A Longitudinal Study of Liverpool Schoolchildren's Experiences of Smoking Aged 9-11

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Appendix H

Acknowledgements

Abstract

Smoking is the greatest avoidable cause of premature death in Britain today, particularly among the poorest people in society. Most smokers take up the habit during childhood, and the age at which children begin to smoke is falling over time. Although patterns of regular smoking are often established during the teenage years, rates of experimentation with cigarettes peak during preadolescence. Despite this, in the UK there has been little longitudinal research into the process of smoking uptake during preadolescence, and this research fills that significant gap.

The Liverpool Longitudinal Study of Smoking (LLSS) is a unique longitudinal study that has tracked a cohort of approximately 250 children during their early years at primary school. This thesis continues and develops the LLSS by exploring the cohort's experiences of smoking during preadolescence in order to understand how children's early smoking careers develop between the ages of 9 and 11. Baseline quantitative and qualitative data collected at age 9 (in 1999) were compared with data collected at age 10 (in 2000) and at age 11 (in 2001) in order to identify key elements of change. These data were analysed longitudinally using a multiple case study approach that identified the individual trajectories of five children during preadolescence. A cross-case comparative method was then used to identify and explain the relationship between views, intentions and behaviour, and how these were shaped by the social context in which the children lived. The themes that emerged from the case studies were then explored and developed in the context of data generated by the whole cohort.

Statistical analysis revealed that smoking by best friends, fathers and brothers, together with knowing someone with a smoking-related disease, at age 9 predicted smoking by age 11. The discourses that the children used to talk about smoking uptake emphasised the role of parents at age 9, but by age 11 the cohort suggested that friends were the key influence on smoking onset. Each year, anxiety about being bullied into smoking by older children also emerged as a key concern for this age group. In addition, the analysis revealed that preadolescents appropriate adult discourses around the use of smoking as a

coping strategy. The use of these discourses was patterned by socioeconomic status. Children who lived in deprived areas suggested that both adults and children might smoke to counter stress and to relieve boredom. However, some of the girls living in relatively affluent areas perceived that adults smoke to control their weight. The study also considered the implications of these discourses for differential rates of smoking uptake at primary school.

A key finding of this phase of the LLSS is that preadolescents construct smoking as an adult behaviour, and therefore some children smoke in order to negotiate status in anticipation of the transition to adolescence and as a strategy of resistance to the exercise of adult power. The reduction of rates of smoking among children and young people is central to the government's tobacco control strategy, and this research has significant implications for the development of both interventions and policy.

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1 Introduction and Review of Literature

1.1   Introduction

This thesis presents analysis of data from the Liverpool Longitudinal Study of Smoking (LLSS) which has tracked the experiences of smoking of a cohort of approximately 300 children throughout their years at primary school (1994-2001). The research described in this thesis represents the preadolescent phase of the study and is based on data collected from the cohort between the ages of 9 and 11 (1999-2001).

1.1.1   Chapter Outline

This chapter introduces the LLSS and its context. The chapter opens with a description of the history and development of the LLSS and with an overview of the structure of the thesis. The chapter then presents a review of the literature and a detailed description of the context of the current phase of the research. The review examines smoking in its global context (section 1.2) before outlining smoking prevalence rates in the UK (section 1.3). The next part of the chapter describes the development of the smoking habit among children (section 1.4), before going on to consider the role that family and friends play in smoking uptake (section 1.5). The literature on children's views on smoking is then summarised (section 1.6). The next part of the chapter considers the social patterning of smoking prevalence among adults and children, and the implications of this for the distribution of health (section 1.7). Passive smoking and its implications for child health and smoking initiation are then described (section 1.8). The chapter then presents an overview of social policies that relate to smoking (section 1.9) and a brief review of existing longitudinal studies of smoking during preadolescence (section 1.10). The chapter closes by setting out the aims, objectives and research questions that will be explored in this thesis (sections 1.11-1.13).

1.1.2   The Liverpool Longitudinal Study

The LLSS started in 1994 and aims to explore children's smoking-related perspectives and behaviour. By using a longitudinal research design, the study is tracking how children's views on and experiences of smoking change over time. The study has been conducted by a team of researchers from Liverpool John Moores University. Lorna Porcellato (1998) designed the research protocol and collected data between 1994 and 1997. Shirley Waters collected data during 1998. Beth Milton updated the research instruments in accordance with the children's growing developmental abilities and collected data between 1999 and 2001. This thesis presents an analysis of the data collected during that period. Dr Susan Woods and Michael Mair will continue with the research from 2002 onwards.

When the study began in 1994, the cohort had just started to attend primary school. The same children have been followed from their reception classes throughout their years at primary school, until in 2001 they left to go to secondary school. The study is unique because it is the first piece of research that has used a longitudinal design to track a cohort of children's experiences of smoking throughout the early years into preadolescence.

The LLSS uses a child-centred, multi-method approach to generate both quantitative and qualitative data with the cohort. The methods used include questionnaires that are completed by the children and their parents, interviews, focus groups and a draw and write exercise. The methods are described in greater depth in Chapter 3.

Analysis of the data collected between the ages of 4 and 7 suggested that from an early age, children have a good knowledge of smoking and the health risks that are associated with tobacco. During the early years, most children reported that they had never tried smoking and held negative views towards the habit. However, many children could offer explanations of why some young people start smoking. See Porcellato (1998) for details of the research method and findings between 1994 and 1997.

The research has been funded by the Roy Castle Lung Cancer Foundation since the study began. The funders plan to use the study findings to develop interventions that will prevent children from taking up smoking. To date, the results from the research have been used to develop a smoking prevention resource for primary schools (Tacade, 2002).

1.1.3   Thesis Overview

Chapter 1 sets the scene for the research by reviewing the literature on children and smoking and by introducing the LLSS. The chapter concludes by outlining the aims, objectives and research questions that will be explored in this thesis. Chapter 2 sets out the epistemological framework on which this phase of the research is built, drawing especially on social constructionism and the 'new paradigm' of the sociology of childhood. Chapter 3 presents the research design that forms the foundation of this phase of the study. It explains how the methods used to collect data during preadolescence both draw on and extend the research that was carried out with the same cohort during the early years (1994-1998). Chapter 4 presents descriptive data on the cohort. Chapter 5 uses a case study method to present an in-depth analysis of the experiences of just five children during preadolescence. This chapter exploits the longitudinal nature of the research design by presenting the individual trajectories of these case study children during their final years at primary school. In Chapter 6 the key themes that emerged from the case study analysis are explored and developed in the context of quantitative and qualitative data generated by the rest of the cohort. A discussion of these data is presented in Chapter 7, with particular reference to the 'new paradigm' of the sociology of childhood. Conclusions and implications for policy are then discussed in Chapter 8.

1.2   Background

This part of the chapter outlines the implications of cigarette smoking for health and the addictive nature of tobacco use. It then goes on to look at the nature of smoking as a global epidemic.

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1.2.1 Smoking and Health

The earliest scientific evidence of the consequences of cigarette smoking for health was published in the 1950s, and the health risks smokers face are now well-known. Half of all regular smokers eventually die from tobacco related disease, and a quarter die prematurely (DeFronzo and Pawlak, 1994; Doll *et al*, 1994; Flay *et al*, 1998; Sweanor, 1998; Peto *et al*, 2000; Smith, 2000; Davis, 2000; Godlee, 2000; Jha and Chaloupka, 2000). This means that smoking is the greatest avoidable cause of premature death in Britain today, particularly among the poorest people in society. In the UK, smoking causes one in five of all deaths and each year more than 120 000 people die from smoking-related illnesses such as cancers of the lung, mouth, bladder, kidney, stomach and pancreas, coronary heart disease (CHD), chronic bronchitis and emphysema (Murray *et al*, 1983; Charlton, 1984; Doll *et al*, 1994; Perry *et al*, 1994; Sturges and Rogers, 1996; Birkett, 1997; Cheung, 1998; DoH, 1998; Adams and Young, 1999; DoH, 2000a; Moxham, 2000; Kannas and Schmidt, 2001). Treating smoking-related disease costs the NHS £1.7 billion per year (Richardson and Crosier, 2001). Therefore, reducing smoking prevalence is a key public health priority (Cheung, 1998). Smoking rates can be reduced both by preventing children from taking up smoking and also by encouraging established smokers to quit (Nilsen, 1959; Distefan *et al*, 1998; Derzon and Lipsey, 1999).

People continue to smoke because nicotine is highly addictive (The Lancet, 1991; RCP, 1992; Slade *et al*, 1995; Cheung, 1998; Goldman and Glantz, 1998; Sweanor, 1998; Glantz, 2000; Bolliger *et al*, 2000; Moxham, 2000). Therefore, many smokers who are attempting to quit seek to gradually reduce their dependency on nicotine by using Nicotine Replacement Therapy (NRT). NRT has been shown to significantly increase success rates among quitters. Products currently available include chewing gum, transdermal patches, nasal spray, tablets and lozenges (The Lancet, 1991; Tang *et al*, 1994; Shiffman *et al*, 1997; Lancaster *et al*, 2000). The most recent pharmaceutical development to help smokers to quit is the release of the drug Bupropion (Zyban) (Davis, 2000).

1.2.2   The Smoking Epidemic

Some researchers have postulated that the way smoking prevalence spreads through a population is comparable to an epidemic (Cavelaars *et al*, 2000). The smoking epidemic has four stages. Firstly, smoking is an unusual and exclusive habit that is principally engaged in by people in higher socioeconomic groups. Secondly, the prevalence of smoking spreads widely in the population. Commonly, rates of smoking among men peak at 50-80% and are evenly distributed by socioeconomic status. The smoking behaviour of women typically lags at least a decade behind that of men, and smoking is first adopted by more affluent women (Graham, 1998). Thirdly, prevalence rates among men begin to fall (to about 40%) as many men begin to quit, especially those in non-manual socioeconomic groups. Smoking rates among women peak during this stage at 35-45%, and then prevalence among women declines. Fourthly, rates of smoking continue to decline slowly among both women and men, with the slowest rates of decline among the lowest socioeconomic groups. Eventually smoking becomes associated with low socioeconomic status. Over the course of the smoking epidemic, there is a transition in the socioeconomic status of smokers from affluence to deprivation (Cavelaars *et al*, 2000).

According to the epidemic model, the UK is now in the fourth stage as adult smoking rates are slowly declining and smoking has become associated with low socioeconomic status (see section 1.7). However, in developing countries where people have only begun to smoke manufactured cigarettes more recently, the fourth stage of the model has not been reached and adult smoking rates continue to rise (Mendis, 1990). Worldwide, 1.2 billion people smoke and globally smoking will cause 450 million deaths in the next fifty years, with 70% of these deaths occurring in developing countries. Preventing young people from taking up smoking would only cut tobacco-related mortality rates after 2050, and as western lifestyles – such as smoking - spread around the world, the prevalence of cancer is increasing in developing countries (Lopez, 1998; Shiffman *et al*, 1997; Sweanor, 1998; Thun and Glynn, 2000; Lancaster *et al*, 2000; Jha and Chaloupka, 2000; LSHTM, 2002).

1.3 Smoking Prevalence in the UK

This section outlines national smoking prevalence rates among adults and children. It then considers smoking rates in the city of Liverpool where the research has been carried out.

1.3.1 Smoking among Adults

For the last 30 years, smoking rates among adults in the UK have been slowly falling. Nationally, the most recent figures show that 26% of both men and women are now smokers (Lader and Meltzer, 2001). The rate of decline is slow because the tobacco industry has been continuously successful in recruiting new smokers to the habit (Gilpin and Pierce, 1997). However, smoking rates are not evenly distributed among the adult population, and section 1.7 will consider the social patterning of smoking.

1.3.2 Smoking among Children

Although smoking rates are falling among adults, smoking rates among children in the UK present a different picture. Four hundred and fifty children take up smoking every day (RCP, 1992), and in 2000 a national survey found that 10% of young people aged 11-15 were regular smokers (usually smoking at least one cigarette per week) (Boreham and Shaw, 2001). Although recent figures show a fall in smoking rates among adolescents (from 13% in 1996 to 10% in 2000), the trend has been for smoking rates to have been rising among young people over the past decade – especially among girls (Amos, 1992; Bhatia *et al*, 1993; Trevett and Bolling, 1997; DoH, 1998; Flay *et al*, 1998; Charlton and Bates, 2000; Boreham and Shaw, 2001; Kannas and Schmidt, 2001). This is highly significant, because trends in smoking behaviour by young people will become the future trends in adult smoking in time (Graham, 1993; Charlton, 1996; Jarvis, 1997). Charlton and Bates (2000) have hypothesised that this recent fall in youth smoking rates is related to the rise in rates of mobile phone ownership among young people. They suggest that owning a mobile phone may have the same functions for teenagers as smoking – namely,

adult style, sociability, peer group interaction and individuality – as well as consuming their disposable income.

1.3.3 Smoking in Liverpool

In the UK, smoking is associated with disadvantage (see section 1.7). This relationship between smoking prevalence and socioeconomic status means that in Liverpool, a city characterised by pockets of deprivation, smoking rates are high. Official reports claim that 32% of adults smoke regularly, although unpublished figures suggest that adult smoking prevalence could be as high as 42% (Crosier, 2001; Liverpool Health Promotion Service, Personal Communication). A survey carried out in Liverpool found that 18% of children aged 10-11 had experimented with cigarettes, while 3% of boys and 2% of girls had smoked a cigarette in the past week (compared to a national average of 1%). This suggests that smoking rates among children are significantly higher in Liverpool than the national average (Dawson and Scott-Samuel, 1995).

1.4 Patterns of Smoking among Children

1.4.1 Smoking Uptake during Childhood

Studies have shown that the age at which children begin to smoke is falling over time (Conrad *et al*, 1992). By the age of 16 (the minimum legal age to purchase tobacco), seven in ten children have tried smoking. Most smokers begin to smoke regularly during their teenage years, and it is relatively unusual to take up smoking during adulthood (Charlton, 1984; McNeill, 1992; RCP, 1992; Cox *et al*, 1993; Graham, 1993; McGee and Stanton, 1993; Boomsma *et al*, 1994; Doherty and Allen, 1994; Eckhardt *et al*, 1994; Balch, 1998; Cheung, 1998; Jensen Arnett and Terhanian, 1998; Moxham, 2000). Smoking among children is of particular concern for health promoters because the earlier a child begins to smoke, the less likely he/she is to quit the habit as an adult, and the more likely it is that he/she will die prematurely from smoking-related disease (Charlton, 1984; Michell, 1990; Graham 1993; Doherty and Allen, 1994; Jackson *et al*, 1997). Smoking

by children is also of concern for policy makers because 'gateway theory' suggests that early use of tobacco predicts use of illegal drugs during adolescence and adulthood (Kandel *et al*, 1992; Kandel *et al*, 1994; Doherty and Allen, 1994; Eckhardt *et al*, 1994; Jackson *et al*, 1997). The government is committed to reducing rates of illegal drug use and the crime which is associated with it (The President of the Council, 1998), and this is a further reason to prevent smoking uptake among young people. It is vital to understand why children experiment with cigarettes and why some go on to become regular smokers, particularly since although the risks smoking poses to health are now well known, large numbers of children continue to take up smoking.

Although it is unusual for regular smoking patterns to be established before the teenage years, regular smoking is preceded by experimentation with cigarettes and this may occur at primary school, or even before children start school (Schneider and Vanmastrigt, 1974; Eiser *et al*, 1986; Charlton, 1987; Isohanni *et al*, 1991; RCP, 1992; Michell and Fidler, 1993; Cheung, 1998). Preadolescence is a key period during which to study smoking uptake because rates of experimentation with cigarettes peak between the ages of 9 and 12 for boys and 10 and 13 for girls (RCP, 1992). There is some evidence to suggest that children's patterns of smoking uptake are gendered. Boys start to smoke earlier than girls, but girls may make the transition from experimental to regular smoking earlier than boys (Baugh *et al*, 1982; Santi *et al*, 1990-1991; Amos, 1992; Henriksen and Jackson, 1998; Lucas and Lloyd, 1999). Some young children may try a cigarette just once, whereas others persevere until a regular smoking habit is acquired (Hirschman *et al*, 1984; Gilpin and Pierce, 1997).

It is after the move to secondary school (at age 11) that the majority of child smokers take up the habit. Research has shown that this is not due to pupils simply getting older, but is associated with the actual transition to a bigger school and the change in status that this brings (Santi *et al*, 1990-1991). Whereas primary school children enjoy the security of a small school where activities are highly organised, by contrast as new secondary pupils some may feel that they have to smoke in order to prove their status and establish their identity in a bigger school, with older peers and significantly less supervision by teachers

and other staff. Only 1% of children smoke regularly when they first start at secondary school, but the proportion of children who smoke increases with age. By age 13 one in ten smokes regularly, and by age 15 a third are already regular smokers (Schneider and Vanmastrigt, 1974; Michell, 1990; Thomas *et al*, 1993; Bolling, 1994; Jarvis, 1997; Boreham and Shaw, 2001).

For many children who are not yet regular smokers but are experimenting with tobacco, their smoking is probably opportunistic and based on their access to cigarettes: they may smoke when a friend or sibling gives them a cigarette, or when they have enough money to buy one (Goddard, 1990). Access to cigarettes is a major factor in preadolescents' experimentation with tobacco, particularly since younger children would be unlikely to succeed in an attempt to buy cigarettes from a shop (Charlton, 1984; Jarvis, 1997). Children with smoking parents may have easy access to cigarettes at home (Chassin *et al*, 1994; Greenlund *et al*, 1997; Jackson *et al*, 1997). Studies have also found that young children who are unable to buy cigarettes may smoke old cigarette butts that they find on the floor in public places (Baugh *et al*, 1982). Furthermore, more than half of children are given their first cigarette, rather than obtaining it themselves. This would suggest that children often do not take the initiative in their first smoking experiences but are instead led by others (Bewley *et al*, 1974; Baugh *et al*, 1982; Balch, 1998; Lucas and Lloyd, 1999).

By the time children reach secondary school they may obtain cigarettes from shops, cigarette machines or their friends. Although children in their early teens are more likely to have been given cigarettes by their peers or to have bought them from other young people, by the time children reach the age of about 15 and are smoking more than just a few cigarettes a day, they are more likely to buy cigarettes from a shop or a machine (Bolling, 1994; Gilpin and Pierce, 1997). Because cigarettes are expensive, children who smoke have been shown to have more spending money than children who don't smoke (Santi *et al*, 1990-1991). This means that children who smoke are more likely to have a paid job than non-smoking children (Banks *et al*, 1978; Bolling, 1994; Stanton *et al*, 1994). Although a few children smoke their first cigarette with their parents, for most the

experience either takes place with young friends or else alone (Flay *et al*, 1998). This means that a child who wants to try smoking needs access not just to cigarettes but also to unsupervised leisure time away from the gaze of adults.

1.4.2   The Stage Theory of Smoking Onset

Some researchers have hypothesised that there are several distinct stages involved in making the transition from having never tried a cigarette to becoming a regular smoker. This is known as the stage theory of smoking onset. Perhaps the best known model is that offered by Flay *et al* (1998) who postulate a four-stage model of adolescent smoking.

The first stage in the model is described as the preparatory stage. This is when the child develops his/her knowledge and beliefs about smoking. The second stage is termed the initial or first trial stage. At this point, the child tries smoking for the first time. Early experimentation with cigarettes is often experienced as unpleasant, and may act as a deterrent from future smoking (Hirschman *et al*, 1984; Flay *et al*, 1998). For this reason, some children will progress no further. However, others will make the transition to the third stage that is described as the experimentation stage. This stage is characterised by repeated attempts at smoking over an extended period, perhaps of many months or years. This experimentation is often situational-specific, that is to say it only occurs in certain circumstances such as at parties, at the weekends, and with specific peers. Regular smoking is the fourth stage, and during adolescence may only mean that the young person regularly smokes at least one cigarette per week. Children are most likely to experiment with cigarettes during preadolescence, between the ages of 9 and 12 (Charlton, and Blair, 1989). The transition from initial trial to regular smoking then takes an average of two years (Baugh *et al*, 1982; Hirschman *et al*, 1984).

Hirschman *et al* (1984) suggest that after these four stages, there is a fifth addictive stage which is characterised by nicotine dependency, craving and withdrawal symptoms. To relieve the craving for nicotine, the smoker may develop a pattern of heavy daily use,

with the first cigarette smoked early in the morning. If a young person smokes in a number of different settings, then he/she is more likely to move to the addictive stage.

Individuals may move through these stages in different ways (Hirschman *et al*, 1984). Children's smoking behaviour is often erratic, and early experimentation does not necessarily predict a progression to occasional smoking or even to regular teenage tobacco use (Goddard, 1990; Stanton *et al*, 1991; Goddard, 1992; Sutton, 1992). There has been little research into the process of addiction among children, but it has been suggested that some children may become addicted to smoking (and feel unable to quit) while they are still at school (Michell and Fidler, 1993; Cheung, 1998; Balch, 1998; Flay *et al*, 1998; Lucas and Lloyd, 1999; Foulds, 2000). By adolescence, some children report smoking for positive effect and argue that they smoke in order to relax, to relieve stress and manage their emotional state, to counter boredom and to bond with their friends (Bynner, 1969; Hirschman *et al*, 1984; Isohanni *et al*, 1991; Trevett and Bolling, 1997; Balch, 1998; Barber *et al*, 1999; Kegler *et al*, 2000).

1.5   Influences on Uptake of Smoking in Children

Smoking initiation is multifactorial in origin (Charlton, 1984; Crisp *et al*, 1999) and much of the research on smoking prevention has sought to identify statistical predictors of smoking onset (Conrad *et al*, 1992). Some of the key factors that influence children's smoking uptake are outlined in this part of the chapter. Children who are exposed to smokers in their social networks – principally their family and friends – are more likely to take up smoking (Distefan *et al*, 1998). The following sections review the roles that family members (section 1.5.1) and peers (section 1.5.2) play in smoking initiation.

1.5.1   Family

Children learn appropriate behaviours by observing their parents (Foshee and Bauman, 1992). Smoking by parents is widely acknowledged to be a significant influence on children's perspectives on smoking and, consequently, their own smoking uptake

(Bewley *et al*, 1974; Banks *et al*, 1978; Wilcox *et al*, 1981; Murray *et al*, 1983; Nolte *et al*, 1983; Charlton, 1984; Best *et al*, 1988; Charlton and Blair, 1989; Oei *et al*, 1990; Santi *et al*, 1990-1991; Green *et al*, 1991; Stanton and Silva, 1991; Goddard, 1992; Conrad *et al*, 1992; McNeill, 1992; Chassin *et al*, 1994; Doherty and Allen, 1994; De Vries, 1995; Jarvis, 1996; Jackson *et al*, 1997; Chopak *et al*, 1998; Henriksen and Jackson, 1998; Lloyd and Lucas, 1998; Flay *et al*, 1998; Sargent *et al*, 2001). Research suggests that parents' smoking influences children in two main ways: firstly, parents set an example of smoking behaviour; secondly, they provide a home environment in which smoking is seen as acceptable or even normal (Marsh and Matheson, 1983; Goddard, 1990; Michell, 1990; Bolling, 1994; Jarvis, 1997). Some studies have found that the mother's smoking behaviour is more influential than the father's on children's smoking uptake (Conrad *et al*, 1992; Distefan *et al*, 1998). Whereas other research has found that the smoking status of fathers is more important (Green *et al*, 1991).

Charlton (1996) considered how parental smoking affects smoking uptake and she concluded that a 'family circle' is formed as low-income parents transmit smoking behaviour to their children from generation to generation:

> Young women and their male partners who are less well-educated and less affluent are most likely to smoke during the woman's pregnancy. The harmful effects on the fetus, including low birth weight and increased risk of respiratory diseases, are carried forward into childhood. The frequent minor ailments can cause absence from school, falling behind with school work and perhaps under-achievement. Children of mothers who smoked during pregnancy are likely to have a smaller stature which can also affect self-esteem. Passive smoking in the home exacerbates these effects and adds others. The child, therefore, can become disenchanted with school and reject its norms and is then at increased risk of becoming a smoker. These young smokers are most likely to leave school early, to start families early and to smoke during pregnancy, thus continuing the 'family circle' or 'cycle of deprivation' (Charlton, 1996: 90).

According to other researchers, for many children, smoking is just a normal part of family life and the daily routine (Michell and Stenning, 1989). The children of smokers are perhaps more likely to experiment with cigarettes, from a motive of curiosity in order to find out what attracts their parents to the habit (Jarvis, 1997; Lloyd and Lucas, 1998).

Although parental smoking has been shown to be a key influence on smoking uptake, the attitudes which parents have to smoking are also highly significant (Wilcox et al, 1981; Nolte et al, 1983). Many parents who smoke disapprove of their children smoking in spite of their own behaviour, although there are indications that parents become more tolerant of their children's smoking as their children get older (Eiser et al, 1989). Parental attitudes have been found to be surprisingly significant in shaping their children's smoking behaviour, independent of parental tobacco use. Studies have shown that regardless of smoking behaviour, if parents display permissive or tolerant attitudes toward smoking, their children are more likely to begin to smoke (Schneider and Vanmastrigt, 1974; Doherty and Allen, 1994; Distefan et al, 1998). Conversely, if smoking parents display strong negative attitudes towards smoking by young people, this may deter their children from taking up the habit (Eiser et al, 1989; Henriksen and Jackson, 1998).

In addition, tobacco use by siblings is of central significance. Studies have shown that smoking by siblings may be even more strongly associated with smoking uptake than smoking by parents, and tobacco use by siblings is especially significant at an early age when few children have smoking peers (Bewley et al, 1974; Banks et al, 1978; Murray et al, 1983; Best et al, 1988; Goddard, 1990; Santi et al, 1990-1991; Stanton and Silva, 1991; Conrad et al, 1992; Fidler et al, 1992; Goddard, 1992; McNeill, 1992; Thomas et al, 1993; Bolling, 1994; Lawson, 1994; Jarvis, 1997; Sargent et al, 2001).

The proportion of children who live with just one parent has increased substantially in recent years. In 1972 there were only 500 000 lone parent households in Britain. This number has now risen to 1.7 million, with a third of all children spending some of their childhood in a lone parent family (Dorsett and Marsh, 1998). Although the majority of lone parents are smokers (Marsh and McKay, 1994; Marsh, 1997), research has shown that being a member of a lone parent household independently predicts children's smoking, regardless of that parent's smoking behaviour (Saucier and Ambert, 1983;

Murray *et al*, 1985; Goddard, 1990; Isohanni *et al*, 1991; Conrad *et al*, 1992; Fidler *et al*, 1992; Goddard, 1992; Thomas *et al*, 1993; Eckhardt *et al*, 1994; Jarvis, 1997).

Graham (1987 and 1993) explored smoking patterns among mothers, and she concluded that there is a strong association between smoking and caring responsibilities. Within the home, mothers use cigarettes to structure their day and to provide physical and emotional space away from the demands of their children. For women struggling to bring up their children on a low income, and amidst the stresses and hardships associated with poverty, smoking represents a coping strategy that enables them to manage their moods while meeting their domestic responsibilities:

> Smoking is experienced as a way of coping with stress and anger: a way of re-imposing order and calm when mothers feel their energy and patience is giving way... When faced with demands they cannot meet, mothers have described how they create a space – symbolic if not real – between them and their children and fill this space with a self-directed activity. Smoking a cigarette provides a self-directed activity which can be instantly accessed when mothers feel that their breaking point has been reached. A recent national survey of mothers with children under the age of seven underlined how central cigarette smoking can be to the management of anger and the avoidance of physical abuse. Over 70% of the smokers felt that smoking helped them to calm down when they felt like smacking their children (Graham, 1993: 35).

In addition to parental smoking behaviour and attitudes towards tobacco, the way in which the family unit functions has also been associated with smoking uptake. Children who experience high levels of familial conflict and are generally unhappy at home are more likely to try smoking and they are also more likely to make the transition from experimental smoking to regular use. Because the majority of parents disapprove of their children taking up smoking, it has been suggested that this decreased likelihood of uptake in cohesive families results from the greater influence that involved parents are able to exert on their children's behaviour (Daykin, 1993; DeFronzo and Pawlak, 1994; Doherty and Allen, 1994; Flay *et al*, 1998). The way in which children model the behaviour of either their smoking or non-smoking parents has also been shown to be mediated by the degree of attachment between child and parent. Children who are more closely attached to their parents are more likely to model both their smoking or non-smoking behaviour.

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Conversely, children who are not closely bonded with their parents are more likely to reject their health behaviours (Foshee and Bauman, 1992). Research also suggests that children who experience familial conflict may place more emphasis on relationships with their peers, and so be more susceptible to peer group influence (Tucker *et al*, 1997). Children who receive little parental supervision of their time and behaviour are also more likely to become teenage smokers (Barber *et al*, 1999).

1.5.2   Peers

Although parents and siblings are important influences on young children as they develop their views about smoking, as children get older and their friends begin to smoke, family influences wane in the early teenage years as peers play a key role in smoking uptake (Eiser *et al*, 1989; Distefan *et al*, 1998). This is in the context of adolescence as a transition from childhood to adult life, and as dependence on parents shifts to an emphasis on life outside the home (Jarvis, 1997; Lloyd and Lucas, 1998). Children who smoke are much more likely to have smoking friends (Bynner, 1969; Bewley *et al*, 1974; Banks *et al*, 1978; Charlton, 1984; Best *et al*, 1988; Charlton and Blair, 1989; van Roosmalen and McDaniel, 1989; Mendis, 1990; Stanton and Silva, 1991; Conrad *et al*, 1992; Bolling, 1994; Eckhardt *et al*, 1994; Hawthorne *et al*, 1995; Chopak *et al*, 1998; Distefan *et al*, 1998; Flay *et al*, 1998; Barber *et al*, 1999; Sargent *et al*, 2001). Furthermore, many studies have found that peer pressure is the single most important predictor of adolescent smoking, and this was the finding of a recent meta-analysis of published and unpublished prospective longitudinal studies tracking the development of smoking during adolescence (Derzon and Lipsey, 1999). Having a best friend who smokes is also associated with taking up smoking (Schneider and Vanmastrigt, 1974; Hirschman *et al*, 1984; Charlton and Blair, 1989; Santi *et al*, 1990-1991; van Roosmalen and McDaniel, 1992; Lawson, 1994; Glendinning *et al*, 1994; Wearing *et al*, 1994; Distefan *et al*, 1998; Barber *et al*, 1999) as is having older friends (Santi *et al*, 1990-1991). As with parents, the attitude of peers towards smoking is also a key factor in smoking uptake. Children are more likely to take up smoking if their friends approve of the habit, independent of their friends' smoking behaviour (Distefan *et al*, 1998; Flay *et*

al, 1998; Barber *et al*, 1999). However, theories of 'peer bonding' suggest that those who smoke have more in common and choose to associate with other young people who support their smoking behaviour and intentions (Eiser *et al*, 1989; Fergusson *et al*, 1995; Jarvis, 1997; Chopak *et al*, 1998). Research suggests that children who experiment with cigarettes are more peer-oriented and spend more of their free time with their friends (as opposed to family members) (Michell, 1989; Cleave *et al*, 1996). Being offered cigarettes by friends has also been found to predict smoking onset (Conrad *et al*, 1992; Eckhardt *et al*, 1994; Flay *et al*, 1998). Studies suggest that a child's first cigarette is usually 'a social act', and children may experiment with cigarettes together with a close friend (Michell, 1990; Lucas and Lloyd, 1999). Peers may influence not only smoking uptake, but they may also reinforce and maintain the emergent smoking habit by offering repeated opportunities to smoke (van Roosmalen and McDaniel, 1992). Smoking may be a behaviour that is established in a wider friendship group, which children may adopt in order to appear popular within that group (Dinh *et al*, 1995; Shucksmith and Hendry, 1998).

However, there is evidence that some children are bullied into smoking, while others are fearful of physical intimidation in future. Lucas and Lloyd (1999) suggest that there are two pathways through early smoking experience. Some children make their own decision to experiment with cigarettes due to a motive of curiosity, whereas others feel themselves to be pressured or coerced into smoking by a group of peers. Although the concept of 'peers' is accepted uncritically in the literature, its meaning is unclear – best friends, friends, bullies, classmates and other young people are all included in the concept, but their roles in the process of smoking initiation may be very different.

Longitudinal studies have also revealed that the influence of family and peers may operate differently on the stages of transition towards regular smoking. Research has demonstrated that peers may be a key influence in determining initial trials with cigarettes during early adolescence. However, the transition from first trial to repeated experimentation or to regular smoking may be influenced more by familial smoking (Conrad *et al*, 1992).

1.5.3   Other Factors

Although the behaviour and attitudes of family and peers are the most significant influences on smoking uptake in children, studies have found a number of other correlates of smoking initiation.

Initial trials have been found to be significantly associated with curiosity about what smoking is like (Charlton, 1984; Conrad *et al*, 1992; Greenlund *et al*, 1997; Turtle *et al*, 1997; Kegler *et al*, 2000).   Children are also more likely to start to smoke if they truant from school (Banks *et al*, 1978; Murray *et al*, 1983; Denscombe and Drucquer, 2000; Boreham and Shaw, 2001), if they have low self-esteem (Stanton and Silva, 1991; Conrad *et al*, 1992; Fidler *et al*, 1992; Doherty and Allen, 1994; Jackson *et al*, 1997), if they are not the first born child in their family (Isohanni *et al*, 1991), and if their mother was still a teenager when they were born (Isohanni *et al*, 1991).   Futhermore, in girls, smoking onset is associated with biological menarchal age (Crisp *et al*, 1999).

Many studies have also examined the impact that tobacco advertising has on children and they have concluded that tobacco advertising promotes smoking among children (Aitken *et al*, 1986; Best *et al*, 1988; Aitken and Eadie, 1990; Aitken *et al*, 1991; Amos, 1992; Goddard, 1992; Nelson and While, 1992; Birkett, 1997; Charlton *et al*, 1997; Feighery *et al*, 1998; Jensen Arnett and Terhanian, 1998).

Smoking by children is associated with absence from school, rebellion against adult authority, and the use of substances such as glue, alcohol and other drugs (Bagnall, 1988; Fidler *et al*, 1992; Michell and Fidler, 1993; Cooke *et al*, 1997; Jackson *et al*, 1997; Foulds, 2000).   For some researchers, smoking by children constitutes an intrinsic part of a wider lifestyle pattern of risky or 'deviant' behaviour (Hirschman *et al*, 1984; Green *et al*, 1991; Foshee and Bauman, 1992; van Roosmalen and McDaniel, 1992; Chopak *et al*, 1998; Henriksen and Jackson, 1998).   Some children may respond negatively to health education messages about smoking by using tobacco to demonstrate that they are anti-

establishment, tough and prepared to take risks with their health (Michell and Fidler, 1993).

1.6   Children's Views on Smoking

Much of the research into children's views on smoking has been carried out from a psychological perspective. These studies have focused on the relationship between attitudes and behaviour among older children, and on how changes in younger children's understanding reflect Piaget's cognitive stages of development theory (for example, Meltzer *et al*, 1984; Eiser *et al*, 1986; Porcellato, 1998). Children's understanding of the smoking habit varies over time and becomes more complex as children get older. Children's views on smoking are changeable (Amos, 1992; Goddard, 1992) and research suggests that although attitudes become more negative between the ages of six and ten, they subsequently become more positive between the ages of ten and fourteen (Schneider and Vanmastrigt, 1974; Botvin *et al*, 1983; Aitken *et al*, 1986; Dinh *et al*, 1995). However, the relationship between knowledge, attitudes and behaviour is very complex, and attitudinal change neither necessarily accompanies nor precedes behavioural change (Banks *et al*, 1981; Goddard, 1990; Foshee and Bauman, 1992; Graham, 1993; Bowling, 1997; Jarvis, 1997). Despite this, research with secondary school children demonstrates that young people with positive or neutral views about smoking are much more likely to experiment with cigarettes than those with negative views (Goddard, 1990; Conrad *et al*, 1992). Although a considerable volume of research has been carried out with teenagers, little research has been conducted into preadolescent children's views on smoking (Bhatia *et al*, 1993).

