulgaria
Instructions:
This survey is gathering information about your attitudes and understandings concerning health and related behaviors. It is being collected as a part of a master's thesis project at Old Dominion University, Norfolk, VA, USA, Department of Communication & Theatre Arts.
The survey is anonymous. Please make no identifying markings. And, if you should encounter a question that makes you uncomfortable for whatever reason, please leave it blank.
If you would like information about the study please [Email]. If you have questions about the survey or its administration by this student please contact (English): Dr. Thomas Socha (tsocha@odu.edu), (757-683-3833)

When were you born?
☐ 1965-1980
☐ 1981-1994
What is your sex?
☐ Female
☐ Male
Please answer the questions below to the best of your knowledge by marking them inside the box with an X symbol.

1. Have you ever looked for information about health or medical topics from any source?

☐ Yes- go to question 2
☐ No – go to question 6

2. The most recent time you looked for information about health or medical topics, where did you go first? (Please mark only one)

☐ Books
☐ Brochures, pamphlets, etc.
☐ Cancer organization
☐ Family
☐ Friend/CoWorker

☐ Doctor or health care provider
☐ Internet
☐ Library
☐ Magazines
☐ Newspapers
☐ Telephone information number
☐ Complementary, alternative, or unconventional
☐
OtherSpecify_____
_____

3. Did you look or go anywhere else that time?

☐ Yes
☐ No

4. The most recent time you looked for information about health or medical topics, who was it for?

☐ Myself
☐ Someone else
☐ Both myself and someone else

5. Based on the results of your most recent search for information about health or medical topics, how much do you agree or disagree with each of the following statements?

	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
a.It took a lot of effort to get the information you needed.....	☐	☐	☐	☐
b.You felt frustrated during your search for the information.....	☐	☐	☐	☐
c. You were concerned about the quality of the	☐	☐	☐	☐

information.....

d. The information you found was hard to understand.....

6. Overall, how confident are you that you could get advice or information about health or medical topics if you needed it?

- Completely confident
- Very confident
- Somewhat confident
- A little confident
- Not confident at all

7. In general, how much would you trust information about health or medical topics from each of the following?

	Not at all	A little	Some	A Lot
a. A doctor				
b. Family or friends				
c. Newspapers or magazines				
d. Radio				
e. Internet				
f. Television				
g. Government health agencies				
h. Charitable organizations				

i. Religious organizations and leaders ☐ ☐ ☐ ☐

8. Imagine that you had a strong need to get information about health or medical topics. Where would you go first? (Please mark only one)

☐ Books
☐ Brochures, pamphlets, etc.
☐ Cancer organization
☐ Family
☐ Friend/CoWorker
☐ Doctor or health care provider
☐ Internet
☐ Library
☐ Magazines
☐ Newspapers
☐ Telephone information number
☐ Complementary, alternative, or unconventional practitioner
☐ Other
Specify_____

9. Have you ever looked for information about cancer from any source?

☐ Yes
☐ No

10. How much attention do you pay to information about health or medical topics from each of the following sources?

	Not at all	A little	Some	A Lot
a. An online newspaper	☐	☐	☐	☐
b. In print newspapers	☐	☐	☐	☐

c. In special health or medical magazines or newsletters	☐	☐	☐
d. On the Internet	☐	☐	☐
e. On the radio	☐	☐	☐
f. On local television news programs	☐	☐	☐
g. On national or cable television news programs	☐	☐	☐

11. Genetic tests that analyze your DNA, diet and lifestyle for potential health risks are currently being marketed by companies directly to consumers. Have you heard or read about these genetic tests?

☐ Yes
☐ No

12. Have you smoked at least 100 cigarettes in your entire life?

☐ Yes-
☐ No- Go to question 18

13. How often do you now smoke cigarettes?

☐ Every ay
☐ Some days
☐ Not at all- Go to question 17

14. On the average, how many cigarettes do you now smoke a day?

Please specify in numbers_____
(If less than one a day put 0, if more than 99 a day put 99)

15. During the past 12 months, have you tried to quit smoking completely?

☐ Yes
☐ No

16. Are you seriously considering quitting smoking within the next 6 months?

☐ Yes- Go to Question 18
☐ No- Go to Question 18

17. About how long has it been since you completely quit smoking cigarettes?

Please specify in numbers Days_____ Weeks_____ Months_____
Year/s_____

18. Do you believe that some cigarettes are less harmful than other?

☐ Yes
☐ No

19. Do you believe that some smokeless tobacco products, such as chewing tobacco and snuff, are less harmful than cigarettes?

☐ Yes
☐ No

20. There are a number of resources that people use to help them stop smoking. Before being contacted for this survey (and regardless of whether or not you smoke), had you ever heard of telephone quitlines such as a toll-free number to call for help in quitting smoking?