Never-smoking children who lack a firm commitment not to smoke have been described as 'susceptible to smoking'. Children with strong negative intentions against future smoking are described as 'nonsusceptible', while those who do not display a strong negative attitude towards future substance use are labelled 'susceptible' (Distefan *et al*, 1998). However, research is divided over whether measures of future intention to smoke or 'susceptibility' are useful predictors of adult smoking status. Some researchers argue

that intention is a useful predictor of future smoking (Bowen *et al*, 1991; Conrad *et al*, 1992; Sutton, 1992; van Roosmalen and McDaniel, 1992; Eckhardt *et al*, 1994; Dinh *et al*, 1995; Distefan *et al*, 1998). However, other studies reveal a considerable difference between actual and predicted future behaviour: children are often unrealistically optimistic that they will not become smokers in future (Goddard, 1992). This is particularly the case at primary school, when children hold very strong anti-smoking views and are often unable to imagine themselves as adult smokers. Nevertheless, research demonstrates that as children get older and their views on tobacco become less negative, measures of their future intention to smoke predict more accurately their adult smoking status (Goddard, 1990; Goddard, 1992). Studies have found that children who have already tried smoking are more likely to intend to smoke as adults than children who have never smoked (Eiser *et al*, 1989). It has also been argued that intentions are more useful predictors for some stage transitions than for others. In particular, intentions have been found to be a stronger predictor of the move from one trial to repeated experimentation rather than from never smoking to first trial (Conrad *et al*, 1992).

1.7 The Social Patterning of Smoking

Tobacco use as a habit is socially patterned, and smoking rates vary considerably by social group. Smoking in the twenty-first century is associated with social inequalities. As a major cause of disease and premature death, smoking also serves to create and deepen inequalities in health. This part of the chapter explores the relationship between smoking and social inequalities, before going on to look at the consequences of smoking for the health gap.

1.7.1 Social Inequalities and Adult Smoking Prevalence

Smoking prevalence among adults in the UK is socially patterned: rates vary by occupational class, income, gender and ethnicity. Smoking among adults is inversely correlated with occupational class. This means that smoking rates are higher among people in manual than in non-manual occupations (Lader and Meltzer, 2001). The

Whitehall studies of inequalities in health among civil servants have demonstrated that there is a clear social gradient in smoking, with higher rates among the lower occupational grades (Marmot, 1996). As smoking prevalence has declined among adults, rates of smoking have declined unequally over the occupational classes: in 1998, 15% of professional men smoked compared with 45% of unskilled manual men; and 14% of professional women compared with 33% of unskilled manual women (Richardson and Crosier, 2001). This variation is due to occupational class differences in trends in smoking initiation and cessation. Adults in non-manual households are more likely never to have smoked, and they are also more likely to have been able to quit than those in manual work (Graham, 1993; Stronks *et al*, 1997). These differences in smoking rates between the occupational classes are actually widening, and the social gradient in smoking behaviour is becoming steeper (Scott-Samuel and Platt, 1998; Shaw *et al*, 1999).

In addition to this gradient across society, smoking in the UK today is now clearly associated with socioeconomic disadvantage, and particularly with poverty. Smoking is inversely related to education level (DeFronzo and Pawlak, 1994; Cavelaars *et al*, 2000). There is also a clear association between smoking and benefit status, and for families which include children smoking prevalence rates rise sharply as income falls (Graham, 1993; Marsh and McKay, 1994; Marsh, 1997; Dorsett and Marsh, 1998; Graham, 1998). Living in a deprived area is also associated with smoking, independent of individual characteristics. This is likely to be because people who live in deprived areas spend more time with others who smoke, and also because if people live in an unsafe and undesirable environment this offers them fewer opportunities to make healthy choices (Duncan *et al*, 1999). In this way, smoking by low-income adults is frequently seen as a response to their poverty – as a means of coping amidst difficult daily circumstances, with financial pressures, social stresses and inequality of choice and opportunity (Graham, 1987; Graham, 1993; Marsh and McKay, 1994; Eriksen *et al*, 1997; Stronks *et al*, 1997; Dorsett and Marsh, 1998). Smoking prevalence rates may be highest among disadvantaged groups because people living in poverty are exposed more frequently to stressful life events and circumstances than the rest of the population (Stronks *et al*, 1997). The group of adults who have been identified as most likely to be in poverty and as most likely to

smoke are lone parents, who juggle the burden of child care while often struggling to manage on a low income. For these reasons, the disadvantage which many low-income parents experience frequently serves as a barrier to giving up. Although rates of smoking are high among lone parents, research has shown that this not an independent effect of being a lone parent, but instead it is as a result of the high levels of disadvantage (associated with smoking) experienced by lone parents as a group (Dorsett and Marsh, 1998).

It is important to note that smoking is associated with poverty, and in itself can also cause hardship. The struggle of bringing children up on benefits is often exacerbated by expenditure on cigarettes from the household budget which usually means that low-income parents have to cut back on other areas of essential household spending such as food, fuel and clothing. Thus, smoking by low-income parents often means that their children go without the things that they need, and research has found that smokers are more likely than non-smokers to be unable to meet their children's needs (Marsh and McKay, 1994; Dorsett and Marsh, 1998). In many ways this unintended consequence of parental smoking is as a result of government policy that aims to tax smokers heavily, and to consistently raise the price of tobacco products above the rate of inflation. This policy is intended to encourage smokers to quit or at least to reduce their cigarette consumption (see section 1.9). However, research has shown that it is the poorest smokers who are least likely to quit, and instead raising the taxes on tobacco merely serves to put poor families deeper into hardship (Marsh and McKay, 1994; Daykin and Naidoo, 1995; Marsh, 1997; Scott-Samuel and Platt, 1998). Poor smokers may also resort to buying contraband cigarettes in order to sustain their habit in the face of tax increases (Wiltshire *et al*, 2001).

The gender profile of smoking is changing, with what Hilary Graham describes as the 'feminisation of cigarette smoking', as more girls than boys take up smoking during adolescence and as rates of smoking for adult women have declined less quickly than they have for men (Graham, 1993). Smoking rates also exhibit variation by ethnicity,

with higher smoking prevalence among white adults than among minority ethnic men and women (Acheson, 1998; Richardson and Crosier, 2001).

1.7.2   Social Inequalities and Child Smoking Prevalence

Some studies suggest that smoking among young people is also socially patterned, by socioeconomic status, gender and ethnicity. Several studies have found an inverse relationship between smoking behaviour and socioeconomic status among adolescents (Johnson *et al*, 1982; Green *et al*, 1991; Stanton and Silva, 1991; Conrad *et al*, 1992; De Vries, 1995; Shucksmith and Hendry, 1998; Hagquist, 2000; Boreham and Shaw, 2001; Sweeting and West, 2001). Although, other research has found no link between adolescent smoking behaviour and class (see RCP, 1992; and Lloyd and Lucas, 1998). These conflicting findings may be related to the difficulty of measuring socioeconomic status among children and young people (Macintyre and West, 1991; Hagquist, 2000; West *et al*, 2001). Some studies suggest that while there is little difference between the social class backgrounds of children who have ever smoked, by adolescence smoking is related to young people's future socioeconomic status – that is to say where young people are headed (class of destination) rather than their family's social status (class of origin) (Glendinning *et al*, 1994; Graham, 1998). Although some researchers have argued that the association between low socioeconomic status and smoking among young people could be explained by the effect of the higher prevalence of smoking among parents (Green *et al*, 1991), others have found that children from manual households are more likely to smoke irrespective of parental smoking behaviour (Johnson *et al*, 1982).

As with adults, smoking among young people is also associated with poverty. Children who grow up in disadvantaged circumstances are at greatest risk of tobacco use (Graham, 1993). This relationship between smoking and disadvantage for children is particularly significant because the proportion of children living in low-income households has dramatically increased in recent years, and currently in excess of 4 million children are still living in poverty (Howard *et al*, 2001). Although the government has recently pledged to eradicate child poverty in 20 years and to halve it in 10 years (DSS, 1999), it

remains to be seen whether this target will be achievable. Because smoking rates among adults are clearly patterned by socioeconomic status, longitudinal studies are required to track how individuals in different socioeconomic conditions follow different smoking pathways from adolescence into adulthood (Graham, 1998).

Smoking among adolescents is also gendered. In much of Europe, smoking is now more common among teenage girls than among boys (Kannas and Schmidt, 2001). In the UK, 12% of girls aged 11-15 are regular smokers, compared with only 9% of boys. There is no gender differential in smoking rates until age 13, but smoking prevalence remains gendered at age 14 and 15 with girls consistently more likely to smoke than boys (Boreham and Shaw, 2001). These patterns may predict the feminisation of adult smoking in future years. In addition, smoking among young people is ethnically patterned. White youths are more likely to smoke than their minority ethnic peers. This difference may be explained by differing cultural taboos around substance use, although arguably these are changing over time as minority ethnic groups become more integrated into British culture (Kohli, 1989; Denscombe and Drucquer, 2000).

1.7.3   Smoking and Health Inequalities

As this section has shown, smoking is both associated with and contributes to social inequalities. Health and disease are socially patterned, with variations in rates of disease frequently determined by differences in socioeconomic status, with poverty representing a particular threat to health throughout the life course (Marmot, 1996; Wadsworth, 1996). Morbidity and mortality rates vary with occupational class (Acheson, 1998), and much of this can be explained by occupational class variation in smoking prevalence (Stronks *et al*, 1997). Smoking is a major cause of health inequalities, and over half of the social class gradient of premature deaths can be attributed to smoking (McNeill and Bates, 2000; Richardson and Crosier, 2001). For example, men in unskilled manual work are five times more likely to die from lung cancer than men in professional work (Richardson and Crosier, 2001).

There is evidence to suggest that adult health is closely related to 'physical health capital' which is built up before birth and during childhood and the early years – this health capital fund is based on pre-natal development, genetic inheritance, and the social and physical environment during infancy (Wadsworth, 1996). Aside from genetic influences, smoking behaviour by parents impacts on the health of their children from the earliest times. Passive smoking begins before birth if mothers continue to smoke and spend time in smoky environments during pregnancy. Being present in a smoky environment also contributes to health inequalities during childhood. It is those children from socially disadvantaged backgrounds who are most at risk from environmental tobacco smoke (ETS), because rates of smoking among their parents are the highest. The next part of the chapter presents a discussion of the effects of passive smoking on child health.

1.8   Passive Smoking

Passive smoke comes from two sources when a smoker has a cigarette. Firstly, mainstream smoke is exhaled by the smoker. Secondly, sidestream smoke is given off at the burning tip of the cigarette. Mainstream and sidestream smoke are dangerous to health, containing both toxins and carcinogens. In the United States, passive smoke is classified as a Group A carcinogen – a classification that is also applied to major pollutants such as benzene and asbestos. Knowledge of the harmful effects of passive smoke have led to the increased regulation of smoking in public places together with a decline in the general social acceptability of smoking (Barnes et al, 1995; Nelson et al, 1999; ASH, 2000; Swann and Wright, 2001).

Passive smoke endangers the health of both adults and children, and is the third leading cause of death in the United States (after active smoking and alcohol) (Goldman and Glantz, 1998; Hovell et al, 2000; Swann and Wright, 2001). In developed countries a large proportion of children are exposed to ETS both at home and in the community. A recent study carried out in Ireland found that 74% of school children reported exposure to passive smoke (Swann and Wright, 2001). The issue of passive smoking is of central importance for children's well-being for two reasons. Firstly, inhaling second-hand

smoke poses serious risks to children's current and future health. Secondly, children who spend time in smoky environments are more likely to become smokers themselves.

In recent years there has been growing awareness of the dangers of ETS to health (Glantz, 2000). Children are particularly at risk, both *in utero* and during childhood. Babies who are exposed to tobacco smoke before birth risk decreased lung function, being born with a reduced birth weight and developing diabetes. In infancy, ETS is implicated as a major cause of sudden infant death syndrome (SIDS) or 'cot death'. During childhood and the early years, passive smoking is associated with health complaints which include lower respiratory tract infections (for example, pneumonia and bronchitis), coughing and wheezing, worsening of asthma, middle ear and meningococcal disease, childhood cancers and leukaemia (RCP, 1992; Fish *et al*, 1996; Ashley *et al*, 1998; Cheung, 1998; McBride *et al*, 1998; Adams and Young, 1999; Nelson *et al*, 1999; Oddy *et al*, 1999; WHO, 1999; ASH, 2000; Dobson, 2000; Hovell *et al*, 2000; Lader and Meltzer, 2001; Swann and Wright, 2001; Toma, 2001; Montgomery and Ekbom, 2002). In the UK in excess of 40% of children live in households where someone smokes, and in 1997, it cost £167 million to treat children who experienced ill health requiring medical attention as a result of exposure to passive smoke (Nelson *et al*, 1999; ASH, 2000; Hovell *et al*, 2000; Jarvis *et al*, 2000; Richardson and Crosier, 2001). There is also evidence to suggest that people who are exposed to ETS as children may be at increased risk of lung cancer, cardiovascular disease and neurobehavioural impairment in adult life (Charlton, 1987; RCP, 1992; Hackshaw *et al*, 1997; Law *et al*, 1997; Nelson *et al*, 1999; WHO, 1999). A study using biochemical indicators found that exposure to passive smoke was – perhaps unsurprisingly - associated with living with a smoker. Exposure to ETS was also related to low socioeconomic status, living with a lone parent and crowding in the home after controlling for living with a smoker (Jarvis *et al*, 1992). In this way, passive smoking among children is independently associated with disadvantage.

Charlton (1996) suggested that passive smoking is a major factor in the transmission of the smoking habit from generation to generation (see section 1.5.1). Young children are most likely to be exposed to tobacco smoke at home or in other family-oriented contexts,

but as children get older they are more likely to experience ETS in public places (WHO, 1999). Crucially, though, children have little choice about their exposure to second-hand smoke: they are unable to 'vote with their feet' and leave smoky environments in the way that adults can (Michell and Stenning, 1989; Charlton, 1996; WHO, 1999). This is particularly the case if the smoky environment is their home, and is especially significant for asthmatic children (Michell, 1990). Although there are now restrictions on smoking in many public places, the home remains – of course – unregulated (Ferrence and Ashley, 2000). At home there are no limits on the smoke that children can be exposed to, and although some parents make an effort to keep tobacco smoke away from their children, this is difficult to achieve. Some parents don't smoke, and so their children are only exposed to smoke from occasional visitors, or they may even choose to make their homes totally smoke-free by asking visitors to smoke outside. However, for the children of smoking parents, their daily experience is very different:

> At the other end of the spectrum there are children who spend their days from birth and throughout childhood in poorly ventilated, smoke-filled rooms. People smoke not just in their own private spaces but throughout the house, in the living room where children spend on average 21 hours a week sitting in front of the television screen, in the kitchen where food is prepared and eaten, in the bathroom and even in the children's own bedrooms. The children see their parents and other members of the family smoking as a normal and routine part of daily life. Visitors light up over a cup of coffee. When the family goes to the homes of friends and relatives, smoking accompanies the meals and the talk. Undoubtedly they hear the arguments parents use to convince themselves that smoking is acceptable – for example, lung cancer is something that happens to other people, not them. Smoking is so ordinary an event that for the first years of their lives children probably do not question it – they know of no alternative (Michell, 1990: 25).

As well as causing absence from school due to ill health, exposure to passive smoke may also be significant in predicting smoking uptake. Although many children dislike spending time in smoky places, children who live with smokers are less likely to regard passive smoking as harmful to health than children whose parents are non-smokers (Bolling, 1994). Children who are themselves smokers are also less likely to dislike spending time in smoky places (Swann and Wright, 2001). Furthermore, studies have shown that children who are persistently exposed to ETS during the early years are more

likely to become active smokers during adolescence. This is because they are already sensitised to the effects of tobacco smoke and therefore the unpleasantness of their early smoking experiences will be reduced (Wakefield *et al*, 2000). Research has even found that exposure to passive smoke *in utero* may lead to smoking uptake. Maternal smoking during pregnancy has been found to be associated with subsequent child smoking independent of current parental smoking status (Kandel *et al*, 1994).

Children may model their smoking behaviour on that of their parents and peers, but societal norms around tobacco use are also a key influence. Therefore, bans on smoking in schools and public places may also reduce smoking onset in children by clearly demonstrating that smoking is socially unacceptable (Ferrence and Ashley, 2000; Wakefield *et al*, 2000). Bans on smoking in both homes and public places have also been found to delay children's transitions through the stages towards becoming a regular smoker. In this way, banning smoking in the home may be an important step that parents can take to protect their children's current and future health even if they themselves continue to smoke (Wakefield *et al*, 2000).

1.9 Smoking and Social Policy

As this chapter has already outlined (sections 1.2 and 1.7), smoking is a major cause of ill-health in the UK, particularly among people who live in disadvantage. Therefore, reducing smoking prevalence and consumption are now key aims of public health policy and are central to government strategy to reduce health inequalities. This part of the chapter describes current government policies to reduce smoking in the context of an overall aim to reduce inequalities in health.

In 1992, the Department of Health published the White Paper Health of the Nation (DoH, 1992), which set targets for reductions in key areas of disease and also in health-risk behaviours. Smoking was identified as one of these behaviours, and targets were set to cut both the prevalence and consumption of cigarettes, with particular emphasis on pregnant women and under-age smokers. After the Labour government was elected in

1997, it published its own White Paper in public health <u>Our Healthier Nation</u> (DoH, 1999) which modified the existing targets. Action on smoking is central to the plans laid out in <u>Our Healthier Nation</u> to tackle death rates from CHD and cancer, and to achieving the goals set:

- To improve the health of the population as a whole by increasing the length of people's lives and the number of years people spend free from illness.

- To improve the health of the worst off in society and to narrow the health gap.

In 1998, the government published the first ever White Paper on tobacco: <u>Smoking Kills</u> (DoH, 1998). This document continues to form the centrepiece for tobacco control policy. The White Paper set out three main objectives:

1. To reduce smoking among children and young people.

2. To help adults – especially the most disadvantaged – to quit.

3. To offer particular help to pregnant women who smoke.

<u>Smoking Kills</u> also set targets that were designed to measure the progress made towards meeting these three main objectives. The targets set were:

- To reduce smoking among children from 13% to 9% or less by the year 2010; with a fall to 11% by the year 2005. This will mean approximately 110 000 fewer children smoking in England by the year 2010 (baseline: 13% in 1996).

- To reduce adult smoking in all social classes so that the overall rate falls from 28% to 24% or less by the year 2010; with a fall to 26% by the year 2005. In terms of today's population, this would mean 1.5 million fewer smokers in England (baseline: 28% in 1996).

- To reduce the percentage of women who smoke during pregnancy from 23% to 15% by the year 2010; with a fall to 18% by the year 2005. This will mean approximately 55 000 fewer women in England who smoke during pregnancy (baseline: 23% in 1995).

In addition, The NHS Cancer Plan (DoH, 2000b) set a target to narrow the health gap by cutting smoking rates among manual groups:

- To reduce smoking rates among manual groups from 32% in 1998 to 26% by 2010.

In order to achieve these ambitious targets, the government has launched a strategy to cut smoking rates which includes a broad range of national action and local initiatives:

- A ban on tobacco advertising and promotion

- Raising the price of tobacco products by increasing tobacco tax by at least 5% a year in real terms

- National tobacco education campaigns targeted to reach populations with high rates of smoking prevalence

- Local help to enable pregnant smokers to quit

- NRT on prescription for smokers on a low-income

- Improving smoking cessation programmes

- Taking action against tobacco smuggling

- Tough enforcement of the law against sales of tobacco to children

- Proof of age cards to prevent the sale of tobacco products to minors

- Toughened industry code to regulate the siting of cigarette vending machines

- Reform of the CAP to reduce rates of tobacco production in the EU.

These measures have been largely welcomed by public health groups, and have been accompanied by substantially increased expenditure, mostly notably on smoking cessation services through Health Action Zones located in disadvantaged areas (Foulds, 2000). However, in some areas the government has been particularly slow to take action, notably to ban tobacco advertising and promotion. Although this measure was initially thought to be the cornerstone of the government's strategy, three years after the publication of Smoking Kills, it has only just been announced that the introduction of the necessary legislation will shortly be debated in the House of Commons (DoH, 2002; Kmietowicz, 2002).

Furthermore, rates of smoking among 11-15 year olds have fallen sharply to 10% in 2000 (Boreham and Shaw, 2001), easily meeting the target of a fall to 11% prevalence by 2005. However, this fall is arguably not as a result of government action particularly since the government has failed to ban tobacco advertising which is known to target young smokers (Jacobson, 1988). Instead, commentators suggest that the decrease is related to increased use of mobile phones among teenagers (see section 1.3). It remains to be seen whether this fall in prevalence will be sustainable.

1.10   Studies of Smoking and Preadolescent Children

1.10.1 In the UK

Systematic reviews have revealed that the majority of studies on smoking uptake among young people have been carried out in the United States (Conrad *et al,* 1992; Derzon and

Lipsey, 1999). However, in the UK, although there have been several cross-sectional studies of preadolescents and smoking (Charlton, 1984; Michell, 1990; Cleave *et al*, 1996), in general studies of young people and tobacco have tended to focus on adolescence, and have concentrated on measuring the prevalence rates of smoking among this age group (for example, Goddard, 1990; Lloyd and Lucas, 1998). During the 1990s biennial surveys were carried out to assess smoking behaviour among secondary school children in the UK between the ages of 11 and 15, and since 1998 these data have been collected annually. These surveys represent a significant source of data on smoking by adolescents (for example, Thomas *et al*, 1993; Bolling, 1994; Jarvis, 1997; Boreham and Shaw, 2001). But although experimentation with cigarettes often begins at primary school, preadolescents have always been excluded from the research.

1.10.2 Longitudinal Studies

Because becoming a smoker is part of a process over time, the contribution cross-sectional research can make to our understanding of smoking uptake is limited. This is because cross-sectional research designs explore relationships between variables that are measured concurrently. In this way, they are unable to explain the sequence of events related to smoking onset or how different variables operate over time. By contrast, the major advantage of a longitudinal design for investigating a process such as smoking initiation is that the study can reveal the order in which events took place. Nevertheless, although a longitudinal design can demonstrate which events preceded others, it does not necessarily indicate patterns of causation. Therefore, longitudinal designs aim to reveal predictors of transitions to smoking, rather than cause-and-effect relationships (Botvin *et al*, 1983; Conrad *et al*, 1992; Jackson *et al*, 1997; Michell, 1997a; Stronks *et al*, 1997).

Despite this, while numerous cross-sectional studies have examined the factors which lead children and adolescents to take up smoking, few longitudinal studies exist which study children's perspectives on the habit. In particular, there has been little research into why some children make the transition from experimental to regular smoking, whereas others experiment but do not go on to take up the habit (Flay *et al*, 1998). There has also

been little longitudinal research that has focused systematically on the influence the social environment has on smoking uptake (Santi *et al*, 1990-1991).

Longitudinal research which has studied children and smoking at this age (9 to 11 years) notably includes the Dunedin Study in New Zealand (Stanton *et al*, 1991; Stanton and Silva, 1991; Stanton *et al*, 1994) and studies tracking groups of children in Washington (Dinh *et al*, 1995) and North Carolina (Jackson, 1998; Jackson *et al*, 1998) in the United States. All the existing prospective longitudinal research on smoking uptake has been quantitative and a systematic review of these studies concluded that "Qualitative approaches may provide rich new insights into understanding how the predictors work" (Conrad *et al*, 1992: 1722). There is therefore a clear need for longitudinal research into smoking during preadolescence in the UK, particularly to use qualitative techniques to give meaning from the child's own perspective to the patterns of predictor variables that have emerged in other studies. A study of preadolescents that uses a qualitative approach is underway in Northern Ireland, but although the researchers plan to collect data longitudinally, to date only cross-sectional findings have been published (Rugkåsa *et al*, 2001a; Rugkåsa *et al*, 2001b). These longitudinal studies will be discussed in depth in section 7.5.

1.11   Aims of the Research during Preadolescence (1999-2001)

This research is of central importance because it continues the LLSS. This next phase of the study is particularly significant because it focuses on the key stage of preadolescence when rates of experimentation with cigarettes reach their peak. In the UK there has been no other longitudinal research that has tracked children's changing experiences of smoking from age 9 to 11. This study aims to examine emerging patterns of first tobacco use during preadolescence, particularly the transition from never having smoked to experimentation with cigarettes. In depth longitudinal analysis of both quantitative and qualitative data will also explore and seek to explain the relationship between intentions, views and behaviour, and the way in which these are shaped by the social contexts in which the children live.

The overall aim of this research is to build on an existing longitudinal study (Porcellato, 1998) to understand children's views about smoking, and to consider patterns of tobacco use by children in the context of the family. The first year of the research gathered baseline data at age 9. In-depth longitudinal analysis of the data gathered in subsequent years was then used to assess changes in views and smoking behaviour between the ages of 9 and 11, both for the sample as individuals and also as a cohort. This unique longitudinal analysis forms a key element of the study.

The aims of this thesis are:

- To build on an existing longitudinal study (Porcellato, 1998) to understand children's views on smoking and to explore their experiences of tobacco use in the context of the family and peer group.
- To perform in-depth longitudinal analyses in order to assess changes in views and smoking behaviour between the ages of 9 and 11 both for the sample as individuals and as a cohort.
- To consider the social context of experiences of smoking during preadolescence.

1.12   Objectives

The objectives of this phase of the study are:

- To develop new research instruments in the context of the existing study design (Porcellato, 1998) to explore children's views on smoking and to measure tobacco use by children and their families.
- To gather baseline data at age 9
- To gather longitudinal data at ages 10 and 11
- To identify key elements of change in children's intentions, views and behaviour as individuals and as a cohort between the ages of 9 and 11.
- To construct accounts of children's first use experiences while at primary school.

- To develop a theoretical model relating to these experiences.

1.13   Research Questions

Main Research Question:

- <u>How do early smoking careers develop during preadolescence?</u>

Supplementary Research Questions

Smoking Uptake
- What impact do smoking and 'not smoking' by parents, siblings, best friends and other peers have on smoking uptake?
- How do children explain their own smoking behaviour and intentions?
- How do children conceptualise the process of smoking initiation?
- What do preadolescent children understand about smoking by children and by adults in general? How is smoking socially constructed by preadolescents? How does this affect smoking uptake at primary school?
- What do children understand about the legal restrictions on the sale of tobacco to people under 16? How does this affect smoking uptake?
- How is preadolescent smoking socially constructed (by society in general)? How does this affect smoking uptake at primary school?

Smoking Cessation
- What do preadolescents know about addiction and smoking cessation? How does this affect their decision to experiment with cigarettes?

Smoking and Health
- What do preadolescents know about the risks smoking poses to health?

- How do children experience smoking-related disease in their families and communities? What impact does this have on their beliefs about smoking and their own smoking behaviour?
- How do children experience passive smoking? How does this affect their own smoking behaviour? How does passive smoking affect their health?
- How do children promote their own health and that of their friends and family in relation to smoking?

Social Context
- How are early experiences of smoking, views and intentions to smoke socially patterned (by gender, ethnicity, family type and socioeconomic status)?

Longitudinal Analysis
- Which factors predict experimentation with cigarettes at primary school?
- Which factors protect against smoking experimentation?
- How do experiences of smoking, views and intentions to smoke change during preadolescence?

Theory Development
- Why do preadolescents believe that smoking is acceptable for adults but not for children?
- Does the paradigm of the sociology of childhood offer a useful theoretical perspective for understanding children's experiences of smoking?
- How does this research contribute to sociological theories of childhood?

1.14 Conclusions

This chapter has reviewed the literature on smoking, children and social policy. It has also outlined the history of the LLSS, which is a unique longitudinal study that has tracked the experiences of smoking of a cohort of Liverpool primary school children during the early years (Porcellato, 1998) and now into preadolescence. The chapter has

also outlined the aims and research questions that shaped the research between 1999 and 2001. Chapter 2 will outline the epistemological framework that has underpinned this preadolescent phase of the study.

2 Epistemological Framework

2.1   Chapter Outline

This chapter sets out the epistemological framework based on social constructionism and the sociology of childhood that underpins the study. Firstly, the origins and key tenets of social constructionism are outlined, together with a critique of the social constructionist approach (section 2.2). Secondly, the paradigm of the sociology of childhood is described. This section of the chapter considers how presociological models of childhood and theories of socialisation and development have given way to the 'new' social studies of childhood (section 2.3). The chapter concludes with the implications of the new paradigm for the Liverpool Longitudinal Study of Smoking (section 2.4).

2.2   Social Constructionism

Social constructionism is a broad approach that encompasses a range of theoretical perspectives. Central to the theory is the assumption that all knowledge is socially and historically specific. Social constructionism is also concerned with the ways in which knowledge is socially produced and how, through discourse, this knowledge then mediates social relationships. A definition of the aims of social constructionism is given by Gergen:

> Social constructionism is principally concerned with elucidating the processes by which people come to describe, explain, or otherwise account for the world in which they live. It attempts to vivify common forms of understanding as they now exist, as they have existed in prior historical periods, and as they might exist should creative attention so be directed (Gergen, 1985: 3-4).

The social constructionist approach has been applied to the study of diverse areas in health and the social sciences, for example: medicine and the body (Lupton, 2000), the patient (Herzlich and Pierret, 1985), alcohol use (Nimmagadda, 1999), knowledge about passive smoking (Jackson, 1996), the person (Gergen and Davis, 1985), the family

(Holstein and Gubrium, 1999) and gender (Lorber and Farrell, 1991). The social constructionist approach is now one of the most significant theoretical perspectives on the sociology of health and illness (Bury, 1986).

2.2.1 The Origins of Social Constructionism

Social constructionism is a multi-disciplinary approach which draws on philosophy, sociology and linguistics (Burr, 1995). Drawing on the approaches of symbolic interactionism and ethnomethodology, in sociology the social constructionist approach originated in the work of the phenomenological sociologists Berger and Luckmann (1967). They argued that everyday knowledge is created through social interactions and the way in which these are interpreted by the people involved. They conceptualised a dialectical relationship between people and society, in which each creates the other. Although people experience society and the material world as an objective pre-existing reality, Berger and Luckmann argued that these 'realities' are being constantly reproduced and reconstructed through social interaction (Lupton, 2000). Social constructionism reflects current thinking in postmodernism and poststructuralism[1] (Nettleton, 1995). Postmodernists accept the existence of multiple realities, and reject the search for meta-narratives or grand theories as explanations for social phenomena. In line with this, postmodernists advocate a breakdown in the 'hierarchies of knowledge'. This means that accounts given by 'experts' and lay accounts are treated as having equal status – that is to say, the account of the expert is not privileged. Furthermore, postmodernists reject the concept of history as a period of linear progress towards the forms of rational knowledge that are privileged in society today. Instead, they favour a conception of the history of knowledge as a series of discontinuous arguments (Nettleton, 1995; Burr, 1995).

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[1] The terms 'postmodernism' and 'poststructuralism' are often used interchangeably in the social constructionist literature.

2.2.2 *Key Tenets of the Social Constructionist Approach*

The problematisation of reality - By deconstructing taken-for-granted assumptions about society and the material world, social constructionists aim to challenge conventional understandings of phenomena (Burr, 1995). In problematising reality, constructionists demonstrate that the social and material worlds are not 'stable realities', but instead are the products of social practices (Bury, 1986; Nettleton, 1995). This approach suggests that knowledge is not based on objective observation of the world, instead 'facts' are socially produced. It argues that 'rational' knowledge about the world is generated by scientific communities or 'thought collectives'. People also generate knowledge through the discourses that surround phenomena (Nettleton, 1995).

All knowledge is both socially and historically contingent - Social constructionists argue that all knowledge (including scientific knowledge) is culturally specific (Nettleton, 1995). This is because knowledge is a product of the social and historical climate in which it is generated. This argument suggests that all knowledge is relative, and an artefact of the culture in which it was produced (Burr, 1995). In the social constructionist literature, the historical construction of childhood is given as an example of the cultural specificity of knowledge. Ariès (1962) studied representations of children through history, and he found that it is only in recent times that children have ceased to be represented as 'little adults', and that 'the child' has assumed a protected status in society.

Social constructionism is an anti-essentialist approach. Because all knowledge is relative, culturally specific and the product of social processes, social constructionists argue that there cannot be any given, pre-existing nature either to people or to the social and material worlds they inhabit. This means that neither things nor people contain 'essences' which make them what they are. They have no essential, discoverable nature (Burr, 1995; Sayer, 1997). In this way, social constructionism can be said to be an *idealist* approach because it claims that it is only the ideas of things that exist – that is to say, not the things themselves (Burr, 1995). Similarly, the theory is *anti-realist* because it states that what we know is not a true observation of reality. Instead, social

constructionists argue that people construct their own versions of reality, and their own 'facts', through interaction. Because the approach is so relativistic, it means that social constructionism offers no concept of 'truth' or a single unified 'reality' (Lincoln and Guba, 1985). As Herzlich and Pierret note, "the symbolic order is not the pure reflection of reality" (1985: 146).

Scientific knowledge mediates social relations - The theory suggests that knowledge is inextricably bound up with social relationships (Bury, 1986). Firstly, the actions that people take are as a result of culturally specific knowledge. For example, in medicine, the type of treatment a doctor will use for a patient is directly related to his/her understandings of the causes and nature of disease. Social constructionists argue that this scientific knowledge is socially and historically contingent, and therefore the treatment that the doctor gives will also be conditioned in this way (see Nettleton, 1995 for examples from medical practice). Secondly, culturally produced knowledge may be used to reinforce social structures, and may give them the appearance of 'naturalness' (Nettleton, 1995). For example, historically, discourses on women and femininity were taken as objective proof of the differences between men and women, and have been used to justify restrictions on women's rights, opportunities and behaviour.

2.2.3 Social Constructionism and the Concept of Discourse

There are several definitions of the term 'discourse':

> [Discourses are] practices that systematically form the objects of which they speak (Foucault, 1972: 49).

> The term 'discourse' is commonly used in poststructuralist writings to denote the patterns of ways of thinking, making sense of, talking or writing about, and visually portraying phenomena (Lupton, 2000: 51).

> A discourse refers to a set of meanings, metaphors, representations, images, stories, statements and so on that in some way together produce a particular version of events (Burr, 1995: 48).

As can be seen from the definitions above, theorists within the approach are divided on the extent to which discourses merely represent or actually produce phenomena. Social constructionists argue that around each phenomenon there are multiple discourses – that is to say, different accounts that represent the object in different ways. Burr (1995) gives an example of the discourses that exist around fox-hunting. She suggests that there could be the 'foxhunting as pest control' discourse; the 'foxhunting as the contravention of basic morality' discourse; also the 'foxhunting as healthy outdoor sport' discourse; and finally 'foxhunting as pastime of the idle rich'. However, in society not all discourses are given equal weight, but some are considered to be more important and more widely accepted than others – some 'warrant voice' more than others. When one discourse is more accepted than others around a phenomenon, it can be described as the 'prevailing discourse'. Using Burr's example, it is possible that today (at least in urban areas) the prevailing discourse on fox-hunting is that of 'foxhunting as the contravention of basic morality'. Because discourses are culturally contingent, that means that they are dynamic and subject to change.

Social constructionists have also considered the relationship between discourse and power (Lupton, 2000; Moss *et al*, 2000). It is also suggested that discourses structure human thought and action. According to this theory, because a person does not have an essential nature or discrete 'personality', he/she does not express him/herself using attitudes or opinions. Instead, a person manifests discourses that have their origin in the discursive culture in which he/she lives (Burr, 1995). In this way, the person is conceptualised as a 'discourse-user'. This argument has significant implications for the concept of identity. It follows that people construct their identities out of the discourses that are culturally available to them, combining the discourses that are appropriate for their age, gender, social class, occupation, ethnicity and sexual orientation. This constructed identity then forms the basis for acceptable forms of action (Burr, 1995). In its most extreme form, the social constructionist view suggests that language is all there is. According to this radical view, all the objects of our consciousness have no essential existence independent of language. Instead, discourse is all there is (Burr, 1995). Alternatively, Nettleton (1995) states that while accepting that 'real' phenomena exist,

radical social constructionists argue that people can only ever know these phenomena in a culturally specific way, through discourse. However, not all social constructionists take so radical an approach. At the weaker end of the continuum of social constructionist thought, external realities are accepted, and phenomena are merely seen as influenced (to an extent) by the social and historical context in which they are located (Nettleton, 1995).

2.2.4   Critiques of Social Constructionism

Although it is widely accepted that the social constructionist approach is useful for studying health and other social phenomena (Nicolson and McLaughlin, 1987), there have also been substantial criticisms of the theory.

Empiricism, realism and 'truth' - The social constructionist approach is in fundamental opposition to the empiricism that forms the basis of much scientific research. While radical social constructionists may argue that 'discourse is all there is', Nettleton (1995) suggests that the majority of sociologists use the perspective of social constructionism to enable them to explore diverse accounts of an accepted external reality. Realists accept the distinction between discursive descriptions and the material world itself. This realist position offers a critique of constructionism by emphasising the proven effects of social, physical and biological factors on human life – for example, the relationship between occupational class and health (Nettleton, 1995).

Relativism - Although in society, some discourses warrant voice more than others, social constructionists argue that all knowledge is relative, and that no single discourse can claim to reflect 'reality' more closely than another (Nicolson and McLaughlin, 1987). However, this assertion of relativism has been widely criticised. This is because a relativist approach does not permit the privileging of certain discourses, for example, the empirical discourses that focus on the real effects of social factors on health and welfare (Burr, 1995). Bury (1986: 152) describes this as the "abyss of relativism". Furthermore, the relativist argument would appear to be a particularly circular one for social

constructionism itself: if all knowledge is culturally contingent, then social constructionism is no more valid than any other theoretical perspective (Nettleton, 1995).

Personhood and agency - Social constructionism has also been criticised for failing to offer adequate explanations of personhood and human agency. The approach conceptualises the person as a 'discourse-user' without an essential personality or fixed characteristics, and this may be criticised on the basis of subjective experience (Burr, 1995). Human agency presents another problem for social constructionism (Bury, 1986). This is because if people are products of discourse and simply manifest existing discourses, how can they be said to be active agents with hopes, desires and intentions? Social constructionists try to answer this by asserting that people *do* have agency in as far as they can exercise a degree of choice over which discourses they manifest. In this way, social constructionists declare that discourse-users can critically reflect on the discourses that prevail in their lives, and either embrace or resist them. However, this assertion has also been critiqued for failing to address the structural ways in which age, gender, ethnicity and social class operate to restrict the potential opportunities each person has – people do not choose or reject discourses in a social vacuum (Burr, 1995).

Social change - The sum of these realist, relativist and human agency critiques is to criticise the approach for failing to advocate improvements in health and social status for people from disadvantaged groups. Arguably, the vast majority of health and social research aims to generate improvements in people's lives and social change, so this is a significant criticism. However, constructionists attempt to answer this by asserting that deconstructionist approaches may be used by advocates of social change (for example, feminists) to challenge prevailing discourses that are oppressive or stigmatising (Lupton, 2000). Nevertheless, using the constructionist approach "There is a real danger that we can become paralysed by the view that individual people can really do nothing to change themselves or their world" (Burr, 1995).

2.2.5   Implications for Researchers

The implications for researchers who adopt the social constructionist approach are outlined here, with a focus on research aims and methodologies.

In terms of research aims, social constructionists may take a relativist approach to the goals of their research. This relativist approach would mean that the aims of the research were not to search for objective 'truth', but instead to explore the different discourses around a phenomenon. When this is the case, the researcher seeks not 'the facts', but instead to bring about change through a fresh interpretation of the phenomenon under study (Nicolson and McLaughlin, 1987). This means that social constructionists may also engage in action research, with the explicit goal of change and intervention. Because this theory focuses on the way knowledge is generated through social interaction, the methods that a social constructionist researcher would adopt are typically qualitative and interpretive (Lupton, 2000). Because of the importance of discourse to the theory, social constructionists frequently engage in discourse analysis in order to deconstruct the underlying sociocultural meanings prevalent in systems of everyday knowledge. The status that social constructionists give to their accounts is quite different from the realist-objectivist warrant that conventional interviewers may claim. Instead, social constructionist discourse analytic researchers consider the accounts their participants give to be representations of the phenomenon under study. The participants' accounts are thus drawn from the discourses which are culturally available to them, rather than from personal private meanings (Alldred, 1998).

2.3   The Sociology of Childhood

The sociology of childhood (or the new social studies of childhood) is an emerging paradigm for the study of children from a sociological perspective. It is this 'new' paradigm that provides the epistemological framework for this study. It is widely agreed that this new approach to childhood emerged in the 1980s and 1990s, and was rooted in interactionist sociology's concern with the social activities of everyday life (Prout and

James, 1997). The sociology of childhood contrasts with presociological models by focusing on children as active social agents instead of the passive objects of socialisation, and by moving away from concepts of 'the child' as a category, to fully acknowledging the personhood of children (James *et al*, 1998). In moving away from universal concepts of 'the child', the approach seeks to explore *childhood* (as a structural feature of society in any given social or historical context) and the experiences of *children* as people (Prout and James, 1997; Hendrick, 2000). Whereas in the past sociology had merely considered children in the context of the family or the school as work for adults (Mayall, 1996; James and Prout, 1997; James *et al*, 1998), the new paradigm aims to explore children's lived experiences from their own perspectives.

Many sociologists have rushed to claim that they are the founders of this new discipline. Although Ritchie and Koller (1964) first published The Sociology of Childhood, Jenks (2000) states that he considers himself to have discovered the discipline with the publication of his book The Sociology of Childhood (Jenks, 1982). Indeed in the USA, as late as 1997, and despite the publication of a considerable volume of theory and research in the UK throughout the 1990s, Griffin (1997) declares The Sociology of Childhood (Corsaro, 1997) to be the first sociology of childhood text.

The second part of this chapter traces the emergence of this new epistemological perspective. It considers the theoretical models of childhood that have preceded the new paradigm, and the way in which these have informed its development. It then goes on to explore the central tenets of the approach – including its links with social constructionism – and the relevance of these debates for the current research.

2.3.1 Presociological Models of Childhood

James *et al* (1998) present a chronology of presociological models of childhood. These are all characterised by their universalist approach to 'the child' and their failure to consider the social contexts in which children are located (Mayall, 1994a). Sociologists have also critiqued these models for being adultist and too individualistic in their focus

(Mayall, 1996). The different presociological models are outlined here, together with their implications for current thinking about childhood.

<u>The evil child</u> - The first model of childhood is that of 'the evil child', and this can be traced back to sixteenth and seventeenth century Puritanism with its emphasis on control and restraint. According to this model, the child is innately evil, and must be disciplined and tamed. Childhood was seen as the period during which the individual was disciplined and trained to produce a 'docile adult body' (James *et al*, 1998). This model gave rise to a fear of the untrained evil child that still resonates today in current debates over children's capacity to commit 'evil acts' such as murder (for example, the case of the killers of Jamie Bulger). According to this discourse, untrained children are regarded as dangerous and as a threat to the social order, and discipline is conceptualised as both necessary and good for the individual child and for wider society.

<u>The innocent child</u> - By contrast, Rousseau's eighteenth century model conceptualises children as naturally good and innocent. According to this model, children are born pure and unpolluted, and they should therefore be protected from being corrupted by adult society. This model - which risks sentimentalising childhood - still finds echoes today in Western conceptions of the child, and in the ways in which parents and educators strive to protect children's innocence (James *et al*, 1998).

<u>The immanent child</u> - This model is based on Rousseau's innocent child, but goes on to assert that children are in need of education to fulfil their potential and to make them into 'socially acceptable' future adults. This model centres on the work of John Locke who believed that each child was a *tabula rasa* (or blank slate), and that children had no innate reason or understanding. By receiving an education, he argued that children would become virtuous and self-disciplined adult members of society (James *et al*, 1998).

<u>The naturally developing child</u> - This model presents a universal, natural child and focuses on the growth of competencies as the child proceeds through a hierarchy of age-based developmental stages. This model reflects developmental psychology's approach

to children, and particularly the work of Piaget on child development. Piaget set out a sequence of stages of development in thought, intelligence and body skills. According to this model, young children are inadequate in their intelligence (Woodhead and Faulkner, 2000) and instead are only just beginning to acquire the adult competencies that represent 'normal functioning'. This model justifies the high status that adults occupy in society in relation to children:

> What it provides analytically and culturally, are some grounds to establish differences between adults and children. The control provided by adult competence justifies the supremacy of adulthood and further ensures that childhood must, of necessity, be viewed as an inadequate precursor to the real state of human being, namely being 'grown up' (James *et al*, 1998: 18).

The unconscious child - The final model is that of Freud's unconscious child, which dates from the start of the twentieth century. This model of the child is different from the others that have been outlined because instead of looking forward to adulthood from the position of the young child, it looks back retrospectively to childhood from the position of the adult who seeks to understand him/herself. Freud sought to explain problematic adult behaviours by looking at childhood experiences (James *et al*, 1998).

2.3.2   Socialisation and Developmental Theories

It is argued that theories of socialisation represent 'transitional theorising' between the presociological models of childhood, and the new paradigm of the sociology of childhood (James *et al*, 1998). Socialisation is the process by which children internalise and adapt to society, as society shapes the individual. In this way, sociology offers an account of how societies sustain themselves over time and of how cultural norms are passed from generation to generation (James *et al*, 1998). Theories of socialisation suggest that society appropriates the child as he/she internalises adult skills and knowledge at home and at school, with a particular focus on cognitive competencies and social norms (Corsaro, 1997). In this way, the anti-social child becomes the social adult (Oakley, 1994; Prout and James, 1997).

However, socialisation theory has been critiqued for its adult-oriented and deterministic focus, and for its construction of children as passive, incompetent and incomplete (James and Prout, 1997). By contrast, the constructionist approach to socialisation suggests that children do not merely internalise society's cultural rules and norms, but instead they play a part in constructing society (Corsaro, 1997). This critique suggests that children are active social agents and eager learners who both interpret and participate in their own peer cultures and wider society, and this approach is reflected in the new paradigm (Mayall, 1994a; James *et al,* 1998). Theories of socialisation have also been criticised for focusing too heavily on the future outcome of socialisation (the perceived adult competencies), whereas instead greater understanding is needed of the present process by which children grow up into adults (James and Prout, 1997). In this way, socialisation theories appear to regard children as 'human becomings' instead of as 'human beings' in the present (Oakley, 1994; Morrow and Richards, 1996; Alldred, 1998). Nevertheless, despite acknowledging that socialisation theory has been heavily criticised, sociologists of the new paradigm argue that social reproduction remains an important area for study (James and Prout, 1997).

Ideas of development are central to the study of childhood. As a period of physical development, childhood is also associated with cognitive, social and personal growth as concepts of biological immaturity have become translated into thinking around the social aspects of what it means to be a child. In this way, biological development is seen as being paralleled by the development of social competencies as children make 'developmental progress'. Central to this idea of developmental process is the presupposition that adults are rational and as 'Other', children are therefore irrational and somehow incomplete. Throughout childhood, then, children are conceptualised as gradually moving towards a state of adult rationality which signifies full human status. This presumed childhood irrationality is rooted in beliefs about the naturalness and universality of children, who then evolve into social adults. Much of this theorising around child development is based on the work of Piaget, who sought to describe and explain the 'normal' transition from irrational child into rational adult during childhood and adolescence (Prout and James, 1997; Moss *et al,* 2000). This thinking which

emphasises the cognitive, rational and social supremacy of adulthood serves to undermine the status of children as people in their own right who are capable of rational and complex thought.

2.3.3   The New Paradigm of the Sociology of Childhood

The sociology of childhood aims to offer a theory of childhood that marks an epistemological break with the past. Central to the new paradigm is the idea that childhood is socially constructed and culturally specific, and this contrasts strongly with earlier constructions of the child as natural and universal. Furthermore, instead of theories that construct children as passive, irrational and incomplete, this new model conceptualises children as active social agents who contribute to society in the different spheres in which they live (Corsaro, 1997; James and Prout, 1997). The sociology of childhood also seeks to emphasise the importance of considering children's experience in the context of their social circumstances. In the past, because children have been seen as universal and natural, too little attention has been paid to the ways in which their experiences are grounded in their social contexts (Prout and James, 1997).

Instead of viewing children as individuals progressing through a series of developmental stages, the sociology of childhood approach conceptualises children as a social group (Mayall, 1994a and 1996), and this represents a significant change from past theorising. It is also argued that childhood is a structural form, meaning that it is a category within society. This means that although any individual is only a child for a finite period of time, childhood is a permanent structural category within society like, for example, social class (Hood *et al,* 1996; Corsaro, 1997). This has led to the assumption that childhood should be considered as a variable of social analysis outside the field of childhood studies, although it should be considered in the context of other variables such as class, gender and ethnicity (James and Prout, 1997; Prout and James, 1997). Therefore, the paradigm of the sociology of childhood seeks to explore the nature of childhood itself as a structural feature of society, and it also aims to research children's own lived experiences (Christensen and James, 2000).

Another tenet that is central to the new approach is the acknowledgement of the importance of studying children's lives as they experience them in the present. This contrasts with presociological models that have frequently taken a future-orientated approach to 'development'. It is argued that too often researchers have concentrated on what children may become and in so doing have failed to consider children's present lives (James and Prout, 1997; Corsaro, 1997; Prout, 2000). However, this does not mean that researchers should fail to recognise that behaviours carried out during childhood (such as smoking) may well have future (health) implications in later years (Morrow, 2001).

Alongside this concern with studying children's lives in the present is the belief that research should enable children's own voices to be heard. It is suggested that in the past too often children have appeared as silent, and have not been given a voice through the studies which have been carried out 'with' them (Prout and James, 1997). Children have frequently also been invisible or 'hidden' in social statistics which do not include childhood as a variable. In some cases this is because children are hidden in the ideology of the family which does not specifically reveal the experiences of children (Oakley, 1994; Qvortrup, 1997).

Although sociologists of the new paradigm are in agreement that children are a social group, there is a debate in the literature as to the extent to which children share one common 'childhood' or whether instead there are 'multiple childhoods'. There is some broad agreement that children's experiences across the globe are so diverse that it is appropriate to talk of a number of different childhoods (Oakley, 1994; James and Prout, 1997; Moss *et al*, 2000; Jenks, 2000), and this is consistent with the central assumption that childhoods are socially constructed and culturally specific. Even within any one country children may experience different childhoods. Researchers have clearly emphasised that children are not a homogenous group (Oakley, 1994; Morrow, 1994; Morrow and Richards, 1996; Morrow, 1998), and that collectivising children into a single childhood risks ignoring differences of gender, ethnicity, social class and other factors

(James and Prout, 1997). However, it is also argued that while children's experiences are diverse because they are informed by a wide range of social contexts, it may be valuable to group them into one 'childhood' during research in order to make children visible (Oakley, 1994). In addition, Qvortrup (2000) cautions that by focusing on the specificity of particular childhoods it is possible to obscure the systematic influence of key socioeconomic factors that impact directly on children as a group. He suggests that childhoods only appear diverse and particular when small units are compared. Instead, he argues that if 'macro-units' are compared, the generality of childhood emerges above any concerns of specificity.

This chapter now goes on to discuss other key areas of debate surrounding the sociology of childhood. Firstly, the social construction of childhood is considered. It then goes on to look at the importance of age in the stratification of society, the implications of the structure-agency debate for the new paradigm, the operation of adult power on children and their resistance to it, the status of children as a minority group, and the question of children's rights.

Social constructionism - The idea that childhood is socially constructed is perhaps the most important tenet of the sociology of childhood (Morrow, 1994; Solberg, 1997; Woodhead and Faulkner, 2000). This means that researchers aim to demystify taken-for-granted and biologically reductionist assumptions (James and Prout, 1997; James et al, 1998; Jenks, 2000). It is a widespread assumption that childhood today is separate and distinct from adulthood (Boyden, 1997), but some sociologists go so far as to assert that there can be no "a priori distinction between children and adults" (Prout, 2000: xi). The understanding that childhood is not universal but instead is culturally specific can be traced back to the work of the historian Philippe Ariès, who with the publication of his book Centuries of Childhood described how concepts of childhood in past centuries differed from modern Western concepts (Ariès, 1962). Although some of Ariès' conclusions have been substantially critiqued (see Prout and James, 1997; James et al, 1998), his discovery that the concept of childhood is relative has proved fundamental to sociology, enabling ideas of the natural child to be replaced by those of specific children

who are located in their social and historical contexts (James *et al*, 1998; Hendrick, 2000; Jenks, 2000; Qvortrup, 2000). In this way, sociologists argue that while biological immaturity may be a universal feature of children (Prout and James, 1997), this physical immaturity has been translated into a range of characteristics which distinguish childhood in our society (Hendrick, 1997). Furthermore, it is argued that while biological 'sex' has been attributed with the socially constructed meanings of 'gender', in the same way, biological 'age' has acquired the meanings contingent with socially constructed ideas around 'generation' (Jenks, 2000). The significance of age for social stratification is explored below.

But how is childhood socially constructed in the UK today? The models of childhood that are currently reflected in dominant discourses, particularly among professionals who work with children, have highly significant implications for children's lives. Researchers have shown that children's early inherent vulnerability, based on their biological weakness and their early needs for adult care, has been translated into concepts of structural vulnerability and social dependency (Lansdown, 1994; Morrow, 1994; Mayall, 1996). This idea of structural vulnerability means that young people in our society lack economic and political power, and also civil rights, and so remain dependent on their parents for much longer than was the norm in the past and is still the case in other societies today (Roberts, 1983; Lansdown, 1994; Boyden, 1997). It is also argued that this operates as an ideology of control (Kitzinger, 1997). Beliefs about children based on the presociological models of childhood continue to prevail and the model of the innocent child that was described at the start of this paper still informs beliefs and practices that affect children. In many ways, children are conceptualised as vulnerable and in need of adult 'protection' (Buckingham, 1994). In this way, policy and legislation seek to protect children's innocence from being corrupted by adult society (Boyden, 1997), and children are not permitted access to many legitimate adult activities which are deemed unsuitable for them (for example, smoking, drinking, betting, and some films). However, a range of constructions of childhood prevail, and even echoes of the evil child still remain amidst concerns about child deviance which arise when children do not conform with stereotypes of innocence, perhaps by engaging in illicit activity, or even in legitimate

activity which is not permitted at their specific age (such as smoking). It would perhaps also be fruitful to consider how young smokers are constructed in dominant discourses, and how this informs research into children and smoking and subsequent interventions.

The significance of age in society - Within the UK, and around the world, age is one of the most important means of stratifying society. Both anthropologists and structural functionalists have described how age is used to ensure social stability, with certain roles allocated to certain age groups. Cultural customs are then used to distinguish one group from another, and are particularly used to create distance between adults and children: "The status difference is enhanced by special dress, special games, special artefacts (toys), special language and stories, which are all considered appropriate to what Ariès calls the 'quarantine' period of childhood" (Ennew, 1986: 18). Anthropologists have identified two principal analytical concepts for describing age stratification: age grades and age classes:

> The former concept – age grade – refers to a formal or informal grouping which has associated with it particular rights and duties which define the relationships of an age grade member to the social structure and polity. In England ... this system is informal and relatively imprecise in its application, with the boundaries between childhood, adolescence and adulthood being unclear and fragmented... Age classes, on the other hand, are very apparent in the construction of childhood in English society (and other western) cultures. Used to refer to a group of coevals who progress through the age structure together, an age class structure finds embodiment in the school system... Promotion through the school age class system takes place at regular scheduled intervals and is involuntary; that is, individuals are promoted through the system irrespective of their individual characteristics. In any particular school, the different age positions carry with them differential status and responsibilities; their school work is different and they carry with them different rights, duties and privileges (James and Prout, 1997: 236-7).

Age-based transitions are frequently an important means by which society is structured, with the move to secondary school representing the transition from childhood to adolescence (James and Prout, 1997). Adolescence itself represents a key transitional stage between childhood dependency and adult responsibility, during which future adult roles can be experimented with and rehearsed (Roberts, 1983; James and Prout, 1997;

Prout and James, 1997)[2]. In some societies - such as the UK - young people make the transition to adulthood gradually by acquiring 'adult' responsibilities in stages. In other countries, the age of majority is regarded as highly significant, and at that age, all of the adult rights and responsibilities are acquired (Roberts, 1983; Boyden, 1997; James and Prout, 1997).

Because age is used to structure society, some activities, rights and obligations come to be associated with some age groups, while they remain prohibited for others (for details of regulative and normative influences, see Qvortrup, 2000). The concept of 'status offence' is used to describe how children are either prevented from (or protected against) participating in some activities, because of their inferior social status (Qvortrup, 2000). This means that age exerts a strong influence on children in the UK today, because some 'adult' activities are simply not available to them:

> In everyday life age is used as a dividing line to legally exclude children from all kinds of 'adult' spaces. Inconsistent though these lines of demarcation are in English culture, age sets boundaries and limits to children's activities. It prohibits 14-year-olds from marrying, 15-year-olds from betting, 7-year-olds from being prosecuted, and 3-year-olds from going to school. A fruitful avenue for exploration could be to examine how this structures childhood and constitutes children, including their own view of themselves as well as the strategies of resistance. Such an approach might, for example, explore the 'age-prohibited' activities of children, such as smoking, drinking alcohol and gambling (James and Prout, 1997: 245-6).

However, although wider society is structured by broad age-based categorisations, on another level empirical studies have shown that for children the activities which are considered to be age-appropriate are negotiated within each individual family (Solberg, 1997). In this way, parents interpret broader understandings of what is age-appropriate and apply these to their own children according to their own perceptions of the appropriateness of the activity and the maturity of their child. (For example, although smoking is legally constructed as illicit for the children in the LLSS (age 9-11), the data

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[2] Research has shown that the transition to secondary school is a key marker for smoking uptake in children. This is particularly interesting in the light of the observation that the move to secondary school represents the transition from childhood to adolescence and especially that adolescence is a time when young people experiment with adult roles and behaviours.

suggest that a few parents permit their children to experiment with cigarettes. Thus parents negotiate the meaning of age-related activities with their children.)

Structure and agency - The debate over the relationship between structure and agency is a key issue for sociology. For the sociology of childhood, although the importance of structural factors in shaping people's lives is clearly acknowledged, the majority of research focuses on children as social agents (Qvortrup, 2000). From this perspective, children are competent actors who engage with other people and with society, and in so doing demonstrate that they are individuals with a creative contribution to make, and that they are a social group worthy of study (Mayall, 1994a and 1994b; Hendrick 2000). This is particularly significant in the context of the heavy emphasis that the presociological models placed on children as passive outcomes of social processes (James and Prout, 1997; Prout and James, 1997). Although the structure-agency debate continues, it is suggested that if research considers how children simultaneously act within and upon structure and how they are also constrained by it, then that research produces an 'authentic' account because it conveys children's experiences of childhood at a specific point in time (Mayall, 1994a; Prout and James, 1997).

Power and resistance - It is argued that childhood is a dominated category, which is dominated by the category of adulthood (Qvortrup, 2000). This suggests that children are a minority group (see below) who exist under the authority of adults in society. Studies have shown that children in recent years have become increasingly subject to adult control and surveillance with the aim of regulating their activities (Lansdown, 1994), and that adults now determine children's use of time and space to a considerable extent (Mayall, 1994a; Qvortrup, 2000). Although the goal of this control and surveillance is often to 'protect' children from the world outside the home, it simultaneously acts to limit and constrain their lives (Qvortrup, 1997). A notable example of this is the way in which children's personal mobility has been restricted in recent years in response to parental fears of 'stranger danger' and traffic accidents (James *et al*, 1998). As has already been discussed in this chapter, children's activities are also clearly restricted by age. Research has found that by the age of 9, children are well aware of the restrictions that are placed

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on their freedom, and perhaps experience a feeling of powerlessness (Lansdown, 1994; Mayall, 1994b). The LLSS and other research have demonstrated that children attempt to resist the exertion of adult power and authority in their lives, perhaps by engaging in age-prohibited activities (such as smoking) in order to demonstrate their autonomy and independence (Mayall, 1994a; Buckingham, 1994).

Children as a minority group - This chapter has already explored how children are dominated by adult authority, and how the classification of some activities as age-prohibited limits children's activities. Some researchers go further and assert that children have the status of a minority group in relation to wider society, and as such that they are an oppressed group. Oldman (1994) puts forward a Marxist interpretation and suggests that children constitute a subordinate social class, because they are exploited by the dominant adult class. Oakley (1994) presents a comparison of children's studies and women's studies. She suggests that children (like women) constitute a minority group because they are subject to collective discrimination on the basis of the physical and cultural characteristics that differentiate them from other groups in society. Oakley also notes that children are deprived of the citizenship rights that other age groups enjoy: only adults are entitled to the rights enshrined in the 1948 UN Declaration of Human Rights. Children's minority status is based on their structural vulnerability and socially constructed dependencies. Children lack adulthood – they are constructed as 'Other' – owing largely to their physical differences from adults (Hendrick, 2000). This lack of adulthood is combined with constructions of children as vulnerable and somehow incompetent (as indicated by the pejorative term 'childish') in order to justify the way in which Western childhoods are characterised by protection and consequently by exclusion from many aspects of society (Alderson, 1994; Mayall, 1994a and 1994b; Oakley, 1994).

This minority status has several significant implications for the health and welfare of children. This chapter has already discussed how age is socially constructed as 'generation', and Oakley (1994) suggests that children are subject to 'generational inequalities'. It is argued that children's minority status means that they are disadvantaged in their access to the resources available in society (Qvortrup, 2000). This

results in material deprivation, as studies have demonstrated that children are more likely to live in poverty than adults, in what has been described as 'the pauperisation of childhood' (Qvortrup, 2000: 91)[3]. Children's minority status also means that they may be considered to be a social problem: as victims of abuse, as truanters from school, as those who engage in criminal or risk behaviours such as smoking, and as those who fail to come up to the standards of 'normal' physical or psychological development or scholastic achievement: "There are, again, so many categories of children who pose problems that we are forced to conclude that it is *children themselves* who are seen as the problem" (Oakley, 1994: 17). Furthermore, it is suggested that because children are oppressed as a group, social scientists have been slow to give them a voice through their research (Oakley, 1994; Alldred, 1998).

Children's rights - Having discussed the perceived oppression of children as a social group, this chapter now goes on to consider children's rights. Although children were excluded from the 1948 UN Declaration of Human Rights, children across the world now have civil rights encoded in the 1989 UN Convention on the Rights of the Child which has been ratified by many nation-states, including the UK in 1991 (Lansdown, 1994; Alderson, 1995). This Convention marked a turning point in the civil status of children because it constructed them as individual people with autonomy independent of the family. Under the Convention, children were given the right to be heard, and their views taken into account with regard to decisions that affect them, instead of just considering adults' interpretations of children's best interests. Furthermore, it is highly significant that this right to be heard is not based on chronological age, but instead on the capacity of each child to understand and form their own opinion (James *et al*, 1998).

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[3] Qvortrup (2000) suggests that the welfare state since the Second World War has been more favourable to older people than to children, and that this has contributed to the 'pauperisation' of the young. However, the present Labour government has introduced several initiatives to improve the welfare of young children (for example, Sure Start), and it has also committed itself to a substantial reduction in rates of child poverty. It remains to be seen whether these policy initiatives will have an effect on levels of deprivation among the young.

2.4 Implications for the Liverpool Longitudinal Study of Smoking

Social constructionist theory and the sociology of childhood are useful paradigms for studying the development of children's views on smoking, intentions to smoke and early smoking behaviour for several reasons. Firstly, there are several advantages to taking a relativist position in gathering data on what, for children, is an illicit behaviour. It is important to listen closely to the voices of the children who participate in the study, even though what they say may not accord with so-called expert perspectives. This is closely in keeping with the child-centred ethos behind the study. This relativist position also accepts that different children use different discourses, without searching for the 'universal child' position that has been criticised so heavily by researchers in the sociology of childhood (for example, Moss *et al*, 2000). Although smoking by children (and of course by adults) is a clear health issue, and although the study is designed to lead to interventions that aim to reduce child smoking, it is vital to remain clearly value-neutral at this stage of the research. This corresponds well with the relativist position of social constructionism.

Fundamentally, too, a significant aim of this study is to consider why some children try (and even take up) smoking. The data indicate that the reasons why children try smoking are bound up with the ways in which both childhood and also tobacco use are socially constructed in contemporary culture. In the UK, childhood is currently a time of protection and exclusion during which children are often excluded from adult activities (Buckingham, 1994; Hendrick, 1997; James *et al*, 1998). Children also experience a significant degree of control by adults in the social worlds that they inhabit – the home and the school – and this may cause some children to rebel in order to demonstrate their resistance to adult power (Mayall, 1994a). Researchers in the sociology of childhood have focused on the ways in which the biological dependencies of infancy have become translated into the social and legal dependencies of childhood and adolescence (Lansdown, 1994; Morrow, 1994; Mayall, 1996; Kitzinger, 1997). In the face of these restrictions, some children seek to demonstrate that they are autonomous and competent by engaging in adult behaviours. In the UK, smoking is socially constructed as an adult

behaviour owing to the legal restrictions and social norms around tobacco use, which intend to limit the sale of tobacco products to people aged over 16. The research therefore considers how the social construction of smoking as an adult behaviour in the UK affects smoking uptake among preadolescents. The social constructionist perspective is extremely useful in exploring the discourses that children hold around smoking, and the ways in which these influence their experiences.

Social constructionism also suggests that people's identities are born from the discourses available in society. It will be interesting to consider how smoking forms part of the identity of a child who is starting to smoke regularly, particularly since the acceptable behaviour for children is not to smoke according to society's prevailing discourse. Theories around the social construction of the body are also highly pertinent. Lupton (2000) writes of the 'civilised' body as a site on which the adult seeks to exert control. She also describes "the bodily chaos of infancy" (Lupton, 2000: 58). Infancy is characterised by a lack of control over bodily functions, and a significant component of growing up is learning to control the body. The research aims to explore preadolescents' perceptions of their bodies, and then to link these to smoking. Is the immature body seen as a physical signifier of childishness? By mastering the unpleasant effects of smoking, is a child seeking to master his/her own body?

However, the social constructionist model has not been adopted uncritically as the theoretical framework for this study. The radical social constructionist position, which suggests that 'discourse is all there is', is rejected in favour of a realist perspective, which sees the children who participate in the study as individuals with personhood and powers of human agency. The findings from the research will clearly demonstrate this agency, which is a key focus of the sociology of childhood. There is also a place for empiricism in this study because, as described in Chapter 1, there is epidemiological evidence that smoking rates among adults are socially patterned. Therefore the research will also explore the social patterning of smoking among children, and this will involve the use of empirical techniques.

The study has been sponsored by the Roy Castle Lung Cancer Foundation who are keen to see change in children's smoking as an eventual result of this study. At this point of intervention, the relativism that must accompany data collection is then suspended, in favour of an emphasis on social change through the warranting of one particular voice. It is the aim of this research that listening to the children's discourses around smoking will enable a fresh understanding of the reasons why some children try smoking, in the face of the knowledge that it is bad for their health and despite the fact that initial smoking experiences are frequently unpleasant. This understanding can then be used to determine interventions that are appropriate for this preadolescent age group, and rooted in the children's own understanding.

2.4.1   A Hybrid Approach

Thus, the theoretical approach that has been adopted for the study is an epistemological blend of 'weak' social constructionism together with a qualified empiricism. Alldred (1998) reflected on the work of Berry Mayall (who has carried out much of the research into children and health from a sociology of childhood perspective), and described her work as a 'hybrid approach' that combines realist ethnography with a social constructionist perspective. This phase of the LLSS will also take this approach. However, Alldred (1998) also suggested that there are pitfalls to research that has a 'hybrid' of theories as its basis. In particular, she argued against using a triangulated method in which discursive and non-discursive approaches are combined. Nevertheless, the advantages of using both quantitative and qualitative methods within a single study have been shown to outweigh Alldred's philosophical argument. Notably, triangulated designs offer several advantages over studies that employ single instruments. Studies that combine multiple methods and data types produce findings that yield a more complete understanding of the phenomenon under study. Furthermore, the use of quantitative and qualitative methods within one study enable many different aspects to be considered together. For example, the use of multiple methods will enable this phase of the LLSS to identify the determinants of smoking behaviour and simultaneously to

consider how these are reflected in the discourses that children use to talk about smoking. These issues that surround triangulation are discussed in greater depth in section 3.7.

In conclusion, the theoretical framework for this study reflects the new paradigm of the sociology of childhood together with social constructionism. Social constructionism is a highly useful approach for studying health and social phenomena, and is central to the emerging paradigm of the sociology of childhood. Aspects of the social constructionist approach are vital for the current research into children and smoking. Within the existing method these will be combined with a qualified empirical warrant in order to discover not only which discourses preadolescents use to talk about smoking but also why some children experiment with cigarettes. Chapter 3 will outline the methods used to collect data within this epistemological framework.

3 Research Design

3.1 Chapter Outline

In the context of the epistemological framework outlined in Chapter 2, this chapter will describe the research design for the study. The chapter opens by describing some special considerations that apply to research with children (section 3.2). It then goes on to review the qualitative longitudinal method, which is a feature of this wave of the LLSS (section 3.3). The sampling frame from which the cohort was drawn is then discussed (section 3.4), together with the consent procedures used (section 3.5). The chapter then details the measures taken to enhance the trustworthiness of the data (section 3.6), and the methodological triangulation that forms the basis of the research design (section 3.7). The pilot study is then described (section 3.8), together with the resulting changes to the methods to be used in the main study. Each of those methods is then discussed in detail (section 3.9), together with an overview of the methods used for data analysis (section 3.10).

3.2 Research with Children

Research with children is special (Greig and Taylor, 1999). Children are a special population, and research with them requires special considerations in terms of methods, ethics and the relationship between the researcher and those who are being researched. Some of those considerations are outlined here, together with a discussion of the way in which these considerations have informed the research design of this study.

When carrying out research with children it is vital to use methods that are appropriate for their age. However, this is not as straightforward as it might first appear because there are a wide range of abilities within an age range (as is also the case with adults). Piloting is therefore of central importance in determining what is appropriate and manageable for the cohort. For this study, the methods which were originally devised

(see Porcellato, 1998) were designed to enable children to express their views fully within their own frame of reference. Furthermore, because the research takes place in a school context, the methods were designed to simulate classroom activities as far as possible. Traditionally, children's views have not been afforded the respect that is given to adult accounts (Backett and Alexander, 1991), but this research has sought to value and promote children's views. The study has taken a bottom-up approach that enables children to direct the research as far as possible by expressing their own views. The emphasis has been on 'listening to children' (Morrow, 1998) and on giving value to accounts of their experiences and to their talk.