☐ Yes
☐ No

21. Have you ever called a telephone quitline?

☐ Yes
☐ No

22. In the past 12 months, did any doctor, dentist, nurse, or other health professional suggest that you call or use a telephone helpline or quit line to help you quit smoking?

☐ I have not smoked in the past 12 months
☐ Yes
☐ No

23. How likely would you be to call a smoking cessation telephone quitline in the future, for any reason?

☐ Very likely
☐ Somewhat likely
☐ Somewhat unlikely
☐ Very unlikely

24. Before being contacted for this survey, had you ever heard of 1-800-QUIT-NOW?

☐ Yes
☐ No

25. Have you heard of any tests to find lung cancer before the cancer creates noticeable problems?

☐ Yes
☐ No- Go to Question 27

26. What tests have you heard of?

☐ Chest x-ray
☐ CAT Scan or Spiral CT
☐ Lung biopsy
☐ Blood test
☐ Cannot recall name
☐ Other- Please specify_____

27. How harmful do you think smoking is for a smoking individual?

☐ Not at all
☐ Somewhat harmful
☐ Somewhat harmful
☐ Very harmful

28. How harmful do you think smoking is for people who are exposed to tobacco smoke?

☐ Not at all
☐ Somewhat harmful

☐ Somewhat harmful
☐ Very harmful

Thank you for completing this survey. If you are interested in participating in a short interview, which will serve as an extension to this research, please contact Iva Stoyneva at the e-mail below. Also, if you are interested in the results of this survey, or have any questions in regards to it, please contact Ms. Stoyneva at survey.ITS.2013@gmail.com.

APPENDIX B

INTERVIEW QUESTIONS

Interview Item

Introduction to study:

This interview is gathering information about your attitudes and understandings concerning health and health related behaviors. It is being collected as a part of a master's thesis project at Old Dominion University, Norfolk, VA, USA, Department of Communication & Theatre Arts.

The interview is anonymous. Please try to avoid identifying yourself as we talk. And, as we talk if you should encounter a question that makes you uncomfortable for whatever reason, please feel free to tell me and we will skip that question.

If you would like additional information about the study please email Iva Stoyneva at istoy001@odu.edu. If you have questions about the survey or its administration by this student pleases contact: Dr. Thomas Socha (tsocha@odu.edu), (757-683-3833)

In all of the questions below, smoking is used in regards to tobacco smoking only.

1. Words can have lots of different meanings to people. What does the word "smoking" mean to you today?
2. Has the meaning(s) of "smoking" changed for you over time [since you began to smoke]? If so, how has the meaning of "smoking" changed?
3. How do you think other Bulgarians in general might understand the word "smoking"?
4. In your current life, how do you think smokers who are close to you understand the word "smoking"?
5. In your current life, how do you think non-smokers who are close to you understand the word "smoking"?
6. In the recent past, have you had a conversation about "smoking" with a close relative or friend who is older than you? If so, can you tell me about that conversation?
7. In the recent past, have you had a conversation about "smoking" with a close relative or friend who is younger than you? If so, can you tell me about that conversation?
8. Is there anything else you might like to tell me about your understandings of smoking in Bulgaria?

VITA

Iva T. Stoyneva
Old Dominion University
5115 Hampton Boulevard
Norfolk, VA 23529

Education and Training

M.A.	Old Dominion University, *Norfolk, VA* Lifespan Digital Communication Advisor: Thomas Socha, Ph.D. (Expected May 2014)
B.A.	The Richard Stockton College of New Jersey, *Pomona, NJ* Communication Studies *Magna cum laude* December, 2011

Background

Iva Stoyneva is a second year graduate student at Old Dominion University. She is pursuing her Master's degree in Lifespan and Digital Communication. She currently a graduate assistant at the Office of Graduate Studies at Old Dominion University. She has also been a teaching assistant on record for Introduction to Human Communication COMM 200s course. Iva's research interests rest primarily in the fields of public health communication, strategic communication, and global health communication.

Selected Publications and Presentations

Socha, T., & Stoyneva, I., (in press). Positive family communication: towards a new normal. In L. Turner & R.West (Eds.). *The Family Communication Sourcebook* (2nd ed.). Thusand Oaks, CA: Sage

Stoyneva, I. (2014, April) Positive spousal communication as breastfeeding longevity predictor. *84th Annual Southern States Communication Association Convention*, New Orleans, LA

Stoyneva, I. (2013, September). The networked patient and mediated empathy- the role of social support health-networks online in coping with a health disparity. *The fourth Annual Transforming Audiences Conference*, University of Westminster, London, UK. (Accepted only)