The nature of the data collected is always influenced by the researcher if he/she is present. This is because the participants' perceptions of the researcher may affect the relationship between researcher and researched, and particularly the amount and type of data that participants choose to reveal. This is especially the case when the researcher differs from his/her subjects on the basis of personal characteristics such as gender, age, ethnicity, regional background and social class (Holmes, 1998). When the research is being conducted with children, the differences in status between researcher and researched are even more acute, notably because the researcher may exercise the power and authority associated with adult status over his/her younger respondents (Fine and Sandstrom, 1988). This may mean that children are reluctant to disclose sensitive information during the course of the research, for fear of censure.

Research in the school context was especially complex in this respect because during methods that were administered to whole class groups, teaching staff and the children to an extent expected the researcher to take on a 'teacher' role. This was symbolised by the children calling the researcher 'Miss Milton' rather than addressing her by her first name. The teacher role was necessary to maintain order in the class, and to safeguard the research – for example, ensuring that the children did not copy one another's 'work'. However, although the classroom basis of the research necessitated it, this type of authoritarian role was not the ideal kind of relationship to establish with the children – instead a 'friend' or 'least-adult' role would perhaps have been preferable (Fine and

Sandstrom, 1988; Holmes, 1998). In interviews and in small groups, the researcher did endeavour to take a much more friendly, non-authoritarian stance because there was less need to maintain order. This approach was most conducive to building up a degree of trust between the researcher and the children, which allowed them to express their views and ideas freely without fear of correction or discipline. The children somehow seemed to perceive this difference, and alone or in the company of a few friends they appeared more confident and at ease as they talked about their experiences of smoking. However, in addition to this, throughout the research there was an awareness that the children perceived the study as anti-smoking simply because they were being asked questions about smoking in a school context. Although the researcher was very careful to display a value-neutral stance throughout the course of the fieldwork, this perception may well have contributed to reporting bias if it affected the children's responses to the study. The research participants were all aware that smoking by children is considered to be undesirable – and often punishable – behaviour, and this may have led to false negative responses to questions about tobacco use (Fergusson and Horwood, 1989). However, steps were taken to enhance the reliability of the children's responses and these are described in section 3.9.1.

3.3   The Qualitative Longitudinal Method

3.3.1   Cross-sectional and Longitudinal Research

The vast majority of research in health and the social sciences is cross-sectional – meaning that data is only collected at one point in time. However, when the phenomena under study is subject to change or is part of a developmental process, it is arguable that conclusions drawn from cross-sectional research can be misleading (Kraemer *et al*, 2000). This part of the chapter considers longitudinal research – meaning that data is collected from the sample at multiple points over time using the same measures or 'instruments'. Longitudinal research offers several advantages over a cross-sectional study, notably because it is ideal for the study of social processes and transitions, and also because it enables the investigation of causal associations between variables. However,

the disadvantages associated with longitudinal research are that it is expensive and time-consuming. Sample attrition (the loss of participants from the study) is another key issue for longitudinal research (Flay *et al*, 1998). Researchers engaged in longitudinal studies must also be aware of 'the Hawthorne effect' which describes the reactive way in which the participants in a study may change their behaviour over time owing to repeated measurement (Banks *et al*, 1978; Bowling, 1997).

Longitudinal studies are distinct from cross-sectional studies in that they aim to identify elements of change. The longitudinal quantitative survey is well established as a means of using statistical analysis to measure change and also to discover cause-and-effect relationships. Several books exist on the topic (for example, Wall and Williams, 1970; Nicol, 1985; Bijleveld and van der Kamp, 1998). There is also a considerable body of quantitative longitudinal research that looks at the uptake of smoking in adolescents (for a meta-analysis, see Derzon and Lipsey, 1999). However, the concept of the qualitative longitudinal study is relatively undeveloped. The rest of this section explores existing qualitative longitudinal research and considers the implications for the LLSS.

3.3.2 *A Review of Qualitative Longitudinal Studies*

A computer search of the literature using ASSIA, PsychINFO and Medline revealed a small number of existing qualitative longitudinal studies. These studies all focused on a period of change or transition. For the purposes of this chapter, the studies have been divided into three types: biosocial transitions, social transitions, and learning processes. These different areas will be explored below, with key emphases on methods of analysis, and on the ways in which each researcher identifies and seeks to measure change.

3.3.2.1 Biosocial Transitions

The studies of biosocial transitions focus on the ageing process among the old old (Ågren, 1998); and also on the changes a woman experiences when she becomes a mother (Miller, 1998; Nicolson, 1999). Ågren (1998) used in-depth interviews to explore

how very old people experience and adjust to life. From this phenomenographical qualitative method, she developed seven 'categories of adjustment'. These categories ranged on a scale from positive to negative, from (A) Self-realising to (G) Withdrawing. She then measured change by considering in which direction and by how many 'categories' each participant moved over time – after seven years, 41% remained in the same category of adjustment, 15% had become more positive, and 44% had become more negative about their life experiences. From a qualitative method, in the analysis stage the experiences of participants became almost quantified in order to measure change.

Both Miller (1998) and Nicolson (1999) described the changes that a woman goes through as she seeks to adjust to her role as a mother. Miller (1998) studied women who were all becoming mothers for the first time. In-depth semi-structured interviews were used to explore the different accounts (public, private, and personal) that women gave of childbirth and the transition to motherhood. Women were interviewed at 7-8 months pregnant, 6-8 weeks after the birth, and when the baby was 8-9 months old. The findings that emerged from the research were that the accounts women give of their experiences of new motherhood are 'multi-layered', and that women are more prepared to reveal their personal narratives retrospectively – particularly the hopes and fears associated with childbirth. In this study, Miller identified change by looking at the changing nature and content of each woman's narratives.

Nicolson (1999) focused on postpartum depression as women adjusted to the birth of a new baby. Some of the women in her study were already mothers, while others were becoming mothers for the first time. The women were interviewed during pregnancy, and three times in the six months following the birth. The analysis that is presented aggregates the experiences of the whole cohort over time, and individual trajectories into motherhood are not detailed. Instead, Nicolson presents a thematic analysis based on the theme of loss (of autonomy and time, of appearance, of femininity and sexuality, and of occupational identity). The study revealed that loss may initially result in depression if women are unable to embrace and adjust to their new role as mother. The use of a

longitudinal design enabled Nicolson to explore how this initial sense of loss gave way to change and re-integration over time as women accepted the change in their lives.

3.3.2.2 Social Transitions

The two studies which explored social transitions focussed on the shift from homelessness into stable housing (Dunlap and Fogel, 1998), and patterns of disclosure among men with prostate cancer (Gray *et al*, 2000). Dunlap and Fogel (1998) described a study of self-sufficiency among nine formerly homeless families as they moved from a temporary shelter to a home of their own. After the families moved out of the shelter, they were interviewed each month for a year, and a further interview took place two years after leaving the shelter. Data were transcribed and then organised into charts and graphs in order to consider the trajectory of each family. The aim of the research was to analyse the effectiveness of the transitional shelter as a means of rehabilitating homeless families back into society. In relation to this, the study found that after two years, eight of the nine families were self-sufficient and resuming 'working class status' (Dunlap and Fogel, 1998: 185).

By contrast, Gray *et al* (2000) studied men with prostate cancer who had opted for a prostatectomy in order to explore how their patterns of disclosure (to friends, family, colleagues and other acquaintances) changed in relation to the length of time elapsed since diagnosis and surgery. Men and their wives were interviewed separately prior to surgery, and then approximately two months and a year after the operation. The data were then analysed for themes using the constant comparative method. The study found that most men were reluctant to share information about their illness due to the stigma of both life-threatening illness and also sexual dysfunction, both of which are associated with prostate cancer. The research also revealed that disclosure decreased over time, as the necessity of telling people about the disease (for example, to explain absence from work) diminished.

3.3.2.3 Learning Processes

In the field of nursing education, the literature search revealed a Canadian study (Reutter *et al*, 1997) and also a British study of Project 2000 students (Marrow and Tatum, 1994; Marrow, 1997). Reutter *et al* (1997) explored the ways in which nursing students were socialised into their professional role as they made the transition from the role of student to that of graduate nurse. Semi-structured interviews were carried out with students from each year of the nursing course throughout their time at University. The data were then analysed thematically to compare the students in each academic year with those in other years of their course. Further analysis was carried out to compare how the perceptions of individual students changed over time, although these findings were not described in the paper.

The British study of nursing education (Marrow and Tatum, 1994; Marrow, 1997) is described as a 'qualitative longitudinal study'. The research aimed to consider the effectiveness of student learning when managed by a clinical supervisor on a ward placement. The research design involved the observation of a cohort of 15 nursing students on their ward placements. The students and their clinical supervisors were then subsequently interviewed, and a constant comparative method was used to analyse all the data. Although both of these papers (Marrow and Tatum, 1994; Marrow, 1997) clearly describe the research as a qualitative longitudinal study, arguably the research design presented is not a longitudinal one. Longitudinal research involves repeated data collection using the same instruments in order to describe change over time. Instead, Marrow and Tatum only appear to carry out one data collection (using a triangulated method), and the results do not give any indication of measuring change or transition. Perhaps the method was not fully described in either of these papers and further data collections did take place, but it would appear – based on the available evidence - that this was not a longitudinal study.

3.3.3   Implications for the Liverpool Longitudinal Study

A review of the existing literature has revealed a small number of qualitative studies that employ longitudinal methods. This review demonstrates that the qualitative longitudinal method is currently under-used and under-developed. There are a few studies that have collected qualitative data from the same sample at multiple points over time, and these employed differing methods of data analysis. Some researchers used a thematic analysis in order to identify key themes (and ideally then how these themes change over time). Other studies used the data to identify individual trajectories, and to see how transitions were experienced in the lives of individuals. The review demonstrates that analysis by individuals is the preferred approach, because one of the major advantages of longitudinal over cross-sectional research is that in a longitudinal study it is the same individuals who are generating data at each point. This means that longitudinal studies are unique in revealing the trajectories of individuals, whereas cross-sectional research can be used to explore thematic change over time (Kraemer *et al*, 2000).

The studies outlined above all focus on periods of change. Childhood is perhaps the most important period of change in the life course, and the LLSS focuses on the transitions that a cohort of primary school children are making into adolescence and beyond into adult life. The study seeks to explore and explain the transitions that some children make into smoking, as they change from the non-smoking child into the smoking adolescent. More broadly, the study also considers how children's knowledge and views about smoking change over time. A qualitative longitudinal study is arguably the best method for identifying change in views and perspectives, and also for seeking to explain changes in behaviour from the child's own perspective. Analysis of longitudinal data reveals individual trajectories, and this is the aim of this phase of the study. This longitudinal analysis for individuals will enable the children's voices to emerge through their individual accounts. Otherwise, the coherence of these accounts may be lost in aggregated cohort analysis of the qualitative data. Therefore, Chapter 5 uses an in-depth case study approach to focus on how changes in views and behaviour are experienced by just a few individuals. The themes that emerge from this analysis are then explored and

developed in the context of data generated by the whole cohort in Chapter 6. This analysis will then be used to produce a theoretical model of children's experiences of tobacco during preadolescence (age 9-11).

3.4   Sampling Frame

The research was carried out in six state primary schools which are representative of the range of socioeconomic conditions found in the city of Liverpool. The schools were chosen at the start of the study in 1994 on the basis of three indicators:

1. Employment data from the 1991 census
2. Lung cancer SMRs
3. Index of wellbeing

For details of the original sampling frame, see Porcellato (1998). Every Year 5 pupil (age 9) registered at each of the six schools was considered to belong to the cohort, and as new children joined the schools each year they were added to the sample.

3.5   Consent Procedures

Research with children presents special ethical considerations, and these focus particularly on the issue of consent. The children who took part in the study were aged 9, and not at the age of legal responsibility (Lewis and Lindsay, 2000). However, arguably they were 'Gillick competent', that is to say, the children were of sufficient understanding to make an informed decision about their own participation in the research (Alderson, 1995). Therefore, they were protected by three layers of consent: from headteachers, parents, and assent by the children themselves. Firstly, headteachers gave written consent *in loco parentis* for their Year 5 pupils to take part for the next three years, in response to a letter outlining the purpose and details of the study.

Secondly, parents received an information letter about the study (Appendix A), together with a consent form (Appendix B). Parents could either opt to exclude their child from the research, to request further information, or to give positive consent to their child's participation in the study, also for three years. As is often standard practice in school-based research, a non-response clause was used to ensure the high level of participation essential for whole class based research activities (Belzer *et al*, 1993; Hill *et al*, 1996; Jarvis, 1997). The use of a non-response clause also sought to limit selection bias in the sample by aiming to use a complete year group within each school (Bagnall, 1988). The use of a non-response clause meant that children whose parents did not return the forms were automatically included in the whole class exercises and the focus groups. The consent form also offered parents the opportunity of obtaining further information about the research before deciding to give consent. This step was intended to ensure that any consent given was informed, and the researcher was pleased to speak to several parents, all of whom eventually gave their consent for their children to participate. However, it should be noted that only children with full positive parental consent were included in the interview sample because it was deemed that children who spoke with the researcher on a one-to-one basis needed the assurance that their parents had agreed for them to participate.

Thirdly, following a developmentally appropriate explanation, each year the children themselves were also asked to give both their verbal and written assent to their participation in the study. By giving their assent, the children were voluntarily agreeing to take part (Ireland and Holloway, 1996; Morrow and Richards, 1996). This step of asking the children to give written assent sought to give the children control and the final decision over whether or not they participated. Although consent by headteachers and parents was a safeguard for the welfare of the pupils, it was essential that the final decision rested with each child. In the event, only four parents (1.5%) withheld their consent, and no child refused his/her assent to participate at any point during the study.

3.6   Trustworthiness

It is vital that researchers are able to show that the conclusions they have drawn from their data are authentic and trustworthy (Lincoln and Guba, 1985; Denzin and Lincoln, 1998). The quality of research carried out in the positivist tradition has conventionally been assessed using four key criteria: internal validity, external validity, reliability and objectivity. Arguably these standards are not applicable to qualitative research, which rather than 'discovering' a single reality instead aims to represent multiple constructions of the social world:

> In order to demonstrate 'truth value', the naturalist must show that he or she has *represented those multiple constructions adequately*, that is, the *reconstructions* (for the findings and interpretations are also constructions, it should never be forgotten) that have been arrived at via the inquiry are *credible to the constructors of the original multiple realities* (Lincoln and Guba, 1985: 295-296).

This means that instead conclusions drawn from qualitative data should meet the criteria of credibility, transferability, dependability and confirmability (Lincoln and Guba, 1985; Miles and Huberman, 1994). The way in which each of these standards for the quality of data interpretation applies to the qualitative aspects of the LLSS will now be considered in turn.

3.6.1   Credibility

The criterion of credibility refers to the 'truth value' of the conclusions drawn from a set of qualitative data. The key to producing a credible account is whether or not the findings produced make sense to the reader, and particularly to the research participants. There are several strategies a researcher can use to make his/her conclusions more credible. Lincoln and Guba (1985) argued that respondent validation or member-checking is "the most crucial technique for establishing credibility" (Lincoln and Guba, 1985: 314). Respondent validation is a technique that involves cross-checking interim research findings with participants in order to corroborate the results. Member checking may also be used to help refine and clarify explanations emerging from the data (Miles

and Huberman, 1994; Mays and Pope, 2000; Barbour, 2001). In order to establish the credibility of the research, the findings from this wave of the LLSS were validated with respondents, and the outcomes of this exercise are presented in Appendix M.

Triangulation is another important means of demonstrating credibility and authenticity. The design employed for the LLSS incorporated a number of different triangulation strategies, and these are discussed in depth in section 3.7. It has also been suggested that credible research is characterised by the way it presents 'thick descriptions' (Miles and Huberman, 1994), and these are used to structure the qualitative data which is analysed in Chapter 5 and 6. Furthermore, research can be considered credible if its findings can be replicated. In Chapter 7, a comparison of the findings of the LLSS with other longitudinal studies of smoking during preadolescence demonstrates that many of the conclusions drawn from this dataset have been successfully replicated in other settings.

3.6.2 Transferability

The second criterion for assessing the quality of a qualitative study is transferability or fittingness: are the conclusions reached transferable to other contexts? Although the findings of qualitative research are not statistically generalisable (in the way that the results of quantitative studies can be applied to the wider population from which the sample is drawn), they can be theoretically generalisable. That is to say, the conclusions drawn from a qualitative study have theoretical validity if they can be used to develop social theory that is applicable beyond the immediate study (Miles and Huberman, 1994; Denzin and Lincoln, 1998). In this way, qualitative studies can have theoretical transferability. The fittingness of a study is demonstrated if its findings are congruent with prior theory. Also, if the conclusions drawn are replicated in other studies, it similarly demonstrates that the interpretation is both transferable and robust. The way in which this research reflects the sociological theories of childhood described in the previous chapter and the robustness of the interpretation of data in comparison with the existing literature are discussed in Chapter 7.

3.6.3 Dependability

A study can be said to be dependable or reliable if the research process is consistent and stable over time. Dependability can be demonstrated using triangulation, if findings are paralleled across different data types or sources. Reliable qualitative studies are also characterised by their explicitness in terms of choice of epistemology and the clarity of the research questions that frame the study (Miles and Huberman, 1994). The dependability of a study is notably also a precondition for credibility. This means that if a study can be shown to be credible, then it must also be dependable: "Since there can be no validity without reliability (and thus no credibility without dependability), a demonstration of the former is sufficient to establish the latter" (Lincoln and Guba, 1985: 316). The credibility of this phase of the LLSS has already been established, and this therefore suggests that the study is also dependable. Furthermore, the consistency of findings using longitudinal measures has demonstrated that the research methods used are stable over time (see data presented in Chapters 5 and 6). A triangulated method has also been used to enhance the reliability of findings, the research questions that guided the collection of data have been clearly stated and the theoretical paradigm that underpins the study has been described in detail. These measures of dependability show that this is a reliable piece of research.

3.6.4 Confirmability

The final criterion for assessing the quality of the qualitative aspects of this study is confirmability or objectivity. An objective qualitative account is one that takes a stance of relative neutrality, is free from unacknowledged researcher biases and is explicit about inevitable existing biases that may affect research outcomes (Miles and Huberman, 1994). As in the cases of credibility and dependability, the use of a triangulated research design can demonstrate confirmability. Confirmable qualitative studies also include a discussion of the role of bias in the study, a detailed description of the methods used, and sufficient data displays to enable the reader to assess whether he/she agrees with the researcher's interpretation of the data. Researchers who produce qualitative data are also

exhorted to keep detailed records of the study or an 'audit trail' to enable peers to review the process of data collection and analysis if necessary (Lincoln and Guba, 1985). This wave of the LLSS can be said to be confirmable because it has been explicit about the role of bias in the study (see sections 3.2 and 6.2), and the researcher was very careful to take a value-neutral stance throughout the fieldwork (again, see section 3.2). Furthermore, the next part of the chapter presents a detailed description of the methods used to collect data, and succeeding chapters contain clear data displays that allow the reader to assess the accuracy of the researcher's interpretation of the evidence. Particularly because this research forms part of a much larger study, and also because the research design is longitudinal enabling the tracking of individuals over time, detailed records have been kept of the participation of each child in the research each year. These add an extra dimension to the confirmability of the study.

As has already been stated, triangulation is an important technique for strengthening the quality of qualitative research. The next part of the chapter continues with a discussion of the different kinds of triangulation on which this study is built.

3.7   Triangulation

The idea of triangulation in essence involves the use of multiple measures to identify a single construct:

> It seems likely that the term 'triangulation' had its origins in the metaphor of *radio* triangulation, that is, determining the point of origin of a radio broadcast by using directional antennas set up at the two ends of a known baseline. By measuring the angle at which each of the antennas receives the most powerful signal, a triangle can be erected and solved, using simple geometry, to pinpoint the source at the vertex of the triangle opposite the baseline (Lincoln and Guba, 1985: 305).

Researchers use triangulated designs with the aim of increasing their confidence in their interpretations of the data collected (Barbour, 2001). Triangulation has two functions: confirmation and completeness (Breitmayer *et al*, 1993). Firstly, multiple measures can be used to measure a single construct, and the results of the different methods are then

compared. In this instance, triangulation is used to confirm the research findings by achieving convergent validity. Secondly, triangulation can be used to give completeness. In this way, researchers combine multiple measures to reveal different dimensions of a phenomenon. Arguably this approach yields a more complete picture of the area of interest, which often includes an understanding of the situated nature of the research participants in their context (Graue and Walsh, 1998; Mays and Pope, 2000). Nevertheless, it is important to note that while the use of triangulation may give breadth and depth to the researcher's findings, triangulation cannot be said to yield 'objective truth' (Denzin, 1989).

Sociological research with children often combines multiple research strategies in triangulation (Morrow and Richards, 1996; Mauthner, 1997). The LLSS used a triangulated design to give as full an understanding as possible of the smoking habit through the eyes of the children who participated in the study. The techniques used in the LLSS are methodological, data type and data source triangulation (Denzin, 1989; Miles and Huberman, 1994). Each of these techniques will now be discussed in turn. Firstly, methodological triangulation can be used to yield a more complete understanding of a phenomenon because the use of different methods enables the researcher to understand different aspects of the area under study:

> If each method leads to different features of empirical reality, then no single method can ever completely capture all the relevant features of that reality; consequently, sociologists must learn to employ multiple methods in the analysis of the same empirical events. This is termed *triangulation* (Denzin, 1989: 13) [original italics].

The LLSS utilised multiple methods to explore children's views and experiences. This methodological triangulation comprised questionnaires for children and their parents, interviews, focus groups, and a draw and write exercise. The use of multiple methods also enabled the researcher to overcome the inherent weakness of single instruments, by combining the findings from a number of research techniques.

Secondly, the study also triangulated different types of data, by comparing quantitative data, qualitative text and drawings. This enabled the study to consider many different aspects of smoking among young people: from statistical predictors of smoking onset, to the discourses that the children used to talk about smoking. In this way, different kinds of data were used to shed light on different aspects of children's experiences of smoking.

The third type of triangulation used in the LLSS was comparison of data sources. Data was collected repeatedly from many different children in the cohort, and the findings from these different data sources were then compared to identify areas of commonality and of difference. Data source triangulation was employed for the case study analysis that is presented in Chapter 5. In this instance, theoretical sampling was used to select children who were dissimilar from each other in terms of their smoking experience and sociodemographic background, yet reflected the range of variation found in the cohort. This data source triangulation was used to identify the unique features of each case in its situated context. All of these different kinds of triangulation were used to strengthen the validity of the study's findings.

3.8   The Pilot Study

As a pilot steers an aeroplane or a boat, so the experience gained during the pilot study drove the choice of methods for the main study. The child's questionnaire, draw and write exercise and focus group schedule were piloted with a class of Year 5 pupils (age 9) at a Liverpool primary school which was not participating in the main study. The interview schedule was not piloted because it was very similar to that used in the previous phase of the research. The pilot study was extremely valuable and led to some key improvements being made to the research tools. It also gave the researcher a real sense of the children's views on the methods, a teacher's perspective on what works well in a classroom situation, and useful experience of managing a whole class. It was also a tremendous advantage that the pilot study was carried out in the classroom of an experienced teacher who was very helpful in providing constructive feedback. While the methods were being administered to the class, she went round the classroom to watch the

children work and to discuss the tasks with them, and used her observations to give feedback at the end of the session. In addition, after the questionnaire and the draw and write exercise had been carried out she gathered the children together onto the carpet to give feedback about what they thought about the research.

In general, the questionnaire worked very well as a whole class activity. However, some children experienced difficulties when they were routed to either the blue or the red sections, and for the main study this was explained more clearly. In addition, the pilot work used a closed-ended question about the reasons why some children take up smoking which involved the children ticking a series of factors that they felt were significant in smoking uptake. During piloting it emerged that many children were ticking lots of boxes without understanding what they were selecting. For this reason, the section was replaced with open-ended questions asking the children to describe in their own words why some children and adults smoke, and also asking them to describe their own thoughts and views on smoking. It also emerged during the pilot study that several children were keen to discuss their experiences of knowing a family member or a friend with smoking-related illness. Although the research design at the piloting stage included questions about children's knowledge of the health risks of smoking, the study had not addressed the issue of children's experiences of smoking-related disease among people they knew. Clearly, experiences of others' smoking-related illness were of central importance to many members of the pilot sample, and therefore a question was added that enabled the children to explore and to voice their concerns on this issue.

In the first wave of this study (Porcellato, 1998) and also in the original protocol of the draw and write exercise (Wetton, 1994) the children completed the draw and write exercise onto blank sheets of paper, on which the children arranged their drawing and writing as they felt best. After using this format during the pilot, the classteacher suggested providing separate boxes for drawing and writing to make the activity more straightforward for pupils. Using separate spaces for drawing and writing enabled the children to better plan and structure their 'work', and was also closer in format to a normal classroom activity. The teacher also suggested printing the questions to be

answered in writing on the children's sheets to enable the children to remember what they had to do. This was because during the pilot the class had been a constant chorus of re-asking what the questions were, because the children had been so engrossed in drawing that they had forgotten what to write. Because of these modifications to the original protocol, the draw and write exercise used for this study represents an adaptation of the standard method. In addition, six draw and write questions were asked during the pilot, but this proved to be too many to fit into the time and to sustain the children's levels of concentration, and so for the main study only five invitations were issued.

For the focus groups, an interactive approach based on three main activities was piloted with a group of girls and a group of boys drawn from the class. The exercise during which the children drew questions from the bag and answered them worked extremely well and was a great success. However, the other two activities were clearly too ambitious. The children were asked to draw a lifeline stretching from age 4 (when the study began) through age 9 (current age) and on to age 14. It was anticipated that they would then discuss the changes that had occurred in their lives in the five years since the study began, and look ahead to changes which they could imagine occurring over the next five years up to the age of 14. In practice, this proved totally unfeasible. The children were able to draw the line and plot the ages, but were completely unable to conceptualise the rest of the task. They argued that they were unable to remember anything about life aged 4, and could have not possibly even imagine what life would be like when they were 14. In addition, it was planned to explore children's perceptions of their friendships by plotting a class chart showing different friendship groups. After what had been learned during the rest of the pilot exercise, this task was clearly inappropriate for this age group, and the researcher did not even attempt to introduce it. After these experiences, only the successful exercise was used for the main study, and it was supplemented by adding more questions. The pilot focus groups also demonstrated the importance of seating children around a table for small group activities to prevent fidgeting and horseplay.

The parental survey was also piloted among a small sample of Liverpool parents. They found the questionnaire fairly straightforward to complete, but suggested that there were perhaps too many questions relating to personal data, such as housing tenure and parental education. This led to a simplification of the questionnaire and a rationalisation of questions about socioeconomic status.

3.9 Methods

Because this research forms part of a longitudinal study dating from 1994, the data collection methods used are comparable to those employed in previous years (see Porcellato, 1998) to enable longitudinal comparison of the data. However, the research instruments have been updated to reflect the growing capabilities of the cohort. The research instruments have also been redesigned to collect additional data on a variety of topics (see detailed descriptions of each method below). Copies of the updated research tools can be found in the appendices to this thesis. The first wave of data for this phase of the longitudinal study was collected in November-December 1999. The second wave of data was collected in September-October 2000, and the final collection took place in June-July 2001. The whole sample took part in the questionnaire and draw and write exercise while a subsample participated in interviews and a different subsample formed the focus groups. Parental questionnaires were sent to the parents of every child, but response rates varied from year to year (see Table 3.1).

Table 3.1: The number of children and parents participating in the study by method, 1999-2001.

Method	1999	2000	2001
	n	n	n
Child's Questionnaire	247	257	239
Draw and Write Exercise	247	257	239
Interviews	37	37	35
Focus Groups	88	73	74
Parental Questionnaire	149 (60%)	139 (54%)	66 (28%)

3.9.1 Child's Questionnaire Survey

The children's questionnaire elicited patterns of smoking behaviour, together with current and future intentions to smoke, and factors that shape perspectives about smoking, including parental, sibling and peer smoking. In addition, open-ended questions invited the children to describe their thoughts about smoking, and their understanding of why some children and adults smoke (Appendix C). The self-completion questionnaire was administered on a whole class basis to the entire sample under quasi-examination conditions. This method of administration has been shown to elicit the most accurate self-reporting of smoking behaviour with teenagers (Charlton, and Blair, 1989). The researcher stood at the front of the class and guided the children through the questionnaire by reading out each question as the children wrote their responses (with the exception of the section on smoking behaviour where the children were routed to different questions). Children were encouraged to complete the questionnaire in silence, and not to look at other pupils' responses. At the end of the survey, each child sealed his/her responses in an envelope. This measure was designed to emphasise to the children that their work was confidential and would only be seen by the researcher (not by their teacher or other school staff) (Nilsen, 1959; Banks *et al*, 1978; Charlton, 1984; Cleave *et al*, 1996; Lloyd and Lucas, 1998; Lucas and Lloyd, 1999). Questionnaires were also marked with identification numbers rather than names to demonstrate confidentiality. Although it has been suggested that young people may under-report illicit or undesirable behaviours such as smoking (Fergusson and Horwood, 1989; van Teijlingen *et al*, 1995), research has shown that self-reported accounts of smoking behaviour among young people can be assumed to be accurate and reliable if anonymity and confidentiality are assured to participants (Bynner, 1969; Michell and Stenning, 1989; Lloyd and Lucas, 1998; Distefan *et al*, 1998). Although some researchers have sought to use biochemical measures of smoking among children, it is argued that self-report data can actually be more reliable than biochemical indicators during the early stages of smoking when cigarette consumption is likely to be low (Hirschman *et al*, 1984; Fergusson and Horwood, 1989; Foshee and Bauman, 1992).

The children's questionnaires used in the current phase of the study have been significantly expanded from the original (Porcellato, 1998). The children's survey gathered data for the first time on a range of new topics that included first use experience, best friend's smoking status and smoking-related disease. The questionnaire also included new qualitative questions which asked the children to explain why some children and adults smoke, together with an open-ended question on the child's own thoughts on smoking. Furthermore, whereas the questionnaires had previously been administered on a two-to-one basis, for this phase of the study the questionnaires were administered to whole classes. This development was possible because at age 9 only a few of the children needed help with writing their responses, thus enabling the researcher to manage the whole class at once. Children who wanted help raised their hands and were assisted by the researcher. Most teachers remained with their classes while the questionnaire was being administered. However, without exception they kept a low profile and generally remained seated at their desks.

An advantage of this study's longitudinal design is that the methods can change and evolve each year as new themes emerge from the data. Because an aim of the study was to explore the social patterning of smoking behaviour during preadolescence, in 1999 experimentation with cigarettes was analysed in association with parental occupational class. However, in 1999 children from the poorest areas returned fewest parental questionnaires. Also, many parents were unemployed, economically inactive, or otherwise unable to list an occupation. Therefore, from 2000 onwards the children were asked to give their postcodes and these were subsequently coded to yield deprivation scores. This represented a significant improvement because the majority of children knew their postcodes, therefore the poorest children were no longer under-represented in the data on socioeconomic status.

Similarly, in 1999 and 2000 parents were asked to describe their child's ethnicity. But in 2001, children were asked to describe their own ethnic origin using a closed-ended question specifically designed for this age group by Professor Martyn Barrett of the University of Surrey (Appendix D). This ensured that minority ethnic children were not

underrepresented in the ethnicity data, as this was a risk when asking parents to provide data for their child. Furthermore, the essence of ethnic identity is self-perception (Senior and Bhopal, 1994), and it was preferable in every way to ask the children to describe themselves rather than relying on parental description.

From 2000 onwards, a question was added to the section on smoking behaviour to measure if any of the children were smoking regularly (defined as one cigarette per week for this age group). In 2001, a question was also added which asked children who had experimented with cigarettes why they had tried smoking. Because triers and non-triers were routed to blue and red sections that they completed simultaneously, from 2000 onwards the red section was extended by asking children to explain their intentions. This yielded useful data and also prevented children who had finished their red questions very quickly from distracting the children who were still completing the more detailed blue questions. From age 10 onwards, the following issues were also added to reflect the children's concerns which emerged in 1999: passive smoking, ex-smoking siblings, number of smoking friends and number of smokers in the household.

3.9.2 Draw and Write Exercise

The draw and write exercise was also administered to the whole class. The researcher read a series of five invitations and instructions out loud (Appendix E), and in response the children completed drawings and produced written comments on their pictures in a workbook (Appendix F). For this stage of the research, three of the original invitations were used (Porcellato, 1998), together with additional questions relating to cessation and the experience of being offered a cigarette. After 1999, the fifth invitation which asked the children to draw themselves being offered a cigarette was no longer used because analysis of the data from age 9 revealed that the invitation was yielding insufficient data.

3.9.3 *Focus Groups*

It has been widely acknowledged that peer pressure plays a key part in young people's lives, and specifically in smoking onset (see section 1.5.2). Therefore, focus group discussions with existing peer groups represent a useful strategy to consider the influence that friends have on beliefs and behaviour (van Teijlingen *et al*, 1995). The subsample for the focus groups was chosen using a peer-selection technique, and the focus group activity was adapted from a card game method for exploring health beliefs and behaviours with young people (Shucksmith and Hendry, 1998). Either the researcher or the teacher selected a girl and a boy at random from each class, and then those children chose up to five same-sex friends. The focus groups took place in a separate room away from the class (typically the library or the staffroom) and lasted between 30-45 minutes. The discussion was tape recorded and transcribed by either the researcher or a paid transcriber. After introductions, the researcher passed round a bag containing a number of folded pieces of paper on which were written smoking-related questions (Appendix G). Each child took it in turns to pull a slip of paper from the bag, and to read out and then answer his/her question. The question was then discussed by the other children. This exercise worked very well - the children enjoyed pulling questions from the bag, and this made them feel that they were directing the discussion. Because the children were among trusted friends they also felt free to discuss topics openly and in depth (Cleave *et al*, 1996; Lloyd and Lucas, 1998). The structure which the researcher imposed on the conversation was intentionally kept to the minimum, and instead the children were encouraged to raise their own concerns and issues and to introduce themes from their own experiences (Foulds, 2000). The focus groups were designed to yield cross-sectional data, and the same children did not participate each year.

Building on existing work (Porcellato, 1998), the focus group protocol was modified and improved. Previously, the children who participated in the focus groups were selected with the aim of mixing children from different classes who did not know each other well. The focus group was then used as an exploratory technique to generate ideas for anti-smoking strategies at primary school level. By contrast, the current research used

established peer groups to focus on the cultural meaning of smoking for this age group. This use of the group interview took advantage of the social interaction between peers to consider the place of smoking in relationships with family and friends. In addition, the number of focus groups conducted was increased from twelve to sixteen.

The literature suggests that group discussions may be dominated by a few outspoken individuals who may influence the flow of the conversation (Aitken *et al*, 1985). However, all the focus groups that were carried out for this research were characterised by their equitable nature. Without exception, the friendship groups who participated were very fair in allowing every child to take part fully in the discussion. They were very strict about taking turns to answer questions from the bag, which was always passed around the circle in order. For example, when the last question was pulled from the bag, if two children were owed a turn then, at the group's suggestion, one would unfold the paper while the other would read the question. Furthermore, because the research took place in a school environment, in every discussion the children spontaneously put up their hands when they wanted to address the group. Although this did not simulate an informal peer group discussion, it did mean that the children were all given a chance to be heard and that they carefully listened to each other while waiting for their turn to speak.

The focus group method continued to work very well and no changes were made in subsequent years.

3.9.4   Semi-Structured Interviews

The interview subsample was designed to include the same children from year to year (to enable longitudinal comparisons of individuals to be made), and was based on those children originally chosen in 1994. However, an additional 14 children were selected to join this sample to counter any attrition that might occur in subsequent years, and to generate a larger body of data. These additional children were selected on a convenience basis by the teacher. They were by necessity children whose parents had returned their consent forms, they had to be present on the day of the interviewing and not involved in

other school activities at the time of the research. Frequently, only one or two children were eligible in each class on the basis of these criteria, which made selection relatively straightforward. These semi-structured interviews were carried out on a one-to-one basis by the researcher, and lasted for approximately 20 minutes. The format was similar to the original method (Porcellato, 1998). Participants were invited to discuss photographs of adults and children smoking (Appendix H) and to direct the conversation as much as possible by talking about their own experiences of tobacco use among family and friends (see the interview schedule in Appendix I). So that the interview was as unintimidating as possible for the child, the questions asked were carefully sequenced so that they moved from adult smoking to child smoking and from abstract questions to detailed accounts of the child's own experience. This ordering worked well, and children were only asked about their own smoking experience towards the end of the interview after a good rapport had been established. The data were tape-recorded and subsequently transcribed by the researcher.

In 2001, a mapping exercise was added to the start of the interview schedule. This exercise was designed to enable the children to produce a participatory diagram of the smokers in their social networks. Children were asked to list the people who lived in their house, which the researcher drew on a piece of paper. Children were then asked to list their friends, together with their family members in household groups. After all the drawing had been completed, the children were asked to stick coloured stars and dots to the diagram in order to indicate smokers, ex-smokers and people who had never smoked. The children enjoyed the exercise and it worked well. The data produced gave a very clear picture of the child in the context of his/her relationships with smokers among his/her family and friends. The exercise was particularly useful in highlighting differences between children's experiences and in portraying the child in his/her social context.

3.9.5 *Parents' Questionnaire Survey*

The survey of parents is a great strength of this wave of the study and is another element of the methodological triangulation on which this research is built. The parents of every child taking part in the study were sent a questionnaire by post together with a consent form and information sheets prior to the fieldwork in 1999. The survey was designed to be completed by one parent (typically the mother) who gave details for the other members of the household. The questionnaire contained both closed and open-ended questions, and was designed to yield data relating to the child and his/her family background (for example: ethnicity, occupational class, benefit status, family type). Parents were also asked if their child had ever experimented with cigarettes, and they were asked to give smoking histories for other members of the immediate family (Appendix J). A letter of reminder and another copy of the questionnaire were sent home with children from school to those parents who had not returned their questionnaires in the first wave. In 2000 and 2001 because parents did not need to receive a consent form, the parental questionnaires were not sent by post but instead were sent home with children from school. In 2001, no reminders were sent to parents who failed to return their first questionnaire because the fieldwork was conducted so close to the end of the school year. This decision not to send reminders may partly account for the low response rate from parents in 2001 (see Table 3.1).

In the first wave of the research (Porcellato, 1998) the parental questionnaires were only administered once at the beginning of the research and were used as a validity check for the children's responses. However, for the current research, the survey of parents has been greatly developed and it now constitutes a significant data source.

3.10   Data Analysis

Quantitative data collected using the children's and parents' questionnaires were analysed using Chi-square tests to test the strength of association between variables using SPSS (version 9.0). A logistic regression analysis was also carried out to identify which

variables at age 9 could be used to generate a model of factors that predicted experimentation with cigarettes by age 11. The statistical analysis aimed to explore the determinants of children's smoking behaviour during preadolescence. These analyses are presented in Chapter 6. A thematic analysis of the qualitative data generated in the interviews, focus groups and children's questionnaires was carried out both inductively using themes that emerged from the data during the course of the fieldwork and also deductively using themes that had emerged from the review of the literature on children and smoking presented in Chapter 1 (Pope *et al*, 2000). Although the draw and write exercise was originally designed to be analysed quantitatively by counting frequencies of responses (Wetton, 1994), here the data are presented qualitatively. This is because although using frequencies does indicate the spread and range of the data, using the data in their original qualitative form conveys so much more of the richness and detail which the children use to describe their own views and experiences. It also presents the data from the children's own perspective rather than imposing the researcher's predetermined concepts as a system of classification. This is in keeping with the child-centred bottom-up approach that underpins the study. Other researchers have also analysed the method qualitatively (for example, Jonker *et al*, 1998).

Thus, the analysis of qualitative data was informed by both *etic* (researcher imposed) and *emic* (participant led) concerns (Stake, 1995; Ireland and Holloway, 1996). These *emic* concerns emerged during the fieldwork throughout the study from the piloting stage onwards. Key themes which emerged from the case study analysis presented in Chapter 5 were then used to structure the analysis of the large body of data generated by the whole cohort which is presented in Chapter 6. The aim of the analysis of the qualitative data was to explore children's accounts of their own personal experiences. The analysis also sought to examine the discourses that preadolescents use to talk about smoking and how these informed their behaviour.

3.11 Conclusions

The guiding principle behind the development of the methods to be used in this phase of the LLSS was the aim of listening to children and enabling their voices to emerge through the research. The research instruments were based on those used for the first wave of the study (Porcellato, 1998) and generated quantitative and qualitative data in a triangulated design. Using these child-centred methods, data were collected at 10 month intervals. As new themes emerged from analysis of the data, the methods evolved over time and the instruments were updated each year to reflect changes in the cohort's experiences during preadolescence. A literature review of existing qualitative longitudinal studies revealed that few studies have been carried out using this approach. The review also showed that whereas some researchers analyse their data thematically, others make optimal use of their longitudinal study design by using their data to identify participants' individual trajectories. Both of these techniques were employed to analyse the longitudinal data collected during this phase of the LLSS. Descriptive data is presented as an introduction to the cohort in Chapter 4. Chapter 5 then uses a multiple case study approach to analyse data collected from five children using a qualitative longitudinal method which explicitly identifies individual children's trajectories of experience during preadolescence. The findings from these case studies are then explored in Chapter 6 using statistical techniques and thematic analysis of the qualitative data.

4 Cohort Description

4.1   Chapter Outline

The chapter presents a brief overview of descriptive data on the cohort. These data set the scene for the subsequent chapters by positioning the children in their social context. The chapter opens by presenting data on participation rates (section 4.2). It then goes on to introduce the cohort by presenting key data on gender, age and ethnicity (section 4.3), socioeconomic status (section 4.4), the smoking behaviour of family members (section 4.5) and of friends (section 4.6).

4.2   Participation Rates

The number of children in the cohort varied from year to year as some children left school and as others joined classes. Some children who were included in the cohort were also absent on the day of data collection. Furthermore, four children were excluded from the cohort because their parents withheld their consent for them to participate. Table 4.1 shows the number of children participating in the research each year.

Table 4.1: The number of children participating in the study, 1999-2001

Year	Total available for sampling	Children present	Children absent	Left school	Joined cohort
1999	267	247 (92%)	20 (8%)	3	12
2000	269	257 (95%)	12 (5%)	9	11
2001	259	239 (92%)	20 (8%)	10	1

As Table 4.1 shows, a very large proportion of the cohort participated in the research each year (92-95%). Every effort was made to gather data from all the children in the cohort and in many cases the researcher made repeated visits to schools in order to survey absent children. This is reflected in the high response rates achieved each year. The table also shows that attrition rates were low. Only 22 children (8% of the cohort) were lost from the study between 1999 and 2001.

4.3   Gender, Age and Ethnicity

Girls were slightly over-represented in the cohort although the gender balance of the sample varied from year to year (see Table 4.2). These data suggest that boys were increasingly more likely than girls to be absent or to leave the study as the children got older.

Table 4.2: The gender of the children participating in the study, 1999-2001

Year	Girls	Boys
1999	127 (51%)	120 (49%)
2000	135 (53%)	122 (47%)
2001	132 (55%)	107 (45%)

When data were collected in 1999, the children were in Year 5. At the data collection points in 2000 and 2001 the children were in Year 6. Because the children were born at different points across the school year, their ages varied at each data collection point. The ages of the children at the time of questionnaire administration are shown in Table 4.3.

Table 4.3: The ages of the children at each data collection point, 1999-2001

	1999	2000	2001
Age 9	188 (76%)	0 (0%)	0 (0%)
Age 10	59 (24%)	227 (88%)	37 (15%)
Age 11	0 (0%)	30 (12%)	202 (85%)

The majority of the children in the sample were white English in ethnicity. There were also a few white children from other countries in the UK and Europe. There was a small group of minority ethnic children, including some children with a mixed ethnic heritage. The ethnicities of the children are shown in Table 4.4. The children's self-defined ethnicity was assumed to be time-invariant, and these data were only collected in 2001. For the purposes of statistical analysis, ethnicity data were recoded into 'white UK' and 'minority ethnic group'.

Table 4.4: The self-reported ethnicity of the children, 2001

Ethnicity	%	n
White English	92	220
White Scottish	0.4	1
White Northern Irish	0.4	1
White Irish	0.4	1
White European	0.8	2
Black Other	0.8	2
Chinese	3	7
Yemeni	0.4	1
Mixed ethnicity	1.8	4

Although 17 of the children belonged to minority ethnic groups in 2001, most of these children were born in the UK. As Table 4.5 shows, only 6 of the children in the cohort were born outside the UK: in Ireland, Europe, the Middle East and Asia.

Table 4.5: The children's countries of birth, reported in 2001

Country of birth	%	n
UK	97	233
Ireland	0.5	1
Germany	0.5	1
Holland	0.5	1
China	0.5	1
Malaysia	0.5	1
Yemen	0.5	1

4.4 Socioeconomic Status

The parental questionnaires gathered data on occupation and these were coded using the Standard Occupational Classification (OPCS, 1991a and 1991b) to generate data on household occupational class. As is usual practice, the child's household was allocated an occupational class on the basis of the occupation of a household reference person. The child's father was always the household reference person unless the child lived in a lone parent household headed by his/her mother, in which case the child's mother became the household reference person (OPCS, 1991b; Roberts, 2001). Table 4.6 shows the

occupations of the parents who returned questionnaires. It should be noted that the households who lived in deprived areas were much less likely to return parental questionnaires. This means that parents in the high occupational groups are likely to be over-represented in these data. Furthermore, parents who were not currently working were asked to list their most recent occupation. Some parents who were currently unemployed or long-term sick/disabled returned questionnaires without giving any occupation. This means that parents who have been out of work for a long period of time or who have never had a full-time job may be under-represented in the data.

Table 4.6: The occupational class of the children's households, 1999-2001

Occupational Class	1999		2000		2001	
	%	n	%	n	%	n
I - Professional	6	8	6	9	11	7
II – Managerial and Technical	13	20	13	18	18	12
IIIN – Skilled Non-manual	20	30	14	20	23	15
IIIM – Skilled Manual	21	32	34	47	30	20
IV – Partly Skilled	18	27	13	18	6	4
V - Unskilled	4	5	4	5	3	2
No occupational data	18	27	16	22	9	6
Total	100	149	100	139	100	66

Although occupational class is frequently used to describe the social gradient in health, for this study, additional measures were used to include families where no one is in work and children whose parents did not return a questionnaire. Measures of socioeconomic status based on either current or most recent occupation have been found to be problematic with samples that include a significant proportion of long-term unemployed people, some of whom may never have had a full-time job and would therefore be excluded from the classification. Instead, receipt of means-tested benefits has been shown to be a useful proxy for low income (Graham and Blackburn, 1998).

Analysis of the data on benefit status revealed that over half the cohort live in low-income households (see Table 4.7). Parents from schools situated in more affluent areas were much more likely to return their questionnaires than parents living in deprived areas. This was particularly the case in 2001, when no parents from the most deprived school returned any data. Therefore these figures are probably an underestimation, and it

is likely that significantly more of the cohort live on a low income than these figures suggest.

Table 4.7: The benefit status of the children's households, 1999-2001

Benefit status	1999		2000		2001	
	%	n	%	n	%	n
Receiving means-tested benefits	55	75	57	75	43	27
Not receiving means-tested benefits	45	62	43	56	57	35

The data on receipt of means-tested benefits could only be collected from parents. In 1999, it became evident when analysing the baseline data that low-income parents were under-represented in the parental data. Therefore, from 2000 onwards the data on occupational class and benefit status were supplemented by postcode data collected from the children. The majority of the children (86% in 2001) knew their postcodes, and Dr Peter Bundred of the University of Liverpool converted these data into deprivation scores. The deprivation score chosen for this analysis was Townsend's score, which has emerged as the best measure of deprivation for explaining variations in health (Morris and Carstairs, 1991). Townsend *et al* (1988) provided an operational definition of material deprivation based on indicators selected from the Census. Four indicators were combined to form an Overall Deprivation Index, with equal weights given to each measure. The four indicators selected for the index were:

1. *Unemployment*. The percentage of economically active residents aged 16-59/64 who are unemployed.
2. *Car ownership*. The percentage of private households who do not possess a car.
3. *Home ownership*. The percentage of private households not owner occupied.
4. *Overcrowding*. The percentage of private households with more than one person per room (Townsend *et al*, 1988: 36).

The major advantage of this measure of socioeconomic position over occupational class and benefit status is that the poorest children are fully represented in the data. Figure 4.1 shows the range of Townsend deprivation scores for the children's households (with '−1' representing the most affluent children and '13' the most deprived). For the purposes of

the statistical analysis presented in Chapter 6, these scores were grouped into quartiles (Bundred, 2001) as shown in Table 4.8.

Table 4.8: The range of Townsend deprivation scores found in the North West

Quartile	Range of scores	Deprivation/Affluence
Lower quartile	-6 to –3	Most affluent
Mid lower quartile	-2 to 0	
Mid upper quartile	1 to 3	
Upper quartile	4 and above	Most deprived

On the basis of this stratification into quartiles, it can be seen from Figure 4.1 that the overwhelming majority of the cohort live in the most deprived quartile in the North West (82%), with a small proportion in the mid upper quartile (1%) and a cluster of children reflecting the location of one school in the mid lower quartile (17%). None of the children lived in households with locations in the most affluent quartile in the North West. The proportion of children living in each quartile was identical in 2000 and 2001.

Figure 4.1: Townsend deprivation scores
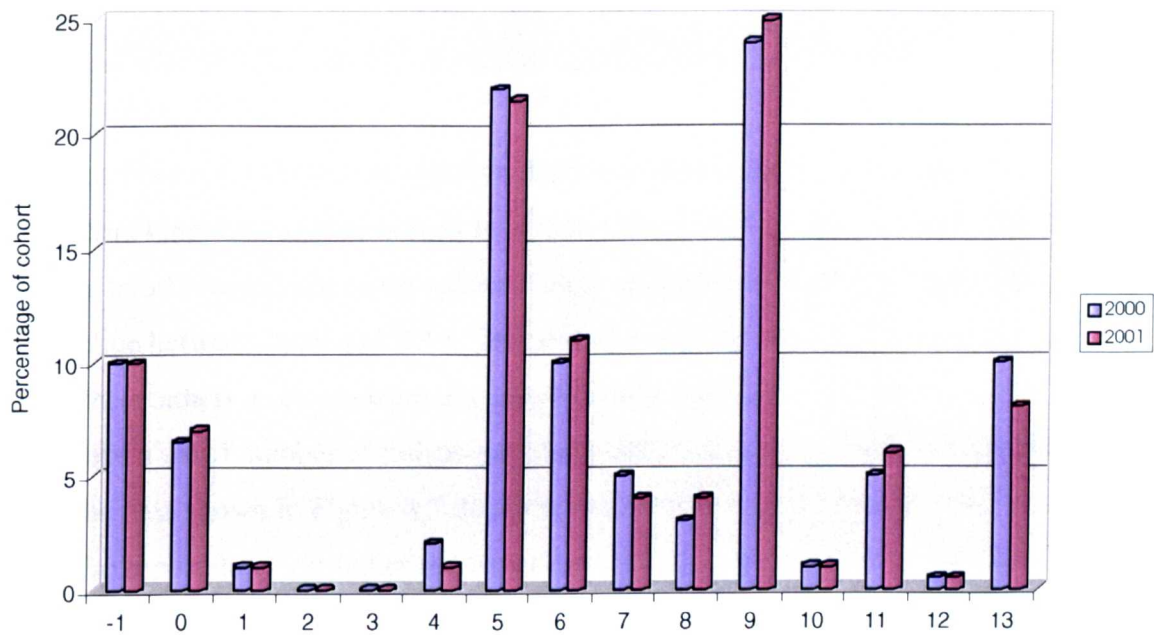
4.5   The Smoking Behaviour of Family Members

The next part of this section describes the smoking status of the children's families and friends. Although official figures suggest that only 32% of adults in Liverpool are smokers (Crosier, 2001), the smoking rates among the parents of the cohort were significantly higher than this and more in line with unofficial reports that suggest an adult smoking prevalence in Liverpool of over 40% (see section 1.3.3). Figure 4.2 shows that the proportion of children with smoking mothers remained stable throughout the study (41%, 1999; 41%, 2000; 40%, 2001).

Figure 4.2: Mother's smoking status as reported by the children
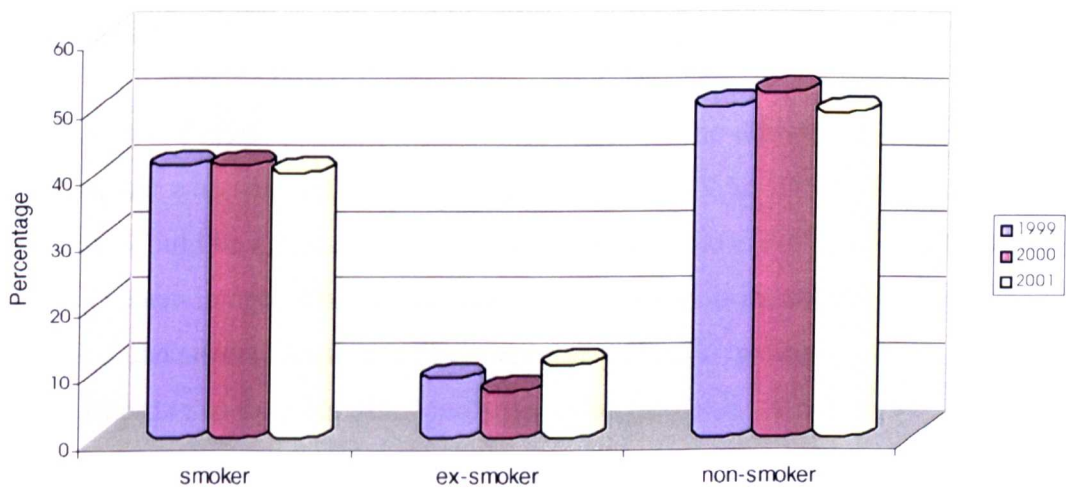
However, as Figure 4.3 shows, the children described decreasing rates of paternal smoking. Smoking rates among fathers fell from 42% in 1999 to 35% in 2001. This downwards trend is surprising since national adult smoking prevalence did not show a similar decline between 1999 and 2001. Because the proportion of children who described their fathers as ex-smokers increased slightly from 14% in 1999 to 16% in 2001, perhaps a small number of fathers gave up smoking during the period of the study. However the data shown in Figure 4.3 do not account for the increase in the number of children who report that their father has never smoked (from 44% in 1999 to 49% in 2001). It is possible that this increase may be explained by some children having more than one father figure, or different people occupying the role of father over time. It is

also possible that children with smoking fathers were more likely to be absent from school over the course of the study.

Figure 4.3: Father's smoking status as reported by the children
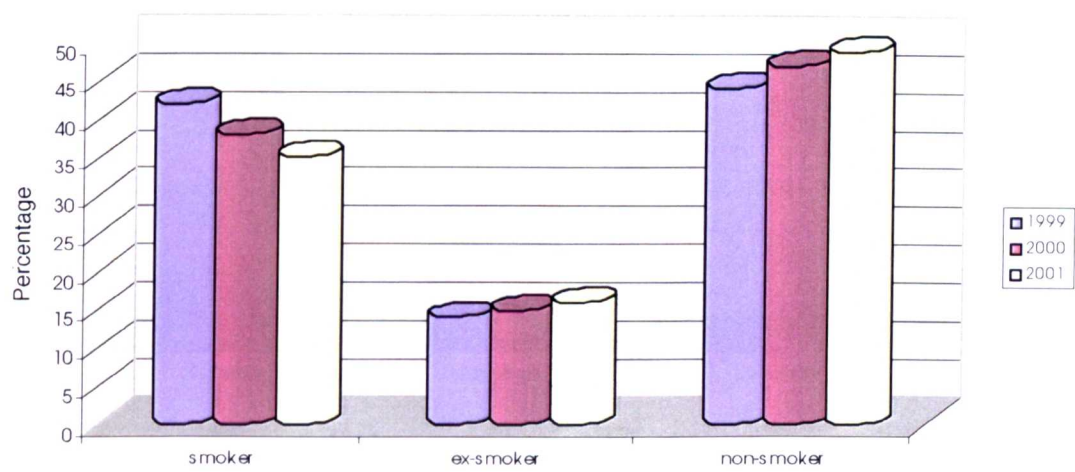
As can be seen in Figure 4.4, the proportion of children who reported that they had at least one brother who smoked increased over time, from 8% in 1999 to 13% in 2001. This increase would be expected because the majority of the children had siblings who were close to them in age. This means that as the children in the cohort got older, in turn their brothers and sisters were more likely to be experimenting with cigarettes or taking up regular smoking as they got older and entered adolescence. Although the proportion of children with brothers who were smokers increased as the cohort got older, it is important to note that the number of children with smoking brothers remained small in relation to the number of children with smoking parents or with smoking friends. Although a few children reported having more than one brother who smoked, the data shown in Figure 4.4 suggest that most children only had one brother who was a smoker.

Figure 4.4: Number of smoking brothers as reported by the children
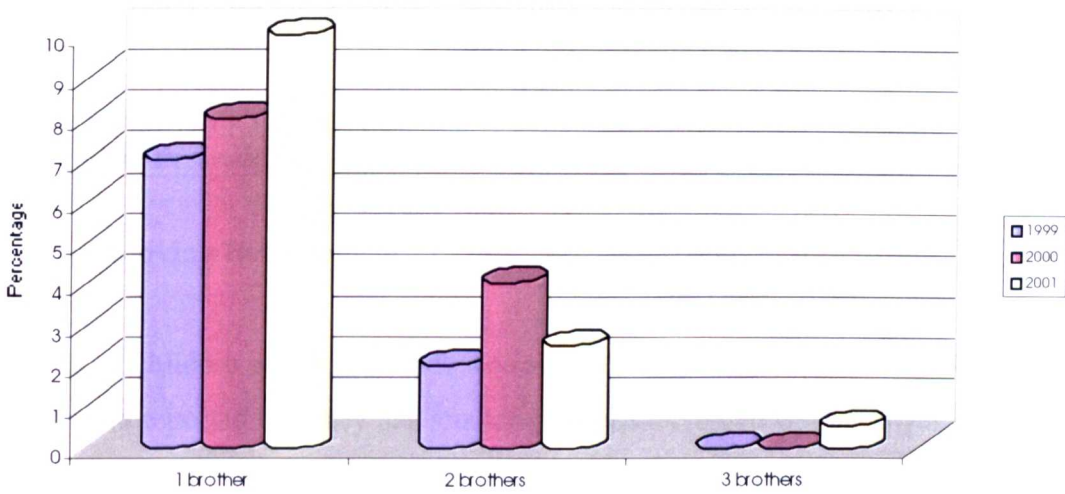
Although the proportion of children reporting smoking brothers increased over time, the number reporting smoking sisters did not increase significantly: from 9% in 1999 to 10% in 2001. Figure 4.5 shows that, as with brothers, most of these children had only one sister who smoked.

Figure 4.5: Number of smoking sisters as reported by the children
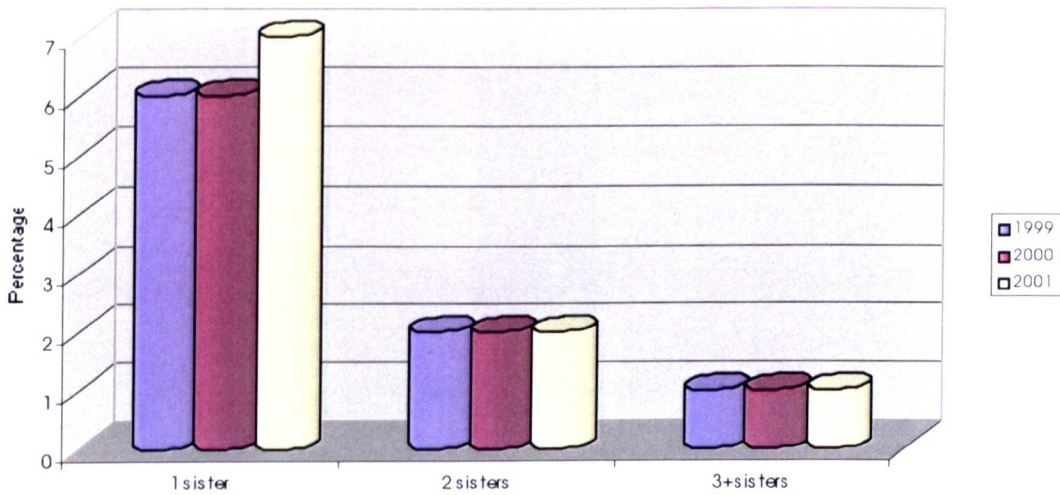
Many of the children lived with more than one smoker and, as the data in Table 4.9 show, over half the cohort lived with someone who smoked. Although the number of children who reported that their father smoked declined over time, the proportion of the cohort who lived with a smoker remained stable. These data are particularly significant in the context of children's exposure to passive smoke (see Appendix L).

Table 4.9: The number of children who lived with a smoker, 2000-2001

	2000		2001	
	%	n	%	n
Lives with at least one smoker	56	143	55	130
Does not live with smokers	44	111	45	108

4.6   The Smoking Behaviour of Friends

The number of children who had friends who smoked is shown in Figure 4.6. The proportion who reported that they had smoking friends increased sharply from 19% in 1999 to 34% in 2000. However, the number of children who reported having friends who smoked remained stable in 2001 at 33%. Because friends are known to be a significant influence on smoking initiation (see section 1.5.2) it is important to note that by age 10 already a third of the children had friends whom smoked. At age 10 less than a third of the cohort had tried smoking and very few of the children were smoking regularly.

Figure 4.6: Proportion of children with smoking friends
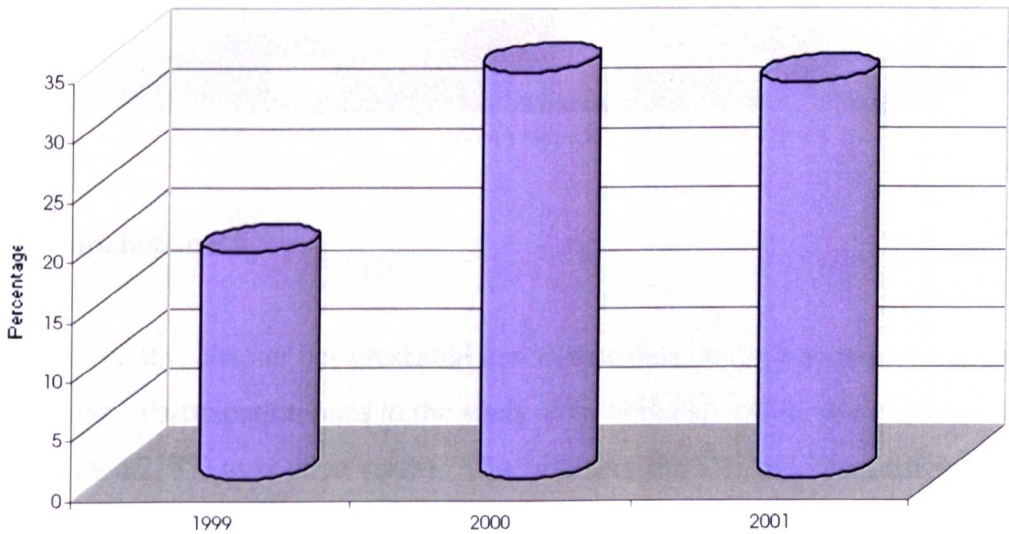
Although a significant proportion of the cohort had friends who smoked by age 10, as Figure 4.7 shows few children reported that their best friend smoked. The number of children who described their best friend as a smoker increased from 5% in 1999 to 9% in

2000. This means that the number of best friends who smoked was still greater than the number of children who reported smoking regularly in the study between 2000 and 2001 (1% and 3% respectively), and also greater than the number of children who reported trying smoking more than once in 1999 and 2000 (1% and 7%), although 12% of children had tried smoking more than once by 2001. These data suggest that either children may have best friends who are older than them who smoke, or alternatively children may describe their best friend as a smoker even on the basis of relatively limited smoking experience.

Figure 4.7: Best friend's smoking status as reported by the children
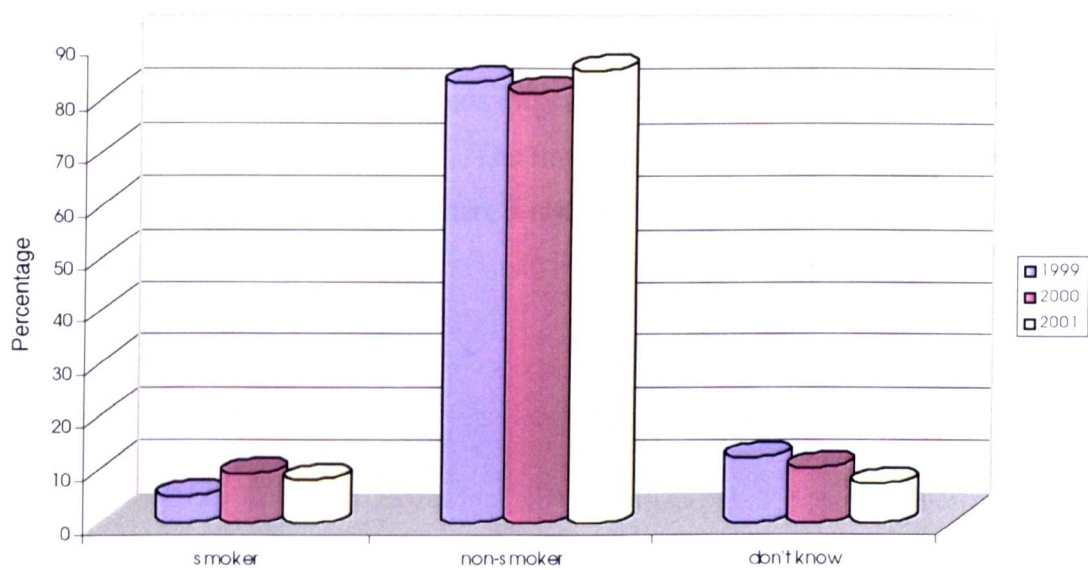
4.7   Conclusions

In conclusion, this chapter has presented descriptive data on the personal characteristics of the cohort. Participation rates in the study were high (92-95%), and attrition rates were low (n=22, 8% over three years). This indicates that the children participating in the research are still representative of the study population. As the data have shown, the sample was fairly monoethnic and the majority of the cohort were born in the UK, including many of the minority ethnic children. Analysis of parental data on occupational class showed that most of the children's parents had occupations classified as skilled manual (IIIM). However, the households who lived in deprived areas were

much less likely to return parental questionnaires and therefore parents in the higher occupational groups are probably over-represented in the data. Occupational class as a measure of socioeconomic status was supplemented by data on income and deprivation to enable the inclusion of families where no-one is in work. Over half the cohort lived in low-income households dependent on means-tested benefits, although this is likely to be an underestimate. Because parental data was skewed towards the higher occupational groups, postcode data were collected from the children. Analysis of deprivation scores revealed that 82% lived in the most deprived quartile in the North West. Parental smoking rates were considerably higher than the national average of 26% prevalence, and four out of ten mothers and fathers smoked. This meant that over half the cohort lived with someone who smoked. Data collected on smoking by peers revealed that the number of children with smoking friends increased to a third by age 11, although few children had best friends who smoked. The impact of these sociodemographic factors on smoking uptake is considered in Chapters 5 and 6.

5 Longitudinal Case Study Analysis

5.1   Chapter Outline

This chapter uses a case study approach to present an in-depth account of the experiences of just a handful of the children who participated in the interview subsample (n=38). The themes that emerge from this case study analysis will be explored in the context of data produced by the whole cohort in Chapter 6.

Firstly, the chapter presents an overview of the case study method (section 5.2). The sampling frame used to select the children from the interview subsample (section 5.3) and the structure of the case studies (section 5.4) are then described. The chapter then continues by presenting in-depth descriptions and summaries for the five children who form the case studies: Maggie Magrath (section 5.5), Sarah Blanchard (section 5.6), Bill Bobby (section 5.7), Chima Chin (section 5.8) and James B. (section 5.9). The chapter concludes by presenting a cross-case comparison that compares and contrasts the central themes in relation to each of these five cases (section 5.10).

5.2   The Case Study Method

A case study can be defined as "an in-depth, multi-faceted investigation, using qualitative research methods, of a single, social phenomenon" (Feagin *et al*, 1991: 2). This chapter presents multiple case studies that focus on the experiences of five of the children who participated in the one-to-one interviews. The method aims not for statistical generalisation but for particularisation. It seeks to understand, describe and explain the complexity of a single, unique case within its real-life context (Feagin *et al*, 1991; Yin, 1994; Stake, 1995). Whereas individual changes may be obscured in aggregated cohort data, the use of a case study shows how an individual experiences change over time. This analysis for individuals is the essence of the longitudinal study.

Stake (1995) distinguished between two types of case study: intrinsic and instrumental. He argued that for the intrinsic case study, the case is predetermined and the researcher's objective is not to learn about other cases or to explore a general question, but instead the aim is to learn about that particular case. In this way, the case has intrinsic value in its own right. By contrast, an instrumental case study seeks to yield general understanding by answering a particular research question. Rather than the case, instead it is the research question that is the focus. In this instance, the case study is instrumental in understanding a wider research question. The case study approach that is used here is clearly instrumental in that the aim is to explore wider research questions about children's experiences of smoking during preadolescence. In this way, the findings of a case study are generalisable to theory, but not to a wider population, because the approach enables the researcher to suggest new concepts and interpretations of data (Feagin *et al,* 1991; Yin, 1994).

5.3   Sampling Frame

Because the case study method seeks to focus on just a few cases, the method does not aim to draw on a sample that is either typical or representative. Because case study research seeks to give a 'thick description' of a small number of cases, the goal of the research is to understand the complexities of each case and not to generalise that understanding to other cases (Stake, 1995).

For an intrinsic study, because it is the case itself that is the focus, the case is often pre-determined. However, for an instrumental case study such as this, a method was designed to choose which children from the interview subsample would make the best cases for an in-depth study. These children were selected during the final analysis phase after all the data had been collected. Although a wealth of data had already been collected from each child, in order to carry out an in-depth analysis the decision was made to focus on just five children as case studies.

Because the case study method does not seek to produce representative or statistically generalisable results, the children who were chosen did not need to be 'typical cases' or to necessarily reflect the exact composition of the whole cohort as presented in Chapter 4. However, the smoking behaviour and household characteristics of the selected children did reflect the variation found in the wider cohort. Because the case study aims to provide depth, it was vital to select cases that were "hospitable to our inquiry" (Stake, 1995: 4). In this instance, a particular factor in deciding which children should be chosen for case study analysis was the richness of the data they had provided in their interviews. Because the analysis was not aiming for representativeness, purposive sampling was used to include a greater proportion of children who had tried smoking (3 out of 5) in the case studies than was found in the whole cohort (2001, 27%). The selection design 'over-samples' from the children who had tried smoking because one of the central issues for this study is to explore why some children experiment with smoking during preadolescence. Therefore so many triers are included in the case study design because they are the children whose experiences shed most light on the research questions. The selection grid that was used to choose the children for the case studies can be found in Table 5.1. The children who were selected for the case studies are *italicised* on the selection grid.

Table 5.1: Case Study Selection Grid

Code	Gender	Receipt of benefits*	Mother smokes	Father smokes	Tried smoking	Ethnicity	Missing data	Rich data
C1-10	F	Yes (2000)	No	No Dad	No	White		
C1-14	F	Yes (1999)	Yes	Yes	No	White		
C1-25	M	Yes (2000)	No	No	No	White		
C1-29	M	Yes (1999)	Yes	No	No	White		
C2-06	M	No data	Yes	Yes	No	Black other		
C2-13	*F*	*Yes (2000)*	*Yes*	*Yes*	*Yes*	*White*		*Yes*
C2-14	M	Yes (2001)	Yes	No	Yes	White		
C2-15	F						Yes	
C3-03	F	Yes (2000)	Yes	No	Yes	White		Yes
C3-12	*F*	*No (2000)*	*No*	*No*	*No*	*White*		*Yes*
C3-18	M						Yes	
C3-27	F	Yes (2001)	Yes	No Dad	No	White		Yes
C3-55	M	Yes (2001)	No	Yes	No	White		

C3-59	F	No (1999)	No	No	No	White		
C3-60	M	Yes (1999)	No	No	Yes	White		
C3-61	M	No data	Yes	No	Yes	White		
C4-01	F	No (1999)	Yes	No	No	White		
C4-03	M						Yes	
C4-12	F	No (2000)	No	No	No	White		
C4-13	M	No (2001)	No	No	No	White		
C4-29	F	No (2001)	Yes	No	No	White		
C4-39	F						Yes	
C4-62	*M*	*No (2000)*	*No*	*No*	*No*	*White*		*Yes*
C4-66	M	No (2000)	No	No	No	White		Yes
C4-67	F	Yes (2001)	Yes	Yes	Yes	White		
C4-71	F						Yes	
C4-74	*F*	*Yes (1999)*	*Yes*	*Yes*	*Yes*	*White*		*Yes*
C4-87	M	No (2001)	No	No	No	White		
C5-06	M	No (2000)	Yes	No	Yes	White Irish		Yes
C5-07	M	No (2001)	No	No	Yes	White		Yes
C5-21	M	No (2000)	No	No	No	White		
C5-34	F	No (2001)	No	No	No	White		
C5-35	F	Yes (2001)	Yes	No	No	White		
C5-41	F	No data	Yes	No	No	White		
C6-04	F	Yes (2000)	Yes	Yes	No	White		
C6-08	F	Yes (2000)	Yes	Yes	No	White		
C6-16	*M*	*No (2001)*	*No*	*No*	*Yes*	*White*		*Yes*
C6-22	M						Yes	

* With the exception of receipt of means-tested benefits, all these data were collected in 2001

5.4   The Cases

In the sections that follow a description of each case is given and these are then followed by a cross-case comparative analysis. The descriptions aim to consider how each child's experiences and views of smoking have changed during preadolescence. Case studies aim to reflect the complexity of each case. Therefore, each child is presented here as a unique individual, embedded in his/her social context and in interaction with family and peers.

The case study method often uses a triangulated research design (Yin, 1994). In this instance, qualitative data from the children's questionnaires ('Q') were triangulated with data generated during interviews ('I') and the draw and write exercise ('DW') at age 9,

10 and 11. Data from the parental questionnaires ('PQ') are also presented. The case descriptions include participatory diagrams that the children produced to show the smoking status of people in their social networks. In these diagrams, each household is represented by a box. Smokers are listed in red and ex-smokers in green.

The research sought to be child-centred and, in keeping with this ethos, in 2001 the children chose their own pseudonyms. These are used to report their talk throughout this chapter. Because these case studies are instrumental in understanding wider research questions about smoking during preadolescence, these issues and questions are used to structure the case descriptions thus facilitating cross-case comparison. The focus of this chapter is on comparative analysis using a longitudinal design. Firstly, the data generated by each child each year is compared with that of the preceding year to identify how the experiences of each child change over time. Secondly, the cases are compared with each other to identify significant areas of similarity and difference to enhance understanding of the social patterning of children's experiences of smoking during preadolescence.

5.5   Maggie Magrath

5.5.1   Case Description

<u>Child in social context and family background</u>

Maggie Magrath was a girl of white English ethnicity who attended a primary school in the most deprived ward included in the study. She lived with both her parents who were heavy smokers, and also with her thirteen-year-old sister who was a non-smoker. She was the youngest child in her family. Maggie's household depended on means-tested benefits to supplement its income. Her mother was unable to work due to long-term sickness but her father worked full-time. Although none of Maggie's friends smoked, she came into regular contact with several adult smokers in her wider family (Figure 5.1).

Figure 5.1: Family and Friends Mapping for Maggie Magrath

KEY: Smokers - Ex-smokers - People who have never smoked

Child's Household

```
Mum
Dad
Sister (age 13)
Maggie Magrath
(Rabbit)
```

Friends

Female Friend 1
Female Friend 2
Female Friend 3
Female Friend 4
Female Friend 5
Female Friend 6

Family

```
Uncle
Aunt
Cousin 1
Cousin 2
Cousin 3
```

```
Uncle
```

```
Uncle
```

```
Aunt
Cousin 1
Cousin 2
```

```
Male Cousin
Female Partner
Child 1
Child 2
```

```
Uncle
Aunt
Cousin 1
Cousin 2
```

```
Male Relative
Female Partner
Child 1
Child 2
Daughter of Child 2
```

<u>Child's smoking experience, intentions to smoke and views on smoking</u>

Maggie expressed clear and consistently negative views about smoking throughout the research. At age 9 and 10 she was concerned about the risks smoking poses to health:

> I think smoking is bad for you because it can damage your lungs and spread into other parts of your body and give you cancer and you might die (Q, 1999)

> That it's bad for your health and it will still damage your lungs (Q, 2000)

At age 11 her views were still negative, but her emphasis had moved away from health to the unpleasant nature of cigarette smoke itself:

> I think it's disgusting and a horrible smell (Q, 2001)

At the ages of 9 and 10, Maggie's negative views on the habit were reflected in her lack of intention to try smoking either now or in the future, which she also justified on the basis of concern about the risks smoking might pose to her health:

> Because it would damage your lungs and I don't want to damage my lungs (Q, 2000)

However, despite her clear negative stance, and lack of interest in experimentation with cigarettes at the age of 9 and 10, Maggie reported that she had tried smoking at age 11. She reported that she had only tried smoking once, and had stolen a cigarette from her parents that she smoked with a friend down an empty alleyway. She was unable to offer any explanation of why she had tried smoking and stated that she had not enjoyed the experience. The inconsistency between views, intentions and subsequent behaviour supports the premise that changes in behaviour are not necessarily predicted by changes in attitudes.

Beliefs about children and smoking

As the child of smoking parents and also as someone who had tried smoking, Maggie's beliefs about children and smoking yield a useful insight into the experiences of children growing up in poverty. Over the period of the study, her explanations of why some children smoke varied from year to year. At age 9 she suggested that some children smoke because they are ignorant of the health consequences of smoking:

Because they think that it will not do any harm [to] them (Q, 1999)

She also argued that children might smoke both in order to improve their social image and to exert power over their peers:

[Children smoke] Because they think it's fun. They think they want to be cool towards other kids and they think they're the boss of the school to other kids. And they might be all going over to people and calling them names and saying 'I'm the boss of the school. I smoke so shut up!' (I, 1999)

However, at age 10 she suggested that some children might smoke in order to manage stress, and this is consistent with her understanding of the way adults use tobacco as a coping strategy:

[Children smoke] because they have a hard time getting on at home (Q, 2000)

At age 11, Maggie argued that some children might smoke because they are accustomed to breathing in smoke as a result of people smoking around them. This is particularly interesting in the context of her own experiences of passive smoking and because she also reported trying smoking herself:

If someone around them smokes and they are used to smoke inhaling into their lungs (Q, 2001)

<u>Beliefs about adults and smoking</u>

As suggested above, Maggie's understanding of why some children smoke was rooted in her knowledge about the way adults use tobacco. Even at the age of 9 she understood that smoking is a way of managing stress and a means of coping in difficult circumstances. It is interesting to consider how Maggie knew this – perhaps because her parents used tobacco in this way. She argued that adults smoke:

Because they think it will get rid of their fear sometimes (Q, 1999)

Because some may think it's for stress, it might relieve stress (Q, 2001)

In an interview at age 10 she was shown a picture of adults smoking and asked why she thought the people shown were smoking:

Maggie: Because they're having a hard time.
Int: Why would they be smoking if they're having a hard time?
Maggie: They think smoking can get rid of their problems (I, 2000)

In response to the same question at age 11, her answer was remarkably consistent and revealed an insight into Maggie's experience of adult preoccupations. She knew that adults needed to smoke to cope with stress, depression and marital conflict:

Maggie: Because they're stressed and depressed or they've been thrown out by their wife.
Int: Why would they smoke if they were stressed or -depressed or if something had happened to them like that?
Maggie: Because they might think that it relieves the stress (I, 2001)

<u>Passive smoking</u>

Maggie had a good knowledge of the dangers of passive smoking:

110

Where is the smoke going?
It is spreading all around the room and it is going into other peoples lungs and damages other lungs

How does your person look and feel?
She feels happy but she is not nowing that it is going into other peoples lungs and she feels cool.
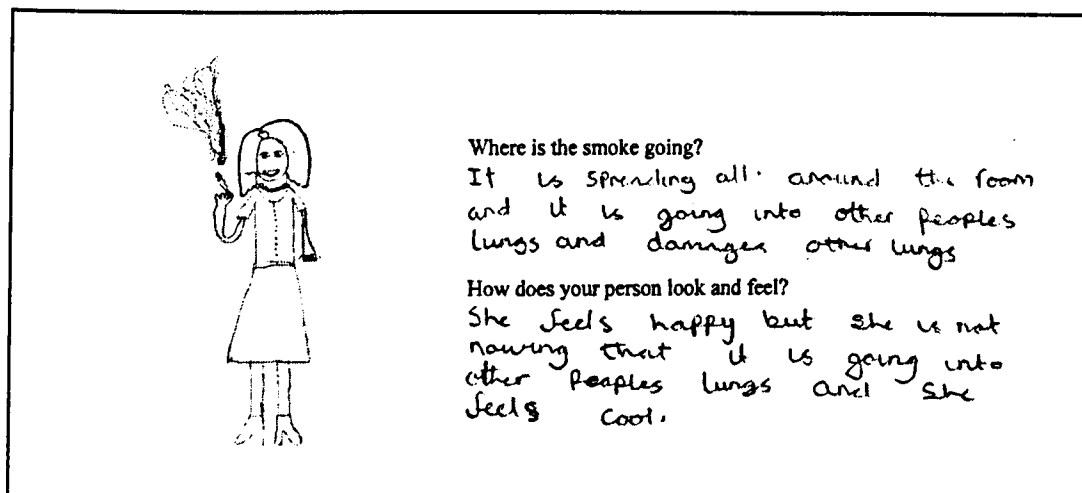
Figure 5.2: Maggie Magrath, DW, Box 1, 1999

Both of Maggie's parents were heavy smokers: her mother reported smoking 30 cigarettes a day and her father smoked up to 40 a day (PQ, 2000). Her mother spent a lot of time at home due to her ill-health and, due to the large number of smokers in her wider family, it is therefore perhaps unsurprising that Maggie reported spending time in smoky environments. She reported that she was doubly exposed to ETS both at home and when she went out with her parents to socialise:

> In my house and somewhere else like pubs and other people's homes (Q, 2000)

However, although Maggie acknowledged that her parents smoked, she was keen to emphasise that they took steps took protect her from second-hand smoke at home. This may be because Maggie knew that smoking harms health, and she was also aware that parents have a responsibility to promote their children's health. She may therefore have been reluctant to communicate that they were exposing her to passive smoke:

> They'll open the window or the back door (I, 2000)

This research has sought to explore how children experience passive smoking and Maggie – like the children of many smokers – had mixed feelings about inhaling secondhand smoke. At age 9 and at age 11 she complained about the negative effects of the smoke on her health and said that she felt:

111

Stuck in the fog (Q, 2001)

This fog metaphor that she used to describe the quality of the air in her home suggests that the atmosphere in her house was in fact very smoky indeed, and this description contrasts with her account of the measures that her parents took to protect her from passive smoke. She also talked at age 9 about how ETS affected her health and sense of well-being:

> I don't like it because it goes ... up your nose and in your mouth and you get a sore throat. And you get pains and it stings your eyes when it goes past (I, 1999).

> When my Mum or Dad smokes near me it does your lungs damage and it hurts your chest (I, 1999)

However, at age 10 she suggested that she was so accustomed to being in smoky environments that she noticed no difference:

> I feel just the same (Q, 2000)

The teachers at the school commented informally to the researcher on Maggie's parents' heavy smoking and pointed out that she frequently had a cough at school.

Smoking and health

From age 9, Maggie understood that smoking damages the lungs, and by age 11 she was also aware that smoking was related to heart disease:

How can you tell from the inside of the person's body that your person has been smoking for a long time?

Because her /his lungs have turnt black and they will die of the tightnes that the smoke has.

Figure 5.3: Maggie Magrath, DW, Box 2, 1999
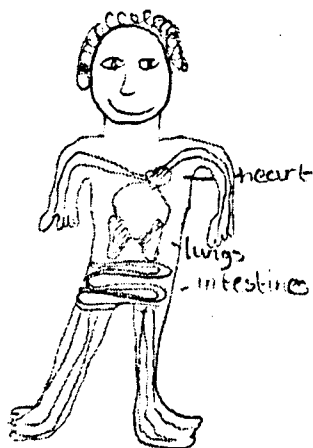
How can you tell from the inside of the person's body that your person has been smoking for a long time?

This person has been smoking because the lungs have turned black and the heart too.

Figure 5.4: Maggie Magrath, DW, Box 2, 2001

Maggie had personal experience of the risks smoking poses to health, not only through her own cough (which she never commented on) but more particularly through the serious health problems which her mother experienced as a result of her heavy smoking and drinking. At age 9 and age 11 when asked if she knew anyone who had been ill because of smoking, she described her mother's ill-health:

My Mum because she had something wrong with her lungs or her heart (Q, 1999)

Int: Do you know what can happen to people sometimes if they've smoked for a long time? What can happen to them inside?
Maggie: They get heart disease and lung disease.
Int: OK. Good girl. That's excellent.
Maggie: My Mum's had so many heart attacks it's a wonder she's not dead yet!
Int: Your Mum's had heart attacks?
Maggie: She's had angina attacks and heart attacks.
Int: How old is she, your Mum?
Maggie: 46.
Int: It's not very old, is it? So has she been into hospital when she's had these heart attacks?
Maggie: She's had about six.
Int: When did she have her last one?
Maggie: She was out drinking with her mate. And she went out for some fresh air and she got a taxi home and she just collapsed in the taxi and she had to be rushed to hospital (I, 2001)

Addiction and cessation

Maggie knew that it is hard to give up smoking, but even at age 11 she did not use the term 'addiction'. Instead, she explained the process in her own terms:

Because once you get into it you can't stop smoking and it's hard to stop smoking (I, 2001)

Although her parents continued to smoke, Maggie reported that they had both made several unsuccessful attempts to quit. She would be glad if they were able to give up smoking – perhaps on the basis of a concern for her parents health and also because she disliked being exposed to passive smoke:

Int: Have they ever tried to pack in?
Maggie: Yes.
Int: … Did they try anything special?
Maggie: My Mum, every time I went to the shop after school, I'd get some sweets and I'd eat them coming home, because I was hungry. And my tea's always done when I get in. And she goes 'Have you got any sweets left?' and I'd say 'No'. And then I go 'Why?' and she says 'Because I'm trying to pack in smoking' and I'd say 'Yeah!!!' (I, 1999).

Health promotion

As someone who understood the risks smoking poses to health, Maggie was active in trying to promote the health of smokers around her. She was particularly concerned about her parents who she encouraged to give up smoking:

> *Int*: Have you ever asked someone not to smoke?
> *Maggie*: Only my Mum and Dad.
> *Int*: ... And what did they say when you asked them?
> *Maggie*: 'I'm trying to, I'm trying to pack in' (I, 1999)

5.5.2 Case Summary

Maggie's parents are both heavy smokers living on a low income. Maggie's experience of her parents' smoking has shaped many of her own views and knowledge about tobacco. Although she held stable negative views, and did not intend to smoke, at age 11 she reported that she had tried smoking. Maggie's beliefs about children and smoking varied over time but centred on her understanding that children may smoke to cope with stress, in the same way that she suggested adults used tobacco to cope with their problems. She also argued that children might start to smoke because they are used to inhaling secondhand smoke. Maggie spent a lot of time in smoky environments and had mixed feelings about passive smoking because she was used to ETS. She had a good knowledge of the risks smoking poses to health and her mother had experienced serious health problems as a consequence of her heavy smoking and drinking. Maggie's understanding of the addiction process was based on her observations of her parents' quit attempts. She remained concerned about her parents' health and had encouraged them to give up smoking.

5.6   Sarah Blanchard

5.6.1   Case Description

Child in social context and family background

Sarah Blanchard was a girl of white English ethnicity. She lived with both her parents who had never smoked. Sarah was the middle child in her family and she also lived with her fifteen-year-old sister and her ten-year-old brother who were both non-smokers. Sarah's mother worked part-time as a biscuit packer and her father worked full-time as a welder. The family was not on a low income. None of Sarah's friends smoked, and her wider family contained only a few smokers who live in the south of England (Figure 5.5).

Child's smoking experience, intentions to smoke and views on smoking

Perhaps because Sarah had so little personal experience of smoking by her family and friends, she had extremely strong negative views about tobacco use. Her views were stable over the period of the study:

> I don't like smoking and I think it smells horrible because it can kill you or give you cancer and your blood and lungs turn black (Q, 1999)

> I hate it. I never want to do it, it is horrible. Even if someone bullies me I hate it. I wouldn't do it (Q, 2000)

> I think that they should be stopped from being sold altogether. I think there should be no such thing as cigarettes (I, 2000)

> I definitely think it's bad. Very, very bad.... And if smoking is something, then it should be good for you or not do nothing. Because it's bad for you, isn't it? And even if it wasn't bad for you, I probably still wouldn't smoke, if it wasn't bad for you. Definitely not. It litters the floor as well doesn't it? It starts fires and kills other people as well, doesn't it? It's bad for everyone (I, 2001)

Figure 5.5: Family and Friends Mapping for Sarah Blanchard

KEY: Smokers - Ex-smokers - People who have never smoked

Child's Household

> **Mum**
> **Dad**
> **Sister (age 15)**
> **Sarah Blanchard**
> **Brother (age 10)**

Friends

Female Friend 1   Female Friend 2   Female Friend 3
Female Friend 4   Female Friend 5

Family

> Grandma
> Grandad
> (Mother's parents)

> Nan
> (Father's mother)

> Aunt
> Uncle
> Cousin 1
> Cousin 2
> Cousin 3

> Aunt
> Uncle
> Cousin 1
> Daughter of Cousin 1
> Son of Cousin 1
> Cousin 2
> Son of Cousin 2

> Uncle
> Aunt
> Cousin 1
> Cousin 2
> Cousin 3

> Aunt
> Uncle
> (9 cats)

> Aunt
> Uncle
> Cousin 1
> Cousin 2

> Aunt
> Uncle
> (Rottweiler)

Her strong negative views were reflected in her stable intentions to never smoke either now or in the future. She was consistently adamant that she would never try smoking, and this was based on her knowledge of the risks smoking poses to health. Sarah also disliked smoking because of the smell of the smoke and the short-term consequences for smokers' physical appearance:

> It will make you die early and you can get cancer (Q, 2000)

> I know it is bad for you and <u>will</u> kill you, and you get yellowish skin, bad skin, teeth, breath and lungs [original emphasis] (Q, 2001)

Sarah's behaviour were consistent with her expressed views and intentions and she did not report that she had tried smoking at any stage of the research.

<u>Beliefs about children and smoking</u>

Although Sarah had not tried smoking and had little contact with children who smoked, she could still understand why some children do try smoking. Each year she consistently explained that some children experiment with cigarettes because they are bullied into doing so. She suggested that fear of name-calling and concerns about group membership might prompt some children to smoke:
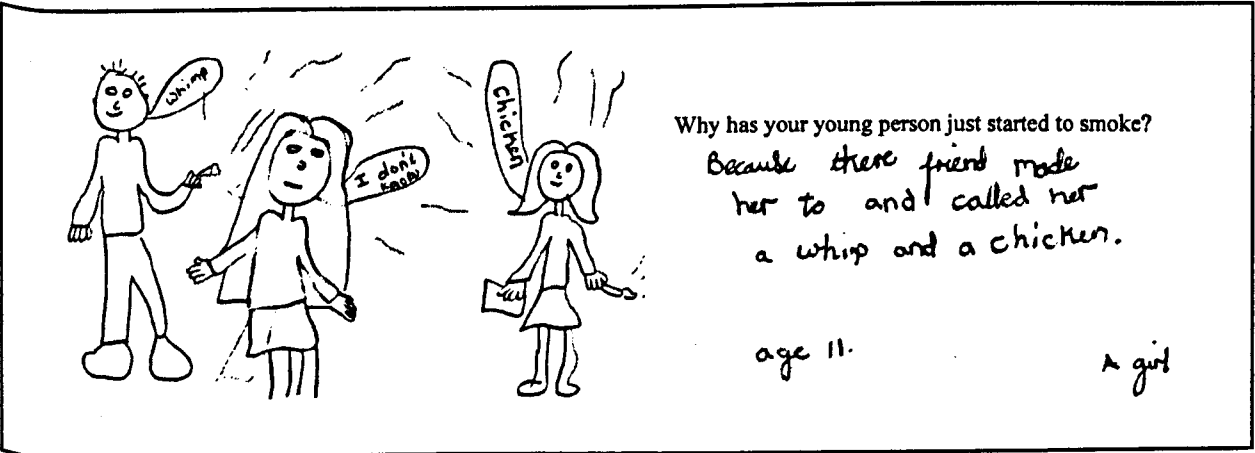
Figure 5.6: Sarah Blanchard, DW, Box 4, 1999

Sarah: I think they've been bullied into it probably. Or because they think it's cool...

Int: Why do you think they think it's cool?

Sarah: Maybe because adults do it and their friends say 'Oh come on, you chicken, you wimp'.

Int: ... Who is it that bullies them into it?

Sarah: Probably their friends or people in school or the people the same age as them.

Int: And what do their friends do to bully them into it?

Sarah: They just tell them 'Oh, you're a wimp' or 'If you don't do it, we don't want you to be in our gang'.

Int: So why do their friends want them to smoke so that they can be in their gang?

Sarah: Maybe because they think it's good and if you don't do it you're just a little wimp and things like that (I, 2000)

Although Sarah was aware that other children may be bullied into trying smoking, she explained the protective effect that her non-smoking peers and family had on her intentions to try smoking:

Int: Why haven't you tried?

Sarah: Since I was little I haven't liked it. And my Mum and Dad just never, none of my friends like it, so no-one would bully me into it. And even if they did, I wouldn't anyway (I, 2001)

Beliefs about adults and smoking

Although Sarah knew few adult smokers, she could still offer a consistent explanation of why adults smoke. She understood that smokers often take up the habit during childhood and then continue to smoke throughout adult life. This understanding was rooted in her knowledge about addiction and the role that family and friends play in smoking uptake:

I think adults smoke because when they were younger their friends told them to and their Mum and Dad did (Q, 1999)

When they were children they started getting into it, then couldn't stop (Q, 2001)

Passive smoking

Sarah understood that tobacco harms not only smokers but also others who inhale their smoke:

Where is the smoke going?
inside her and into the air.

How does your person look and feel?
Happy they like smoking but she doesn't know it's doing others harm aswell. Her hands have gone yellow she looks horrible
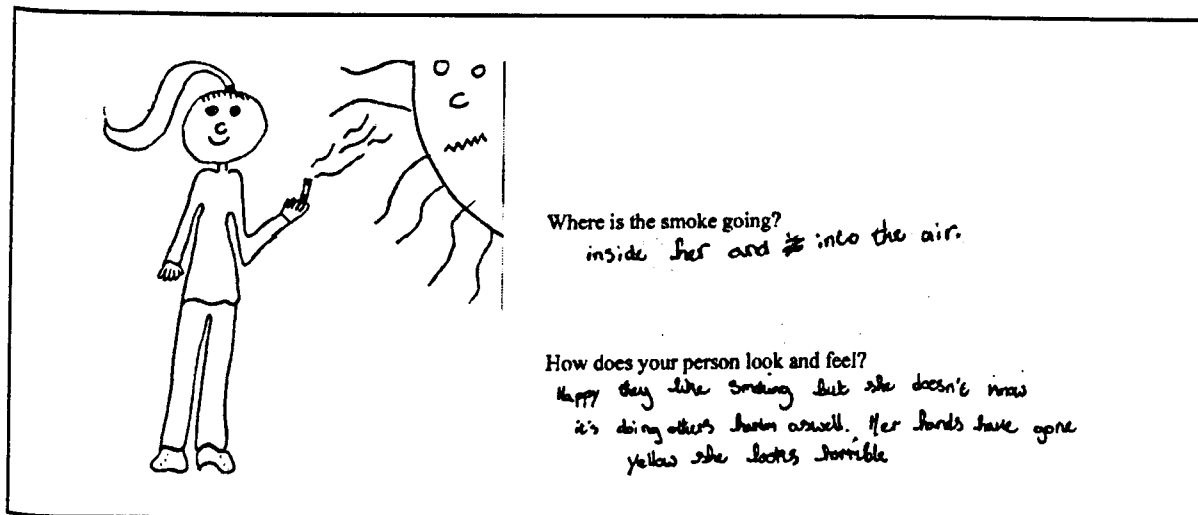
Figure 5.7: Sarah Blanchard, Draw and Write, Box 1, 2000

She did not live with smokers, and did not spend much time in smoky places:

I don't see that many people smoking (Q, 1999)

However, perhaps this made her more aware of smoky environments when she did go out into public spaces and when she visited her only relatives who smoked. Although smoking is not permitted on buses in Liverpool, the ban is widely unenforced and Sarah said she experienced ETS:

On a bus or in my aunties (Q, 2000)

Perhaps because she did not live with smokers, Sarah was unable to tolerate inhaling second-hand smoke:

I want to get some fresh air. It's horrible. I want to get out (Q, 2000)

I feel like I am going to suffocate. It is horrible (Q, 2001)

<u>Smoking and health</u>

Sarah understood that smoking causes external physical signs (bad breath, bad cough, yellow fingers) as well as significant health problems (bad heart, black lungs):

How can you tell from the <u>inside</u> of the person's body that your person has been smoking for a long time?
<i>the have blank blood, black lungs and a bad heart.</i>
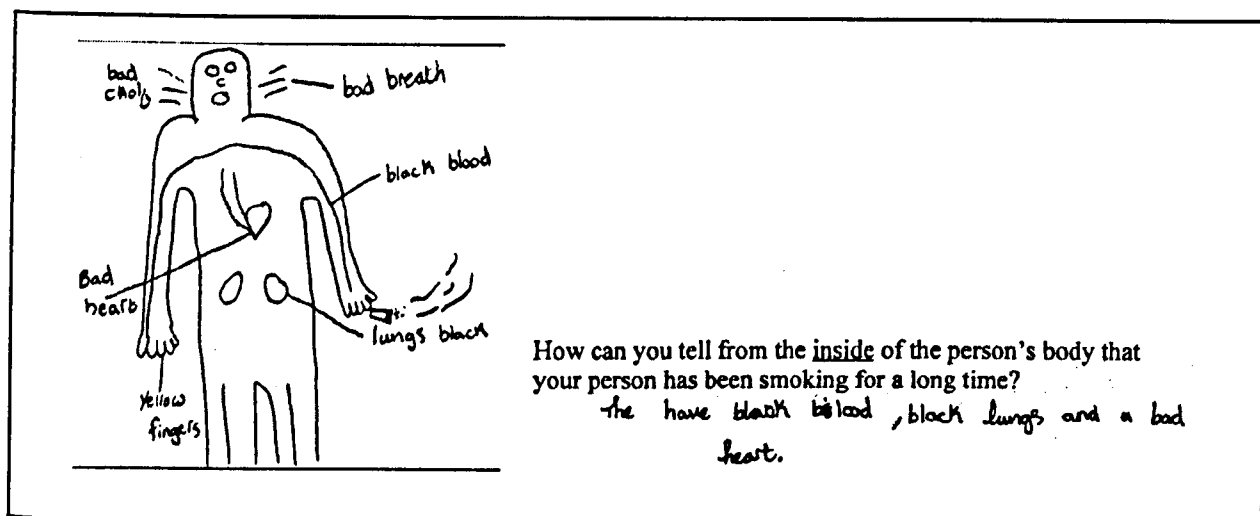
<u>Figure 5.8: Sarah Blanchard, DW, Box 2, 2000</u>

Perhaps because there were so few smokers in her family, Sarah did not know anyone who had suffered from a smoking-related disease.

<u>Addiction and cessation</u>

Although she had no personal experience of knowing a smoker who had attempted to quit, Sarah understood that smokers find it difficult to give up the habit.

> Because once you get used to it you like it (I, 1999)

> If they start smoking when they're a child, they smoke all their life (I, 1999)

In 2000 she first used the term 'addiction' to explain why smokers find it so hard to quit, and her understanding of the concept grew the following year:

> *Sarah*: I've heard that people get addicted to it.
> *Int*: What does it mean, to be addicted to it?
> *Sarah*: Like you can't stop smoking because you're stuck with it (I, 2001)

Although Sarah was unsusceptible to experimenting with cigarettes, she explained that the fear of addiction deterred her from trying smoking:

> Because if I like it I might get – you know – addicted to it (I, 2000)

Health promotion

Due to Sarah's dislike of second-hand smoke, and in the context of her knowledge that passive smoking harms health, she aimed to protect herself by trying to leave when people started smoking near her:

> *Int*: How do you feel when you're somewhere smoky?
> *Sarah*: I try and walk away (I, 2001)

5.6.2   Case Summary

Both of Sarah's parents were lifelong non-smokers, and the household was not on a low income. Sarah held strong negative views on smoking, she did not express any current or future intention to smoke, and did not report that she had tried smoking at any point during the research. Although Sarah did not have any smoking peers, her explanation of why children take up smoking centred on bullying. She suggested that adults smoke because they begin as children and then become addicted. Sarah had a good understanding of the addiction process and argued that it deterred her from trying smoking for herself. Although she had a good knowledge of the risks smoking poses to health, Sarah did not know anyone who had been ill because of smoking. Perhaps because so few people in Sarah's family smoked, she was rarely exposed to ETS. Nevertheless, she disliked spending time in the company of smokers. She attempted to protect her own health by trying to leave if she was in a setting where someone was smoking near her.

5.7   Bill Bobby

5.7.1   Case Description

Child in social context and family background

Bill Bobby was a boy of white English ethnicity. He lived with both his parents. His mother had never smoked and his father was an ardent ex-smoker who gave up smoking when Bill was born. He was the youngest child in his family and also lived with his nineteen-year-old sister who was a non-smoker. Bill's mother was employed full-time as a bank worker and his father worked full-time as a gardener. The family was not on a low income. A couple of Bill's friends either smoked now or used to smoke. His wider family contained only one smoker (Figure 5.9).

Child's smoking experience, intentions to smoke and views on smoking

Bill displayed stable negative views on smoking between the age of 9 and 11. His dislike of smoking centred on the risk of fatal illness associated with tobacco use. His answers in response to the question 'What do you think about smoking?' were:

> That it kills people. It's not nice to see people smoking (Q, 1999)

> It's stupid. You can be very ill. You can die at an early age (Q, 2000)

> I think it's stupid if you smoke you must want to die early in life. But if you're addicted you can't stop (Q, 2001)

His parents also held strong negative views on smoking and it is likely that these had influenced his perspectives on the habit:

> *Int*: Do they smoke, your Mum and Dad?
> *Bill*: My Dad used to but he says now that it is just a terrible thing and he doesn't like doing it anymore. And my Mum thinks it's bad as well for you. And my Mum and Dad don't really like smoking (I, 1999)

Figure 5.9: Family and Friends Mapping for Bill Bobby

KEY: Smokers - Ex-smokers - People who have never smoked

Child's Household

```
┌─────────────────────────┐
│                         │
│  Mum                    │
│  Dad                    │
│  Sister (age 19)        │
│  Bill Bobby             │
│                         │
└─────────────────────────┘
```

Friends
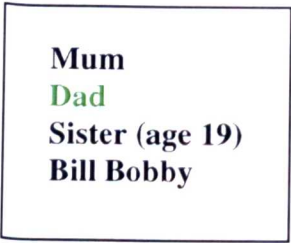
Male Friend 1	Male Friend 2	Male Friend 3
Male Friend 4	Male Friend 5	Male Friend 6
Male Friend 7	Male Friend 8	Male Friend 9

Family

```
┌─────────────────────────┐      ┌─────────────────────────┐
│                         │      │                         │
│  Nan                    │      │  Uncle                  │
│  Grandad                │      │  Aunt                   │
│  (Mother's parents)     │      │  Cousin 1               │
│                         │      │  Cousin 2               │
└─────────────────────────┘      └─────────────────────────┘

┌─────────────────────────┐      ┌─────────────────────────┐
│                         │      │                         │
│  Aunt                   │      │  Uncle                  │
│  Aunt's Partner         │      │  Aunt                   │
│  Cousin 1               │      │  Cousin 1               │
│                         │      │  Cousin 2               │
└─────────────────────────┘      └─────────────────────────┘
```
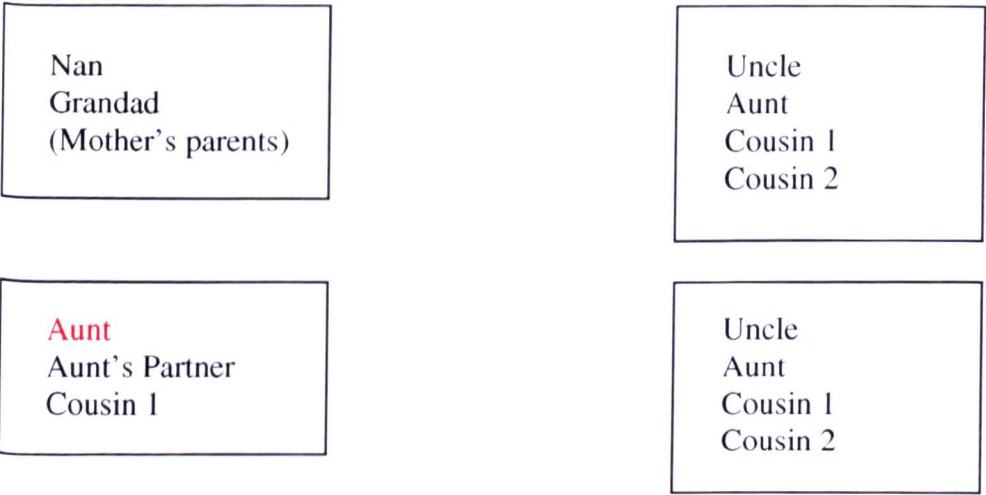
Bill's stable negative views on tobacco were reflected in his lack of any intention to try smoking either now or in the future. Again, he justified this on the grounds of wanting to avoid any smoking-related disease. Bill's responses were remarkably consistent over time, and he did not currently want to experiment with cigarettes:

Because I would be sick (Q, 2000)

Because it damages your health (Q, 2001)

He did not want to be smoker as an adult for the same reasons:

Because you can die at an early age (Q, 2000)

Because you can die early in life (Q, 2001)

Bill's behaviour between the ages of 9 and 11 was consistent with his views and intentions, and he reported that he had never tried smoking.

Beliefs about children and smoking

Although Bill had not experimented with cigarettes, he had some friends who had tried smoking. He understood that because young smokers occupy a high status among their peers, children may smoke to give them a tough image in front of their friends:

Because they think they look boss (Q, 1999)

Bill: [responding to a picture of a child smoking] He thinks he's boss...
They just think they're better because they're smoking.
Int: Why do people think they're boss when they're smoking, or they're better? Why do people think that?
Bill: Because they think they're dead old, if people that are older than them smoke (I, 2000)

To show off and act boss in front of older kids (Q, 2001)

However, although he appreciated that this was the image that young smokers were trying to convey, Bill himself thought that children who smoked were not tough but instead:

They're stupid (Q, 2000)

Bill also knew that some children were bullied into smoking, especially during their teens, and the discourse that he used emphasised the importance of group membership:

Bill: Sometimes you can get forced into smoking by older people.
Int: What do they do to force you? How do they force you to do it?
Bill: [They say] you're not going to play with them any more.
Int: Does that happen at primary school, do you think, or more at senior school?
Bill: Senior school (I, 2000)

Bill was familiar with the term 'peer pressure' and the interview at age 11 explored why some people are 'forced' into smoking. His account describes some of the many reasons why children feel pressured into smoking. He explains that children are under pressure to at least have tried smoking, perhaps as some kind of initiation rite. Bill argues that some children smoke because they don't want to be left out of the peer group. He suggests that the gang makes children smoke with the aim of getting them into trouble. In many ways this is a confusing explanation which raises more questions that it answers. Who are the gang? Why do children want to fit in with the gang when its aim is to get children into trouble? Bill's account shows that children experience peer dynamics as complex, and the discourses that they use to describe smoking uptake may be contradictory:

Bill: There's usually kids round by ours and there's always big gangs and they're putting pressure on the kids who haven't smoked before. So maybe peer pressure might have forced the kids to smoke and then it might have been a horrible taste for them, but they just want to keep having more.
Int: This thing about the gangs trying to make people smoke, why do the gangs do that, do you think? What's in it for them?
Bill: Probably because it makes people get in trouble, like older people. But it could be by smoking they think they're fitting in well with the gang, so that's probably why they do it.
Int: So why if they were smoking would that mean that they were fitting in well with the gang?
Bill: Say they thought all the gang were smoking, then they couldn't be the odd one out so they've got to as well. [It's in] about Year 7 or 8 when that happens. I think when my mate started – this lad who I know, he's not one of my good mates – but he was put under pressure by an older girl... The person who's trying to make them smoke, it's like they're forcing them to get in trouble. They could tell the Mum and the other person would get in trouble with them (I, 2001)

Although Bill had stable negative views on smoking and reported no intention to try, he did report at age 11 that some of his older peers who smoked had already offered him the

opportunity to experiment with cigarettes. Bill described how teenagers use tobacco in association with other substances – in this case, alcohol. He recounted how he could withstand pressure from older children to smoke, with the support of his non-smoking friends:

> *Int*: Who do you know who smokes – young people?
> *Bill*: Four of my mates do – there's a few of the older lads and a few of the girls who do.
> *Int*: And have they been putting pressure on you to smoke...?
> *Bill*: What we do is like, when we go out, I don't really go round with the older ones. I go with the younger ones. So if I said No – if they put pressure on me – then my younger mates would back me up so it would be easier to say No.
> *Int*: Do they put pressure on you? Has that happened yet?
> *Bill*: I think it was because they were drinking as well, and they were a bit bladdered, and they asked me to. They might have just been messing around. It was just the odd bottle of beer.
> *Int*: So when they said to you, did you say yes and try it or...?
> *Bill*: I said No and just went away with all my mates... When I talk to my mates about it and we say 'Would you smoke?' and every lad said No (I, 2001)

Beliefs about adults and smoking

Although Bill had little contact with smoking adults, from the age of 9 he had learned from his father – an ex-smoker - that adults used tobacco for positive effect:

> Because they might think 'relax' (Q, 1999)

> When I go to the football match there's a lot of people smoking, and I asked my Dad and he said because they feel relaxed now (I, 2000)

Passive smoking

From age 9, Bill understood that non-smokers also inhale when people are smoking near them:

Where is the smoke going?

Its effecing other people lungs

How does your person look and feel?

He will fill dizzy and sick

Figure 5.10. Bill Bobby, DW, Box 1, 1999

Because Bill's father gave up smoking before he was born, and because his mother had never smoked, Bill did not experience ETS at home. When he went to visit his one smoking relative, he observed that she took care to regulate her smoking in front of him although he noticed that the air was smoky in her house:

> The only person I know of is my Dad's auntie... She smokes sometimes and it is quite puffy in her house, but every time she has guests I noticed that she doesn't do it as much. She doesn't smoke as much. When I am there she smokes one and puts it out and then leaves it for half an hour (I, 1999)

However, he was a keen supporter of Everton football team and when he went to watch them play he did spend time among smokers. He said the only smoky place where he spent time regularly was:

> Goodison Park, Everton's football ground (Q, 2000)

> In an Everton football match (Q, 2001)

As the child of non-smokers, Bill was not used to spending time in smoky places and found the experience unpleasant. When he was forced to spend time among smokers, he reported that it affected his sense of well-being:

> It doesn't smell very nice and then I start to feel a bit sick (I, 2000)

I feel a bit sick and dizzy (Q, 2001)

Furthermore, he explained that his dislike of passive smoking reinforced his belief that it would be unpleasant to try smoking:

You can probably tell what it tastes like (I, 1999)

The smell makes me sick, so if I actually took a puff of one, I probably would be sick (I, 2000)

Smoking and health

From the age of 9, Bill demonstrated an awareness that smoking causes ill-health (lung disease) and also that smoking may be reflected in external appearance (dirty teeth, wrinkles, smelly breath):
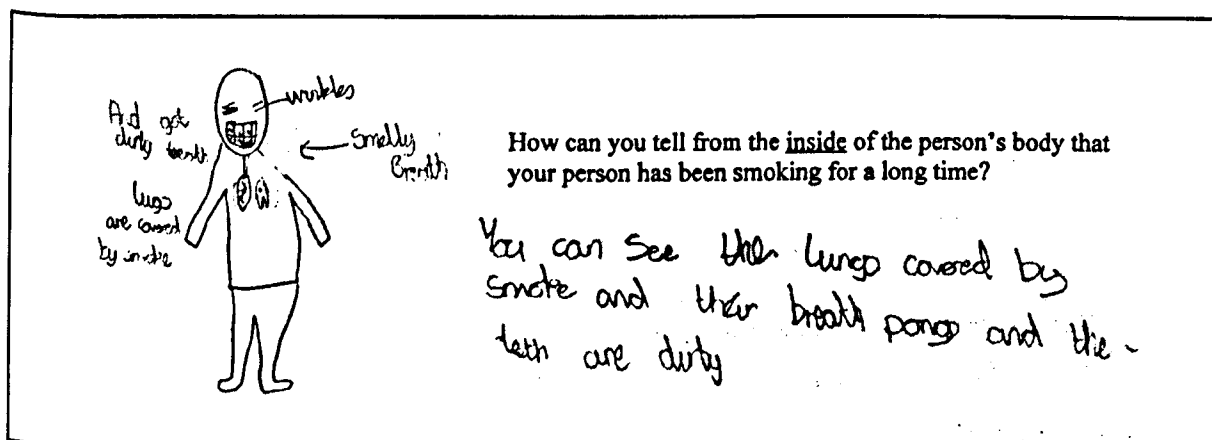
Figure 5.11: Bill Bobby, DW, Box 2, 1999

He was also aware that smokers are at greater risk of premature death than non-smokers:

They start to have problems with their lungs, and they probably die younger (I, 2000)

Although there was only one smoker in Bill's family, he was aware of smoking-related disease in the families of his friends:

One of my mate's Grandad. He had lung problems (Q, 2000)

One of my mate's Grandads due to lung disease (Q, 2001)

Addiction and cessation

His father stopped smoking at the time of Bill's birth, and he suggested that his father found it easy to quit:

> For my Dad it was dead easy because he just said 'I am not having any more' because I was about to get born. But for some people who do it all the time it would be quite hard for them (I, 1999)

At the age of 10, Bill began to use the term 'addiction'. He knew that many smokers found it difficult to quit because they were addicted to their habit. He also alluded to the role that nicotine plays in maintaining addiction:

> *Bill*: I think it'd be hard because once you've started, it's probably dead hard to stop. It's like an addiction or something.
> *Int*: Do you know why it's addictive?
> *Bill*: Has it got like a type of drug it in that makes it addictive? (I, 2000)

Health promotion

Bill's knowledge about the risks smoking poses to health had led to a concern to encourage the smokers he knew to give up. He reported that he had spoken both to his peers and to the only smoker in his family about the health consequences of smoking:

> *Int*: Have you ever asked somebody not to smoke?
> *Bill*: Yes.
> *Int*: Whom did you ask?
> *Bill*: My Dad's auntie, and these lads in our street (I, 2000)

As a child with strong anti-smoking views, Bill endeavoured to protect his own health when he was in the company of smokers. He was principally exposed to tobacco smoke at football matches, and from the age of 9 he said he took steps to minimise his exposure

to ETS at Goodison Park. In his account he suggests that it is the responsibility of adults to protect children's health:

> Every time I sit next to somebody in a match I say 'Can you smoke your cigarette somewhere else please?' And they just do because not really many adults smoke in front of kids because they know it can be bad for them (I, 1999)

Perhaps because his father quit was when he was born, and because he knew that children model their parents' behaviour, Bill believed that parents should safeguard their children's health by setting a good example to them by not smoking:

> *Bill*: When I was born, he just stopped then for the sake of me... he packed in because I was being born.
> *Int*: So why would he want to pack in when you were born?
> *Bill*: Because he would have thought that it was a bad example. Kids take after their Mum and Dad so he probably would have thought it was a bad example set for me so he probably stopped for that (I, 2001)

Bill was one of the few children who participated in the study who seemed to have an open relationship with his parents that included frank discussions on health issues such as smoking. They gave consistent advice to him not to smoke, based on their own experiences:

> *Bill*: My Mum said when she was young, she said she'd do it once, and she didn't want to do it again. Because she said every kid always tries the first cigarette when they're about 13 or 14, something like that. She said it tastes disgusting. And then my Dad said when you get older and get into it more, it makes you feel more relaxed. So when you have it at a young age it's just like to show off, but when you have it at an older age it's not as stupid as at a younger age.
> *Int*: So your Mum and Dad, you've talked to them about smoking or they've talked to you about smoking?
> *Bill*: Usually when this type of thing goes on [the research], I'll tell them what we've been doing today and they'll just sit me down and say 'You'll never smoke will you, because you know the things that can happen' (I, 2001).

5.7.2   Case Summary

Bill's parents were both non-smokers: his mother had never smoked and his father had quit when Bill was born. The household was not on a low income. Bill held stable negative views on smoking, which had perhaps been influenced by his parents' perspectives on the habit. He had no current or future intention to smoke, and although he had not tried smoking by age 11, Bill had been offered the opportunity to smoke by his peers. His beliefs about smoking uptake centred on the relationship between smoking and status in the peer group. Bill suggested that children may smoke to appear tough in front of their peers, and he also knew that some children are bullied into smoking. Although he had little contact with adult smokers, Bill knew that people smoke to feel relaxed. He was not accustomed to spending time in smoky places, and found exposure to ETS unpleasant. He knew that smoking is associated with ill-health and premature death and was aware of smoking-related disease in the family of one of his friends. Although Bill was too young to have witnessed his father's successful smoking cessation, he understood the addiction process. Bill was active in encouraging both his friends and his aunt not to smoke, and he also tried to protect his own health when he was exposed to passive smoke at football matches.

5.8   Chima Chin

5.8.1   Case Description

<u>Child in social context and family background</u>

Chima Chin was a girl of white English ethnicity[4]. She lived with her mother who was a lone parent and who smoked, with a consumption of 15 cigarettes a day (PQ, 1999). She had regular contact with her father and his partner, who were also both smokers. Chima

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[4] Research with ethnic minority young people in the UK has concluded that they construct their own ethnicity in a fluid and dynamic way, thus creating multiple cultural identities (Ackroyd and Pilkington, 1999). Although Chima described herself as white English in the survey, observation would suggest that

was the youngest child in her family and she had several older brothers and sisters, including some step-brothers and sisters. The majority of her siblings were current smokers. Chima's mother worked part-time as a care worker, and her household was receiving means-tested social assistance. Chima had a large group of both female and male friends. Many of Chima's friends either smoked or had given up, and her wider family also contained many smokers – including all her grandparents (Figure 5.12).

<u>Child's smoking experience, intentions to smoke and views on smoking</u>

Although Chima was surrounded by a large number of smokers in both her family and peer group, she held stable negative views on smoking. Her perspective on the habit focused on the risks smoking poses to health. In 2000, she also suggested that smoking was not appropriate behaviour for someone her age:

> It is bad for your health. It does nothing for your lungs but kills them. You can have heart attacks. You can die when you're older. Because you can get cancer and because it has drugs in it (Q, 1999)

> I think it is bad and it's not right for people the age of 10 (Q, 2000)

> They should not be invented. They kill. They're disgusting. Can't stand the smell. It makes you sick (Q, 2001)

In accordance with her stable negative views on smoking, Chima did not express any intention to experiment with cigarettes at the ages of 9 and 10. Between the ages of 9 and 11 she also consistently maintained that she did not intend to smoke as an adult. At age 10, she suggested that her lack of interest in smoking was based on concern for her future health:

> Because you could get cancer (Q, 2000)

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she was of mixed ethnic origin. However, it is her perspective that is most important and she clearly considered herself to be white English.

Figure 5.12: Family and Friends Mapping for Chima Chin

KEY: Smokers - Ex-smokers - People who have never smoked

Child's Households

Mum **Chima Chin**	Dad (Dog)

Friends

Female Friend 1	Female Friend 2	Female Friend 3	Female Friend 4
Female Friend 5	Male Friend 6	Male Friend 7	Male Friend 8
Male Friend 9	Male Friend 10	Male Friend 11	

Family

Brother (age 22)	Dad's girlfriend (Dog)	Uncle Uncle's Girlfriend Child 1
Sister (age 30+)	Step-sister (age 21) (Dog)	Uncle Aunt Cousin 1 Cousin 2 Cousin 3 Cousin 4
Sister (age 32) (Dog)	Step-brother (age 24)	
Mum's best friend	Sister (age 30) Sister's boyfriend Nephew 1	Sister (age 25+) Sister's Boyfriend Niece 1 Niece 2
Grandad		
Nanny	Godmother	Uncle
Aunty	Uncle	Aunt Cousin 1 Cousin 2
Cousin	Cousin	

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She also described how she had been quite reflective in thinking about her own future as either a smoking or non-smoking adult. Interestingly, she suggested that media exposure might persuade her to take up smoking, not the influence of all the adults in her social network (Figure 5.12). She cited several factors that would deter her from taking up smoking: health concerns, fear of addiction and the expense of cigarettes:

> *Chima*: On the telly, when they smoke, I've been thinking 'Would I want to smoke when I'm older?' But I think it's bad for you. I just don't want to, even if someone put a ciggy in front of me and then said 'Just have a go with it', I'd say No.
> *Int*: Why would you say No do you think?
> *Chima*: Because one puff and you could be either all choky in your lungs, or coughing your lungs... And you've got nicotine inside you. And when you go back out you look, they'll offer you more, and you'll be taking it again, and then you'll start having it again and again and again. And you'll be taking all your Mum's money off her or your Dad's money. And they'll be saying 'Where's all this money going, eh?' (I, 2000)

Despite having a consistent negative attitude towards smoking, and no expressed intention to start using tobacco, at age 11 Chima reported that she had tried smoking. She said that she had only tried smoking once a few months previously. Chima did not enjoy her first smoking experience. She described how she had been under pressure from her friends to try smoking, and how even when she did try, they made fun of her because she had not inhaled. Although she describes the peers who feature in her account as friends, she suggests that she was scared and found them intimidating. In this way her account mirrors the discourse that Bill used which suggested that groups of teenagers intimidate children into their first trial. She succumbed to trying smoking because she feared exclusion from the peer group:

> *Int*: Have you tried smoking?
> *Chima*: Once. I didn't take it back though. That's one thing I wouldn't do. I put it to my lips... Then I threw it back. It was just that horrible. I just flung it on the floor and stood on it. I was coughing and didn't touch it again. That was at New Year.
> *Int*: And what made you try smoking, do you think? Why did you try it?
> *Chima*: Because I felt scared that they were going to do something to me, because they all had looks on their eyes like that.
> *Int*: Who were all these people? Who was it?
> *Chima*: My friends.

Int: So what did you think they would do to you?

Chima: At the time, they were my only mates. And I was like 'If I lose these, I'll have no-one else', because I fell out with the others at that time. And I thought 'If I lose these, I won't have no-one to play with'. And I thought 'They're going to hurt me' so I just like pretended and just threw it down and stood on it.

Int: So what did they say when you tried it? Were they pleased?

Chima: They just thought like 'Ah hah! You didn't even take it back, you wimp!' They were just laughing at me. And I was just saying 'So? I don't want to wreck my life' (I, 2001)

Beliefs about children and smoking

Chima was highly aware of teenagers smoking in her everyday environment and even at the age of 9 she could list several places where young people went to smoke:

> *Int*: Where do you see people smoking?
> *Chima*: Down entries, by shops, in bushes, or by the sports centre and in the park and that.
> *Int*: Is it young people or old people or Mums and Dads? Or all kinds of people?
> *Chima*: Teenagers (I, 1999).

Perhaps because she had first-hand experience of watching her friends smoke, even at the age of 9 Chima was able to offer multiple and complex explanations of why some children smoke. She knew that children who smoked perceived many benefits from smoking. She suggested that they smoked to fit in with their friends, to appear tough, to demonstrate autonomy, because their parents smoked and because smoking had a positive effect on their mood:

> Because their friends do. Because they want to. Because they think if their Mum and Dad can they can. Because they think it's good. Because they think it will help them (Q, 1999)
>
> Because they want to feel hard with their friends (Q, 2000)
>
> To act hard. To look good. To feel good. But they're just killing themselves (Q, 2001)

In Chima's drawings of a young person who has just started smoking, the theme of pressure from friends dominates her pictures and writing at every stage. At the age of 11, her comments suggested a move away from subtle encouragement to active force and bullying, and it is interesting to consider the extent to which this reflected her own experiences of trying smoking:

Figure 5.13: Chima Chin, DW, Box 4, 1999
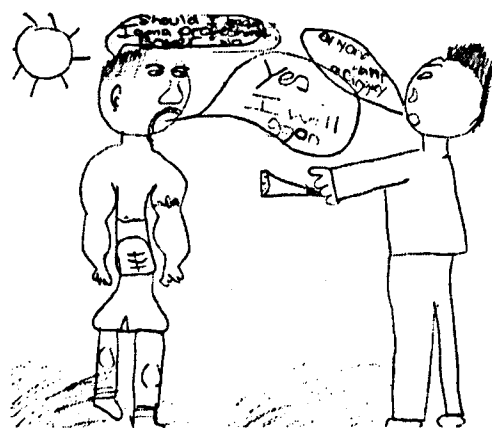
Why has your young person just started to smoke? Boy = Because he wanted to because all his friends dose

Figure 5.14: Chima Chin, DW, Box 4, 2001
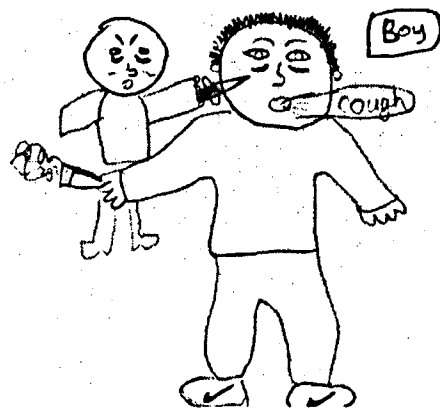
Why has your young person just started to smoke? Because all his friends said if he dose'nt they will bulie him an beat him up intill he's 15.

Although her concern about bullying only appeared in her drawings at the age of 11, from the start of the study she felt that smokers occupied a high status among their peers, with

the potential to exercise force against other children if they wanted to do so. She suggested that this was because they were imitating adult smokers:

> They think they are all this and that, saying 'Oh I smoke, and you don't, and I can have you' and everything (I, 1999)

> *Int*: [shows picture of young smokers] Why do you think those teenagers are smoking?
> *Chima*: Because they want to act hard and they want to think they're real big and they know what they're doing. They're like 'I smoke, you can't do anything to me' and all. They can push people around to get them into smoking and that (I, 2000)

> My mates, when they've got a ciggy, they think because they're smoking they're tough. Because they've seen older people smoking and they think they're like them (I, 2001)

In her first picture (1999), Chima drew a muscular professional boxer and wrote that the high value he placed on physical fitness might dissuade him from becoming a smoker (Figure 5.13). Her concern with staying physically fit was also reflected in her own lack of any intention to try smoking at the same age:

> People who don't smoke, they are all fit and healthy. But the people who do smoke, when someone is running or something they say 'Oh, wait up. I can't run any more' (I, 1999)

> I did once want to [try smoking], but I said to myself 'No, it's not worth it'. Because I play football and everything and I said 'If I do that it will just wreck my whole life'. Because I love football (I, 1999)

Her interest in sport remained throughout the research. At age 11, although she had tried smoking, Chima remained adamant that she would not grow up to be an adult smoker because she wanted to remain fit:

> *Int*: So do you think that when you grow up you'd like to be somebody who smokes?
> *Chima*: No. Because I might be a footballer when I'm older. I love football (I, 2001)

Beliefs about adults and smoking

Perhaps because she came into contact with many adult smokers in her family, Chima also understood that adults perceive benefits from smoking, particularly that smoking makes them feel calm (see Figure 5.15). In addition, she knew that adults continue to smoke because they are addicted and may have smoked for much of their lives:

> Because they want to. Because they have smoked all their life. Because they think they're doing good (Q, 1999)

> Because they want to and they feel good (Q, 2000)

> Because they were smoking from when they were younger so they're addicted to it so it is hard to get off it (Q, 2001)

Passive smoking

Surprisingly, although Chima must have inevitably spent a lot of time in the company of smokers, she was reluctant to report that she spent time in smoky environments. At the ages of both 10 and 11 she said she was only in a smoky place 'sometimes'. Perhaps this was because she was reluctant to conceded that the smokers in her family were putting her health at risk:

> In the house. But not always (Q, 2001)

She explained that this was because although her mother obviously smoked at home, she took care not to smoke in front of her daughter, if at all possible, in order to protect her health:

> *Chima*: My Mum smokes in the house, but she doesn't smoke by me. She goes and sits in the other room
> *Int*: Right. So if you're watching TV... would she smoke in the living room with you? Or would she go somewhere else?
> *Chima*: No. She'll go in the back room and smoke.
> *Int*: Why doesn't she want to smoke near you?
> *Chima*: Because she doesn't want it all going on my chest and coughing and choking and that (I, 2000)

By age 11 – and with several smoking friends – Chima was exposed to ETS not only by her family but also by her friends:

> *Int*: Are you ever in a smoky place? Are you ever somewhere where it's a bit smoky in the air from cigarettes?
> *Chima*: When I'm with my Mum, she doesn't smoke, like, actually in front of me. Or I either go out. But when I'm with my friends, I just take a few steps back and I don't breathe it in or nothing (I, 2001)

Although she claimed not to spend much time in smoky places herself, it is clear from her drawings that she understood the effects that secondhand smoke has on non-smokers:

Where is the smoke going?
The smoke is surounding the room and people that don't smoke are coufing

How does your person look and feel?

Caim and brechless

Figure 5.15: Chima Chin, DW, Box 1, 2000

But while she was unwilling to admit spending time in smoky places, Chima was clear about how she felt when she was in a smoky environment:

> *Int*: Are you ever somewhere where it is smoky?
> *Chima*: Once, but I just go out.
> *Int*: So you don't like it?
> *Chima*: No.
> *Int*: So if you are in a smoky place you move away?
> *Chima*: Yes.
> *Int*: Why don't you like it, do you think?
> *Chima*: It's bad for you, your chest gets all stuffy (I, 1999)

Stuffy and coughing, choky (Q, 2000)

Sick (Q, 2001)

Because Chima had experienced the negative effects associated with inhaling second-hand smoke, she reported that she had successfully taken steps to protect her own health by asking her mother not to smoke near her:

> *Int*: Have you talked to your Mum about her smoking? Or to your Dad?
> *Chima*: Yes. I haven't talked to my Dad about it, but I have talked to my Mum.
> *Int*: And what did your Mum say?
> *Chima*: 'Alright, I won't smoke around you'. And that's when she started not to smoke round me and that.
> *Int*: So she used to smoke round you?
> *Chima*: Yes.
> *Int*: And then what did you say to her?
> *Chima*: I used to be sitting there, she used to be there. And I'd go out – it'd get on my chest so I had to go out. And when I came back in, she kept on going. So I said 'Mum, this has got to stop. It's you going out. You've got to go'. And she went 'I know, it's got to stop this, hasn't it?' So she's trying now (I, 2001)

Smoking and health

From the age of 9, Chima demonstrated that she had a good understanding of the effects of tobacco use on smokers' health:
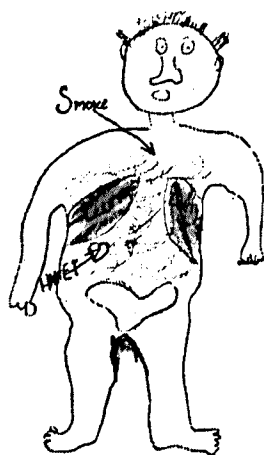
How can you tell from the **inside** of the person's body that your person has been smoking for a long time?

Because their isSmoke around the Lungs, and the Lungs are black and yellow, and the hart is traped by smoke.

Figure 5.16: Chima Chin, DW, Box 2, 1999

It was also surprising that Chima did not report knowing anyone who had suffered from a smoking-related disease at the ages of 9 or 10. Because she was surrounded by so many smokers, it is likely that some had experienced health problems. Perhaps Chima was unaware of smoking-related disease in her family because her relatives did not discuss their health concerns with her. At age 11 she still did not report knowing any adults whose smoking had affected their health. Instead she described the unpleasant effects her young friend had experienced while smoking, and the care she had given at the time:

> *Int*: You said your friend had a nicotine rush?
> *Chima*: She had a nicotine rush, yes.
> *Int*: What does that mean 'to have a nicotine rush'?
> *Chima*: She kept getting headaches and like going dizzy and feeling sick. So I just told her to sit down and made her a cup of tea, but she wouldn't take it. She felt really ill. I said 'Look you can't take a tablet'. And she said 'I'll have to, I'll have to'. Because she had a little bit of wine – you know the orange wine? And she had a bit of that and I said 'You can't drink with tablets'. So I got her to drink the cup of tea in the end and she fell asleep. And the next morning she felt really ill, and she was vomiting...
> *Int*: So how does somebody get a nicotine rush? What causes a nicotine rush?
> *Chima*: I think it's poison in the nicotine. They've been smoking too much so it's the smoke (I, 2001)

Addiction and cessation

Unusually in the context of the drawings produced by the whole cohort, Chima knew that smokers fear that they will gain weight when they stop smoking. Three of her older sisters smoked, and perhaps this was because either they or other adults she knew used fear of weight gain to justify their continued smoking. Chima was one of very few children who commented on this aspect of the cessation process:
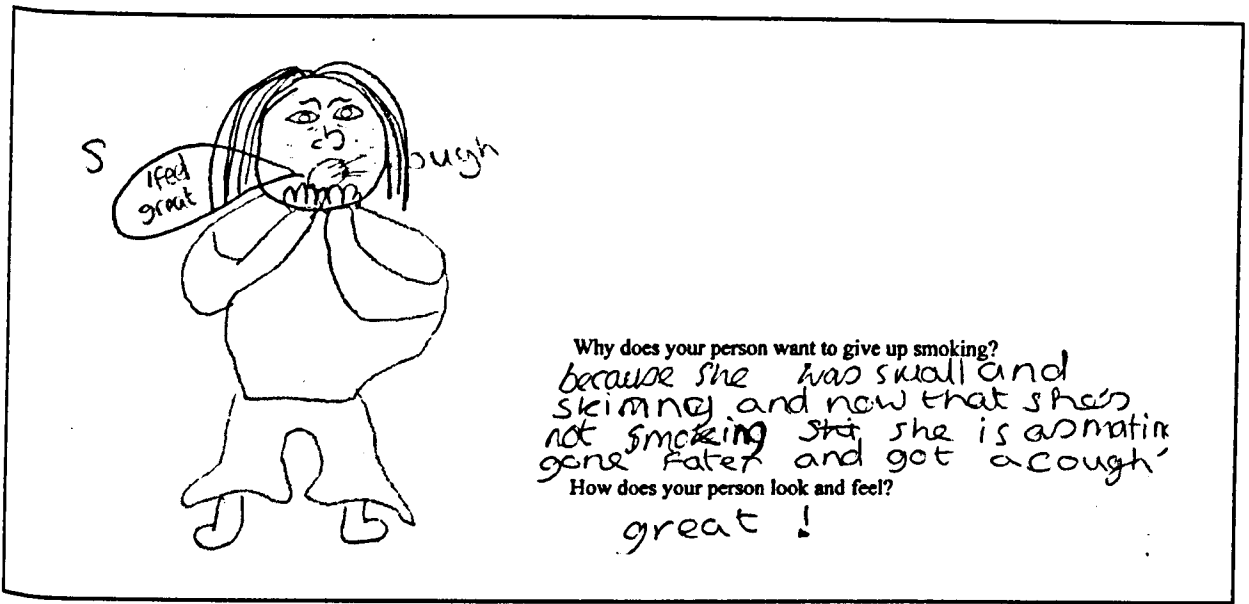
Figure 5.17: Chima Chin, DW, Box 3, 2001

From the age of 9, Chima demonstrated an understanding that adults continue to smoke "because they have smoked all their lives", although she only used the term 'addiction' for the first time when she was 11. She also knew from the age of 9 that tobacco was a drug (see above). At the same age, she used the term 'nicotine', although she was unsure exactly what the word meant:

> *Chima*: They will have all nicotine on their fingers and that and it won't look nice.
> *Int*: So they will have nicotine on their fingers. What is nicotine?
> *Chima*: That yellow thing that gets on... Is it the smoke? (I, 1999)

By age 10, Chima was able to give an accurate description of the addiction process and she was clearer about the function of nicotine. She understood that while early smoking was often experienced as unpleasant, smokers gradually got used to the smoke and used it for positive effect:

> *Int*: [showing pictures of adult smokers] Why do you think they're smoking, those people in the pictures?
> *Chima*: They feel good.
> *Int*: Why do you think they feel good from smoking?
> *Chima*: Because the first time that they started, they were all coughing and sick with it and that. But when they start to keep going and going, they start to feel like good about themselves and the nicotine's getting into their

body and they're starting to be on it more and more and more. It's the same as drugs (I, 2000)

At age 11, Chima began to describe this process as 'addiction':

> *Chima*: Adults... they're addicted.
> *Int*: What does it mean to be addicted?
> *Chima*: It means if you're smoking at a young age or something, and someone goes 'Put the ciggy down, put the ciggy down'. And they're going 'No, no I can't'. And it's like someone that's on drugs and they can't get off it, can't get away from it (I, 2001)

Maybe because both her parents smoked, at age 10 Chima offered a particularly sensitive and insightful explanation of the meaning of addiction, using an analogy from her own childish experience. It is fascinating that at age 11, she used the same image. The simile she used draws on her experience as a child of becoming emotionally attached to a toy or doll. She compares smoking with a broken plaything to emphasise that something that initially appeared attractive and fun must be parted with when it is no longer any use. She also describes the painful nature of giving up something when one has been attached to it and enjoyed it for so long. Smoking may serve a similar function for an adult as a toy or doll does for a child because both are something that give pleasure and are used as part of leisure. Furthermore, children may use dolls and teddies for comfort when they are sad, and the analogy may also reflect the function that tobacco has for smokers in enabling them to cope during stressful times:

> If you've been on it for a long time, you can't get off it. It's like if you've got a toy and you've had it for years and years, you don't want to leave it when it's broken, and you have to throw it away. You just don't want to throw it away (I, 2000)

> If you've got a doll and you've had it for so long, your Mum goes 'Come on. That's been enough. That's getting wrecked. You've got to throw it out'. And you've had it for so long you don't want to leave it, but you've got to. And it's just like that, but with a ciggie. And you're addicted to it (I, 2001)

Health promotion

Although both Chima's parents and many of her siblings smoked, she described how some of them were trying to give up or at least to cut down their tobacco consumption. She also described the mixed messages that she received from some family members who advised her not to become a smoker, despite their own continued smoking:

> [My Dad and I] were talking about smoking one night and he told me you should never smoke because he is trying to cut down (I, 1999)

> My [smoking] sister just says you shouldn't do that – it's bad for your health (I, 1999)

> My Mum said never ever smoke (I, 2000)

Chima also described the way in which she sought to promote the health of her friends and family. At age 9 she had unsuccessfully advised a girl she knew to stop smoking:

> We were by the shop once and I saw this girl from ages ago. She was about 11 and she was just smoking and I went 'You shouldn't be smoking, it's bad for your health' and she said 'Oh. So?' like that and just walked away (I, 1999)

Perhaps because she was highly aware of the risks smoking poses to health, Chima recalled the strategies she had employed to try to stop her siblings smoking. However, she noted that her family failed to take her advice seriously:

> *Int*: Have you said anything to your family?
> *Chima*: Yes. Loads of times.
> *Int*: Have you? What do you say to them?
> *Chima*: I tell them to stop smoking: I will hide your ciggies, I will throw them in the bin and everything. And they just start laughing at me.
> *Int*: Is this your Mum or your brother and sister?
> *Chima*: My brother and sister (I, 1999)

As many of these data have demonstrated, the relationship between children's stated views and behaviour is complex and perhaps contradictory. At age 11, although Chima had tried smoking herself, she was currently engaged in helping a friend who was trying

to quit. Perhaps this did not seem contradictory to her because she had only tried smoking once – possibly under duress – and by contrast her friend was a regular smoker:

> *Int*: Have you ever asked somebody not to smoke?
> *Chima*: Yes... My friend, I'm helping her – trying to cut out. And she's helping herself as well, so we're nearly there (I, 2001)

5.8.2 Case Summary

Chima lived with her mother who was a lone parent living on a low income. Chima's mother smoked, as did her father and his partner with whom she had regular contact. There were a large number of smokers in Chima's family, including many of her older siblings and all of her grandparents. Despite knowing so many smokers, Chima held stable negative views about smoking. She reported no intention to smoke during the course of the research, but despite this she reported at age 11 that she had tried smoking. From age 9, Chima could offer multiple and complex accounts of why some children take up smoking, but by age 11 she was more concerned about the role of bullying in smoking initiation. She knew that adults smoked in order to keep calm, and also because they are addicted to their habit. Chima had a good understanding of addiction and could offer an analogy of the process drawing on her own frame of reference. She knew that smoking poses risks to health, but surprisingly did not report knowing any adults with smoking-related disease. Instead she had cared for a friend during her 'nicotine rush'. Chima was exposed to ETS by her family and also by her friends. She disliked passive smoking and did her best to protect her own health in smoky environments. She also endeavoured to promote the health of her family and friends by asking them to stop smoking.

5.9   James B.

5.9.1   Case Description

Child in social context and family background

James B. was a boy of white English ethnicity. He lived with his birth parents. His mother had never smoked and his father was an ex-smoker who quit in 1997. James was the youngest child in his family and he had one older brother, who he also described as an ex-smoker. James' mother worked full-time as an administration manager and his father worked full-time as a police officer. The household was not on a low income. James had a small group of male friends who were all non-smokers. Although neither of James' parents were current smokers, his wider family did contain several smokers – including his grandfather (Figure 5.18).

Child's smoking experience, intentions to smoke and views on smoking

Between the ages of 9 and 11, James displayed remarkably stable negative views about smoking. In response to the question, 'What do you think about smoking?,' he consistently argued that smoking was a 'horrible' habit:

> It stinks and it's horrible (Q, 1999)

> It's horrible (Q, 2000)

> I think smoking is horrible and it stinks and it can kill you (Q, 2001)

At age 9, James reported that although he had not tried smoking, he had already come close to experimenting with his friend when they found a cigarette butt on the floor. He explained that he had stopped short of experimenting at the last minute when he saw his cousin coughing:

<u>Figure 5.18: Family and Friends Mapping for James B.</u>

KEY: Smokers - Ex-smokers - People who have never smoked

<u>Child's Household</u>

Mum
Dad
Brother (age 16)
James B.
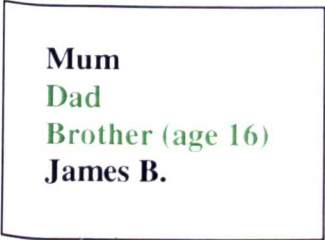
<u>Friends</u>

Male Friend 1   Male Friend 2   Male Friend 3   Male Friend 4

<u>Family</u>

Aunt
Aunt's Partner
Cousin 1
Cousin 2
Cousin 3

Uncle
Aunt
Cousin 1

Aunt
Cousin 1
Cousin 2
Cousin 3

Aunt
Uncle
Cousin 1
Cousin 2
Cousin 3

Nana
Grandad
(Father's parents)
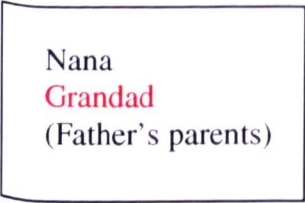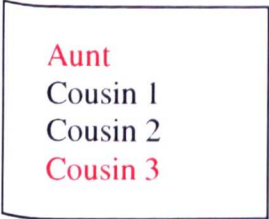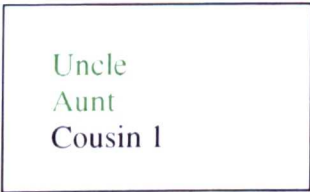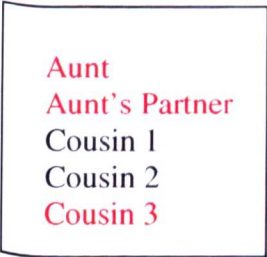
> *Int*: Have you ever tried a cigarette?
> *James*: No. I was *going* to, but I changed my mind.
> *Int*: You were going to?
> *James*: There was a feller, and – because – he picked it up, and then it fell on the floor and then he threw it away... And then my mate picked it up off the floor and smoked it, and then he started coughing. He was only about 8. And I was only about 7. I didn't know what it was and all that, and then I got to know what it was because my mate tried it. I got to know what it was, and I started coughing.
> *Int*: So you had a little go with it, and then you started coughing?
> *James*: No! I was *about* to.
> *Int*: Oh! You were *about* to...
> *James*: Yes, because my cousin was coughing ... and I saw him and said 'No, I don't want it' (I, 1999)

Although James reported at age 9 that he did not intend to experiment with tobacco, by age 10 he was one of the few children who admitted in the questionnaire that they would like to try a cigarette (n=12, 2000). He explained that although he felt curious about trying smoking, he had not translated his intention into behaviour because he feared future ill-health and also because his mother would not permit him to smoke:

> *Int*: Have you ever wanted to try a cigarette?
> *James*: I've wanted to try once, but I never.
> *Int*: How old were you when you wanted to?
> *James*: This age.
> *Int*: And what makes you want to?
> *James*: Don't know. Just to try it. See what it feels like and stuff.
> *Int*: So do you think you will try one?
> *James*: Not now.
> *Int*: No. So what made you change your mind about trying one?
> *James*: Because my Mum says, she told me all about it, what happens to you and dying. If I kept on doing it I'd die, and Mum won't let me smoke (I, 2000).

This expression of current intention to smoke was a highly important shift in attitude, the real significance of which only became apparent at age 11 when James reported that he had recently tried smoking. His friend had given him his first cigarette, and he had smoked it with that friend in a derelict house. He had tried smoking out of curiosity and he had not enjoyed his first smoking experience. The account James gives emphasises his own agency and he explains how at age 11 the concerns that had previously deterred him from smoking had been overcome by social pressures to smoke:

Int: What happened? Tell me about what happened.

James: By ours, [friend] one's of his mates come and he had a ciggie. And he had half and he said 'Do you want a bit?' and I said 'No, I'm alright'. And he went 'Just taste it'. And I went 'No I'm alright'. And he went 'Just have a bit, and see if you like it'. So I just had a little pull and threw it away because I didn't like it.

Int: So was your mate forcing you to smoke or do you think you chose to just try it?

James: He wasn't forcing me to smoke. I chose. Just to see what it was like.

Int: So why did you want to see what it was like?

James: I don't know. Because everyone else has had one and I just wanted to see what it was like (I, 2001).

Between the ages of 9 and 11 - and despite wanting to try smoking and subsequently experimenting with tobacco – James remained adamant that he did not intend to become a smoking adult.

Beliefs about children and smoking

James' beliefs about why children smoke centred on the attractive image that smoking has for some children. James reasoned that children may try smoking because they think it is cool, and also because they like the smell of the smoke:

Because they think it's boss and cool (Q, 1999)

Because they like the smell of smoke. Because they like it (Q, 2000)

I think children smoke because they think it's cool to smoke with their friends (Q, 2001)

In his drawings and in the interviews, James offered different reasons for smoking initiation. He suggested that children begin to smoke because their friends do:

Int: [shows picture of children smoking] Why do you think these children are smoking?

James: Because their mates told them to. To try one (I, 1999).

Int: Why do you think those children in the pictures are smoking?

James: Because their friends do, and they've asked them to go and smoke.

Int: Why would their friends ask them to start smoking?
James: Because all their friends smoke and they don't and they think that they're stupid because they don't smoke and everything (I, 2000).

Interestingly, at age 10 – when James reported that he wanted to try smoking himself to "see what it feels like" (I, 2000) – he drew a young smoker who wanted to try smoking due to a motive of curiosity:

Why has your young person just started to smoke?

because he wanked no try it
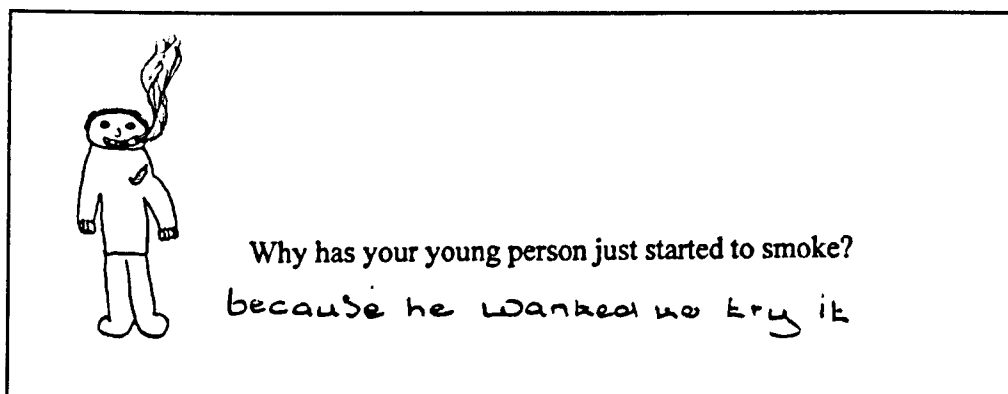
Figure 5.19: James B, DW, Box 4, 2000

Although the friends described on his mapping were all non-smokers at age 11 (Figure 5.18), the data generated in interviews revealed that James certainly had other friends who were smokers. Perhaps because James had some friends who were smokers, he offered an interesting account of how children learn how to light and to smoke cigarettes. He argued that the children of smokers learnt how to smoke by copying their parents, and they then taught their friends how to smoke:

Int: [showing picture of children smoking] Where do you think these children learned to smoke?
James: From their friends.
Int: How would they learn off their friends?
James: Because their Mum and Dad taught them. Because they smoke.
Int: How would their friends learn off their Mum and Dad?
James: No. Their son or daughter learns off their Mum and Dad. And then their son teaches the friend.
Int: OK. So the one that learned off his Mum and Dad, how would he learn off his Mum and Dad?
James: Just watching them all the time.
Int: So what would he learn?
James: How to put it in.

Int: How to put it in?

James: Yes.

Int: How to light up and everything?

James: Yes.

Int: And then you said that the friend would learn off his Mum and Dad and then the friend would teach the other person.

James: Yes.

Int: So how would the friend teach the other person? What would they do to teach them?

James: Have a ciggie (I, 2001).

Beliefs about adults and smoking

At the age of 9, James understood that adults may have started smoking when they were young because they thought that it might improve their social image:

Because when they were little they thought it was cool and stuff (Q, 1999)

However, in subsequent years his explanation of why adults maintain their smoking habits focused on the nature of addiction, which James suggested could occur in childhood:

Because they're used to it (Q, 2000)

Because when they were kids they got addicted to it (Q, 2001)

He also argued that adults smoked because they enjoy it:

Int: [shows pictures of adults smoking] Why do you think they're smoking, those people in the pictures?

James: Because they think it's good for them.

Int: Why do you think they think it's good for them?

James: Because they like smoking (I, 2000).

Passive smoking

Although James' family included several smokers, the only place where James consistently described being in a smoky environment was the Pirrie Club (Q, 2000; Q, 2001). His feelings on spending time in a smoky place varied over time. At age 10 he

said that he felt 'Alright' (Q, 2000) at the Club. However, at ages 9 and 11 – and when he had actually tried a cigarette himself – James said:

> It makes me feel sick and coughing all the time (I, 1999).

> I think it's a horrible feeling when it's smoky (Q, 2001)

Smoking and health

Although many members of his family smoked, James' grandfather was the only person who he described as having had a smoking-related disease. Perhaps James' grandfather had experienced a range of different problems with his health, or perhaps James' understanding of his condition changed over time:

> My Grandad. Something wrong with his lungs (Q, 1999)

> My Grandad. He had a heart attack (Q, 2000)

> My Grandad. He nearly died but now he's stopped smoking (Q, 2001)

Perhaps because of his grandfather's health problems, James knew that smoking could affect both the heart and the lungs:

How can you tell from the inside of the person's body that your person has been smoking for a long time?

your lungs fill up of acid.

Figure 5.20: James B, DW, Box 2, 2000

Addiction and cessation

James knew that cessation was difficult from age 9. He described this in terms of the addictive nature of tobacco, although he did not use the term 'addiction':

> *Int*: Is it easy or hard to stop smoking, do you think?
> *James*: Hard.
> *Int*: Why is it hard?
> *James*: Because after you've smoked loads and then you can't give up. It's hard because you need to keep on having cigarettes, but you can't (I, 1999).

At age 11, James first used the term 'addiction'. He demonstrated an understanding that smokers become addicted to cigarettes and that they experience withdrawal symptoms if they try to quit:

> *Int*: Why do you think [your auntie] carried on with it?
> *James*: Because she got addicted to it.
> *Int*: What does it mean 'addicted'? What does that mean?
> *James*: You can't stop smoking.
> *Int*: What is it about smoking that's addictive? Do you know why people get addicted to it?
> *James*: Because if they have a few and then they stop, they start shaking and that (I, 2001).

James' father had given up smoking when James was 7, so James had some experience of the smoking cessation process. Perhaps because he had watched his father give up smoking, he knew that cessation attempts were stressful and may make quitters feel 'nervous'. He was also aware that people perceive smoking cessation to be associated with weight gain, perhaps because quitting increases appetite:

> *Int*: What do your Mum and Dad think about smoking? Do they smoke?
> *James*: My Dad used to, but he's given up.
> *Int*: How long ago did he pack in? Can you remember?
> *James*: A year ago.
> *Int*: Oh right. So you can remember him packing in?
> *James*: Yes.
> *Int*: Did he find it easy or hard, do you think?
> *James*: Hard.
> *Int*: Why did he find it hard?

James: Because he was nervous and he put some weight on (I, 2000).

Int: Is it easy or hard to give up smoking, do you think?
James: He said he was nervous when he first gave up. He was shaking. And he kept eating a lot (I, 2001).

Health promotion

Although James was himself susceptible to trying smoking from age 9, he still tried to promote the health of his friends and people in his family who smoked. At age 9 he reported that he had advised his cousin not to smoke:

> *Int*: Have you asked someone not to smoke?
> *James*: Yes.
> *Int*: Who have you asked?
> *James*: My cousin. Because she's 15 and she smokes because all her mates do. And she was smoking and she said 'Don't tell anyone'. And everyone knows except her Mum and Dad and I told her not to because it's bad for you and that (I, 1999)

At age 11 – and although he had tried smoking - he also described how he had advised his friend to give up smoking with only a limited degree of success:

> *Int*: Have you ever asked somebody not to smoke?
> *James*: Yes.
> *Int*: Who have you asked not to smoke?
> *James*: My mate.
> *Int*: And what did he say when you asked him?
> *James*: He said alright, because his Mum found out and he was grounded for three months. And my mate, he hadn't smoked since. But then he's started again now. And I said 'Don't smoke'. It's bad for him, isn't it? (I, 2001).

5.9.2 Case Summary

James lived with both his parents. The household was not on a low income. James' mother had never smoked and his father quit in 1997. James held stable negative views about smoking and although he did not intend to smoke as an adult, at age 10 he reported that he wanted to try smoking. James had first had the opportunity to try smoking at the

age of 7 with his friend who had smoked a cigarette butt that he found on the floor. However, James first reported that he had tried smoking at the age of 11. James believed that children smoke because they think it's cool, and also because their friends smoke. He knew that adults smoke because they are addicted to cigarettes, and also because they find smoking enjoyable. Because he had watched his father give up smoking when he was age 7, James knew that smokers find cessation attempts difficult. Although he only reported being exposed to passive smoke at the Pirrie Club, he had mixed feelings about spending time in smoky environments. James knew that smoking can affect the heart and lungs and his grandfather had experienced smoking-related disease. He also tried to promote the health of the smokers that he knew by encouraging them to give up smoking.

5.10   Cross-Case Comparison

This part of the chapter presents a comparison of the different cases and seeks to establish areas of commonality and also of difference between the case study children. The comparison is based on the key issues explored within the description of each case. The conclusions that can be drawn from the cross-case comparison are presented in section 5.11.

5.10.1 Social Context and Family Background

The children in these case studies appear polarised in terms of the contact that they have with smokers. The children either have many smokers in their social networks or they have none. Both Sarah and Bill have parents who have either never smoked (Sarah) or have not smoked during their lifetime (Bill). In addition, neither of them have smokers in their wider families. By contrast, Maggie, Chima and James have parents who either currently smoke (Maggie and Chima) or who recently quit the habit (James). In addition to having smoking parents, these children are also exposed to other adult smokers in their families. The case which is most striking in this respect is that of Chima, whose family contains barely any adult non-smoking role models.

It is vital to consider how these family influences are reflected in the children's own smoking behaviour, and the patterns which emerge from the comparison demonstrate the importance of adult smokers in the family for experimentation with cigarettes during preadolescence. Both Sarah and Bill have no contact with adult smokers in their family and neither of them have tried smoking. However, by contrast, Maggie, Chima and James have all spent many years watching either one or both of their parents smoke, together with spending time with many other family members who smoke. These three children have all tried smoking while at primary school.

In terms of the influence of friends, Bill, Chima and James all reported that they had friends who were smokers at age 11. Chima and James both reported that they tried smoking in the company of friends who were already smokers. Bill reported that he had already experienced some pressure to smoke from his friends, but he had yet to try smoking. His case suggests that perhaps a non-smoking family may have a protective effect on experimentation with cigarettes during preadolescence even in the context of pressure to smoke from peers. Although Maggie tried her first cigarette with a friend, both she and Sarah reported that they had no friends who were already established smokers. It is interesting to note that while Maggie shared her first trial with a friend, she obtained her first cigarette from home. This suggests that her first tobacco use experience was therefore based on the influence of familial role models and the easy access that she had to cigarettes at home.

Although neither Bill nor Sarah had yet tried smoking, it would appear that at age 11 Sarah was the least susceptible to experimenting with cigarettes. While Bill was subject to some pressure to smoke from his peers, Sarah was not subject to any pro-smoking influences. Instead, both her parents had never smoked and remained strongly anti-smoking. She did not have any friends who smoked either. Although neither of these children had smoked during preadolescence, it will be interesting to see how their smoking (or non-smoking) careers unfold during adolescence as they join new peer groups at secondary school and as the LLSS continues.

In terms of household income, Maggie and Chima both have mothers and fathers who are current smokers, and they both live in households that are dependent on means-tested benefits. Their social context thus demonstrates the association between low income and adult smoking which has been found in other studies (Graham, 1993; Marsh and McKay, 1994; Dorsett and Marsh, 1998; Graham, 1998). It also raises questions about the relationship between poverty and child smoking because both these children have tried smoking. This association will be explored in Chapter 6 using data generated by the whole cohort.

5.10.2 Child's Smoking Experience, Intentions to Smoke and Views on Smoking

These case studies reveal the complex relationship between views, intentions and smoking behaviour during preadolescence. All of the children expressed consistent and stable negative views on smoking between the ages of 9 and 11. These negative views centred on the risks smoking poses to health, the unpleasant smell of tobacco smoke, and the description of smoking as a 'horrible habit'. Furthermore, none of the children expressed any intention to become adult smokers in future. Although three of the children had tried smoking at age 11, none of them foresaw the development of their own smoking careers into adulthood.

Although none of the children intended to smoke in future, their current intentions to smoke do offer an insight into the development of the smoking habit at primary school. Sarah and Bill expressed no intention to try smoking between the ages of 9 and 11, and Maggie and Chima expressed no intention to smoke at age 9 and 10 (prior to their own first smoking trials). Because Maggie and Chima expressed no current intention to try prior to experimenting with cigarettes, their cases would suggest that current intention may not be a useful predictor of subsequent first tobacco use. Perhaps changes in intention occur only shortly prior to first use, and therefore although questionnaires were administered every nine months, data may have been collected too infrequently to detect changes in intention. Alternatively, perhaps Chima's lack of intention to smoke can be explained by her perceived sense of coercion that is a feature of the account of her first

trial. Chima felt pressured into trying smoking, and if her experience of trying smoking was not voluntary, this may explain why her smoking behaviour was not preceded by a change in intention. However, Maggie's account does not suggest that she felt pressured into trying smoking. Her case suggests that either first smoking trials are not preceded by a change in current intention, or that changes in intention only occur immediately prior to first use.

However, the experience of James suggests that in some cases current intention data may usefully predict subsequent first tobacco use. Although James was not intending to try smoking at age 9, by age 10 he was currently intending to try a cigarette. This change in intention was followed by experimentation with cigarettes prior to the collection of data at age 11. Although James was intending to try smoking at age 10, it is particularly striking that at that age he still expressed strong negative views on tobacco. This demonstrates that children may hold dichotomous views about smoking simultaneously.

In terms of first use experiences, it is useful to compare the different accounts which Maggie, Chima and James gave of their experimentation with tobacco. The children obtained their cigarettes from different sources. Maggie stole her first cigarette from her parents whereas Chima and James were given their first cigarettes by friends. All of the children smoked their cigarettes outside away from the protective gaze of parents or other adults who might either disapprove of their behaviour or intervene to prevent them being coerced into smoking. Maggie smoked in an alleyway, Chima smoked in the street and James smoked in a derelict house. It is also interesting to consider how the children's accounts of their motives for trying smoking differ. Although of the three children, Maggie took the most initiative in trying smoking by stealing her own cigarette from home, she was unable to offer any explanation of why she had tried smoking. Chima argued that she tried smoking because other children had coerced her into doing so, whereas James suggested that he had been motivated by curiosity. It is interesting to note that although James' account also includes a description of mild peer pressure that accompanied his first trial, he insists that he was not 'forced' to smoke, but instead his experimentation was based on curiosity. In this way, it is important to consider how

children construct their accounts of early smoking experience with some choosing to emphasise peer pressure, while others focus on their own agency. All of the children insisted that they had not enjoyed their first smoking experiences.

One of the most significant findings of this part of the cross-case comparison is that the views and intentions of children who report that they have tried smoking generally do not differ significantly from those of children who have not tried smoking. All of the children continued to express strong negative views about smoking, and they continued to assert that they would not become adult smokers. These assertions would appear to be inconsistent with the behaviour of the three children who had tried smoking. With the exception of James, the children all also expressed no current intention to smoke despite two of the girls going on to experiment with cigarettes. Although these case studies shed light on the development of smoking behaviour at primary school, further research is still needed to explore the complex relationship between views, behaviour and intentions to smoke during preadolescence. It is particularly important to explore why some children try smoking while continuing to hold strong negative views about the habit.

5.10.3 Beliefs about Children and Smoking

The case study children held a wide range of beliefs about children and smoking. The key themes in their accounts of why some children try smoking focused on peer pressure and bullying, the use of cigarettes to make a child appear cool or tough, and the positive effect that smoking has on mood.

Both Sarah and Bill, neither of whom had tried smoking, offered simple explanations of why children might take up smoking and these were consistent over time. Each year, Sarah argued that children try smoking because they are bullied into it. Bill also consistently described the importance of peer pressure on smoking uptake and in addition he suggested that children might smoke to appear tough in front of their peers.

By contrast, the children who reported that they had tried smoking offered more complex, multiple explanations of why some children smoke. Maggie's views evolved over time. At age 9 she argued that children smoke because they are ignorant of the risks to their health and also because they want to exert power over their peers. At age 10 she suggested that children might smoke to manage stress, and this was consistent with her understanding about the way adults use tobacco (see section 5.10.4). At age 11 Maggie proposed that children might begin to smoke if they are used to passive smoking. Thus her accounts of why children begin to smoke varied entirely from year to year. In the same way, Chima's accounts of smoking uptake varied over time. From the age of 9 she was able to offer multiple explanations for smoking onset. Because she had smoking friends she knew that children who smoked associated many benefits with tobacco use. She understood that children smoked to fit in with their friends, to appear tough, to demonstrate autonomy and because tobacco had a positive effect on their mood. However, by age 11, her account of smoking uptake centred on the importance of bullying as she argued that children who smoked could exercise force over other children. Just as Maggie's explanations varied widely over time, James' understanding of why children smoke also differed from year to year. At age 9 he argued that children might smoke because it is cool and also because their friends smoke. At age 10 he suggested that children who tried smoking might begin out of a motive of curiosity, and also because they like the smell of the smoke. At age 11 he offered an explanation for the mechanics of how children actually learn to light up, and he asserted that children learned how to smoke a cigarette either by observing their parents or by being taught by friends whose parents smoked.

The children were asked not about their own smoking experiences, but more abstractly about why 'some children' take up smoking. Although the children who had tried smoking perhaps had more insight into the question after they had themselves tried smoking, their answers were more complex from age 9 prior to their experimentation with cigarettes. Because they could offer more sophisticated explanations prior to experimentation, this suggested that these 'triers' really had a more complex understanding of smoking uptake and were not just rationalising their own smoking

behaviour. Although from age 11, their understanding of smoking onset would of course have been informed by their own first use experiences. Perhaps Chima and James could also offer multiple explanations of why some children start smoking because they had witnessed their friends taking up smoking and had more contact with smokers. It is also interesting to consider whether Maggie, Chima and James had tried smoking because they were more aware from age 9 of the range of benefits that children who smoke perceive to be associated with tobacco.

5.10.4 Beliefs about Adults and Smoking

All the children were able to offer explanations of why adults continue to smoke, although their accounts were not as detailed as those of why some children begin to smoke. Their understanding about smoking maintenance centred on the addictive nature of tobacco and the perceived function that cigarettes have for smokers in enabling them to regulate mood. The explanations that the children offered of why adults smoke were more stable than their accounts of smoking uptake, and generally did not exhibit variation over time.

The children of current smokers - Maggie and Chima - both knew from age 9 that adults smoke for positive effect: to relieve stress, to cope in difficult circumstances and to keep calm. Bill also knew that adults smoke in order to relax, because his father who had successfully quit smoking many years ago had told him this. Chima and James also argued that adults continued to smoke because they enjoyed smoking. Sarah, Chima and James all knew that adults remain smokers because they are addicted to cigarettes.

It is important to consider how knowledge about why adults continue to smoke is reflected in patterns of smoking uptake and also in children's intentions to smoke in adulthood. As previously stated, none of the children currently anticipated that they would become adult smokers. Even those children who had tried smoking did not conceptualise themselves as on the path to becoming adult smokers. Beliefs about smoking during adulthood did not appear to be differentiated by smoking during

preadolescence either. Children who had not tried smoking and children who had tried smoking alike both displayed knowledge about addiction and the positive effect of tobacco on mood.

5.10.5 Passive Smoking

The case study children's experiences of exposure to passive smoke varied on the basis of the smoking behaviour of their parents and also according to where they spent their leisure time. Both Maggie and Chima, whose parents were current smokers, reported being exposed to passive smoke at home. Bill and James, whose parents no longer smoked, reported being exposed to ETS in public spaces. Bill described the smoke at Goodison Park and James complained that it was smoky at the Pirrie Club. In addition to exposure at home, Chima also complained that her friends who smoked exposed her to ETS. Perhaps because Maggie's parents smoked, she also experienced ETS outside the home when she went out with her parents. Because her parents would presumably have smoked during their leisure time, Maggie reported spending time in smoky environments at the pub and at other people's homes. By contrast, Sarah was barely exposed to secondhand smoke because no-one was permitted to smoke in her home and because when she went out with her parents they chose to spend their time in smoke-free settings. Thus, the children of smokers are likely to be exposed to ETS not only at home but also in public spaces such as pubs and restaurants. Alternatively, the children of ardent non-smokers are likely to be protected from passive smoke not only at home but also outside it. This association between home and leisure compounds the experience of the children of smokers who may be doubly exposed to ETS.

Nevertheless, smoking parents may take steps to protect their children from inhaling their smoke. It was encouraging to note that Maggie's parents sought to protect her by opening the window or the back door. Similarly, Chima's mother took care not to smoke in the same room as her daughter. However, despite these symbolic measures, it is likely that both girls continued to inhale secondhand smoke at home.

The children's feelings about spending time in smoky environments also varied. Maggie and James both held mixed feelings about being exposed to ETS. Both were regularly exposed to other people's smoke. They both disliked inhaling secondhand smoke but also argued that they were so accustomed to passive smoking that they felt no different in smoky environments. Sarah and Bill were both highly intolerant of ETS, perhaps because they were not used to being exposed to passive smoke. Although the majority of adults in her family smoked and although she also reported being exposed to secondhand smoke by her friends, Chima remained intolerant of ETS perhaps because she had been over-exposed to passive smoke. Therefore, she had taken positive action by asking her mother not to smoke near her. It is interesting to note these differing responses to exposure to ETS. While Maggie and James had become accustomed to inhaling others' smoke, despite spending a lot of time in smoky environments Chima remained intolerant of passive smoke in the same way that Sarah and Bill (the children of non-smokers) did.

With the notable exception of James, all the children were aware of the dangers ETS poses to health. They knew that inhaling secondhand smoke made them cough and feel sick. They also knew that passive smoking could damage the lungs. This knowledge may well have informed Chima's strong negative views about secondhand smoke.

5.10.6 Smoking and Health

From age 9, all the case study children had a good knowledge of the risks smoking poses to health. Their understanding of the health consequences of tobacco use focused on lung and heart disease. With the exception of Sarah who knew very few smokers, all the children knew someone with smoking-related health problems. Maggie's mother and James' father had both had serious smoking-related illnesses. Surprisingly, Chima was not aware of any smoking-related disease among the many adult smokers in her family, but instead described a friend's short-term reaction to nicotine. Bill had no smokers in his family, yet he was still highly aware of the risks smoking poses to health. He described how his friend's grandfather was ill because of smoking.

Maggie, Chima and James all knew that the health of someone close to them had been affected by smoking and appeared to have been profoundly personally affected by the experience. However, despite a good theoretical knowledge of the risks smoking poses to health and personal experience of smoking-related disease among friends and family, these three children had all tried smoking by age 11. The impact of knowing someone with smoking-related disease on children's smoking behaviour will be explored in Chapter 6.

5.10.7 Addiction and Cessation

From the start of this phase of the study, all the case study children understood that cigarettes are addictive and that the addictive nature of smoking inhibits cessation among smokers. However, the children only gradually began to use the term 'addiction' from age 10 onwards. Sarah and Bill first used the word 'addiction' in 2000, and Chima and James first spoke of 'addiction' in 2001. Although Maggie clearly understood the addictive nature of smoking from age 9, she never used the word 'addiction' in the course of the research. The idea of becoming addicted to cigarettes was seen as highly undesirable by these children. In particular, Sarah argued that the fear of becoming addicted to cigarettes would deter her from trying smoking.

Both Maggie and James could offer an insight into the cessation process based on their observations of their parents' attempts to quit smoking. While James' father had stopped smoking successfully when he was seven years old, Maggie had witnessed her parents making several unsuccessful quit attempts. All the children knew that smokers find it difficult to give up the habit. They also knew that smokers may be motivated to quit for a number of reasons. Every child knew that smokers quit in an attempt to escape the burden of future smoking-related disease. Sarah and Bill also suggested that smokers may give up because cigarettes are so expensive. In addition, Bill knew that some smokers quit because they are currently experiencing illness as a result of their habit.

5.10.8 Health Promotion

All of the children who feature in these case studies took active steps to promote health in relation to smoking. This desire to minimise the impact that smoking has on health was rooted in the thorough knowledge that all of these children displayed of the risks smoking poses to health.

Although Sarah knew no smokers, all the other children did and they encouraged both family members and friends to quit or to cut down their cigarette consumption. Again, this demonstrates the complex and perhaps contradictory nature of the relationship between the child's own smoking behaviour and their views on the smoking behaviour of others. Maggie, Chima and James had all tried smoking, yet they were still engaged in encouraging the smokers they knew to quit the habit.

It is of particular interest that the children encouraged both adult family members and also young friends to quit. While there is now cessation support widely available to adult smokers, there is little cessation advice or support available to children who smoke. Therefore, this informal encouragement from friends may be the only support to stop smoking that young smokers receive as they potentially embark on their adolescent and adult smoking careers. The fact that the children were active in encouraging their friends to stop smoking is also interesting in the context of the heavy emphasis that many members of the cohort placed on peer pressure to smoke both from friends and from bullies. Since the children were keen to promote the health of the smokers they knew, perhaps future research could consider how children can be resourced to promote the health of those around them.

In addition to a concern to promote the health of smokers, Sarah, Bill and Chima also sought to actively protect their own health from passive smoke by either moving away from smokers or by asking adults not to smoke near them. It is encouraging that these children were prepared to take steps to promote their own health on the basis of knowledge of the dangers secondhand smoke poses to those who inhale it. It is

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interesting that Maggie did not describe taking measures to protect herself from passive smoke, despite being exposed to ETS both at home and in a number of other settings. Are the children of smokers more or less concerned about passive smoking than children who live in households where no-one smokes? Although Maggie would have been exposed to ETS much more frequently than Sarah and Bill, and although there was evidence that this was impacting on her own health, perhaps she was so accustomed to spending time in smoky environments that she did not see the need to take action. Alternatively, Sarah and Bill were unused to inhaling secondhand smoke, and therefore experienced passive smoking as particularly unpleasant and endeavoured to take health-promoting action when they were forced to spend time in the company of smokers. However, in contrast to Maggie, Chima was also exposed to ETS at home and by her friends, yet she remained intolerant of secondhand smoke. Further research is needed to determine how and why children respond to passive smoking in different ways, and how this is related to their own smoking behaviour.

5.11 Conclusions

The data presented in this chapter have demonstrated that the multiple case study approach is a useful longitudinal method for studying change in children's views, beliefs, experiences and behaviour over time. The case study method aims not at statistical generalisation but at particularisation, and the method has permitted the in-depth analysis of the complexities and uniqueness of each of these children, their social context and experiences of smoking. In this way, the experiences of Maggie, Sarah, Bill, Chima and James do contribute to the understanding of the research questions that are explored in this thesis and to theoretical generalisation. Stake (1995) argued that the findings from case studies can be applied to our understanding of other settings as 'petite generalisations', with the limits to their generalisability that the label implies.

The cross-case comparison revealed the importance of adult smokers in the family for experimentation with cigarettes during preadolescence. It emerged very clearly from this analysis that the three case study children who had tried smoking all had parents who

either currently smoke or have recently quit the habit. The case studies also demonstrated that friends who smoke are a key influence on smoking uptake. The three children with smoking friends all reported that they had experienced peer pressure to smoke. However, the case of Bill also shows the importance of the protective effect that a non-smoking family may have in countering this peer pressure to smoke.

By considering the cases of individuals, the analysis also revealed the complex relationship between views, intentions and smoking behaviour during preadolescence. Although three of the children had tried smoking, their views on the habit were as negative as those of the children who did not report trying smoking. Furthermore, the case studies suggest that in some cases, current intention is not a useful predictor of experimentation with cigarettes: only James expressed a desire to smoke prior to his first trial. Further research is needed to determine why the views and intentions of children who report that they have tried smoking do not differ significantly from those of children who have not tried smoking.

Although the children's views on smoking did not vary by smoking behaviour, the cross-case comparison showed that children who try smoking during preadolescence can offer more complex accounts of smoking uptake, even prior to their own first smoking experience. Perhaps this is because children try smoking because they are more aware of the perceived benefits that other children associate with tobacco use. The accounts of smoking initiation offered by all the children focused on peer pressure and bullying, the use of tobacco in the negotiation of peer group status, and smoking as a coping strategy. All of these explanations of smoking onset are rooted in the construction of smoking as an adult habit, and also in the ways in which these children have observed that adults use tobacco. These issues will be discussed further in Chapter 6.

In terms of passive smoking, the case studies demonstrated that the children of smokers are much more likely to be exposed to ETS than the children of non-smokers, both at home and in other settings. However, the analysis also found that children who are used to inhaling secondhand smoke may have mixed feelings about their exposure to ETS.

Children may become accustomed to breathing in others' smoke, and Maggie even suggested that regular exposure to passive smoke may contribute to smoking uptake.

The children all had a good knowledge of the risks smoking poses to health, and – with the exception of Sarah – all described knowing people with smoking-related disease. However, it is particularly interesting that the three children who knew someone close to them who had been ill because of smoking had all tried smoking themselves. It is encouraging to note that the children were all active agents of health promotion: either endeavouring to protect their own health in the face of exposure to ETS, or by advising smokers to quit.

In Chapter 6, the 'petite generalisations' which have emerged from the analysis of these case studies will be explored and developed in the context of the data provided by the whole cohort.

6 Longitudinal Cohort Analysis

6.1   Chapter Outline

This chapter presents quantitative and qualitative data generated by the whole cohort (n=247, 1999; n=257, 2000; n=239, 2001). It aims to consider how early smoking careers develop during preadolescence and how children's views and experiences of smoking change between the ages of 9 and 11. The chapter aims to explore and develop some of the key themes that emerged from the case study analysis presented in Chapter 5.

The chapter begins by considering smoking uptake in terms of first use experiences (section 6.2) and the risk factors that predict smoking during preadolescence (section 6.3). The chapter then outlines children's beliefs about smoking initiation (section 6.4). The next part of the chapter considers the social construction of smoking, specifically how children construct smoking as an adult behaviour (section 6.5). The emphasis then shifts to children's understanding of other aspects of the smoking habit. Data are presented on children's views on addiction (section 6.6) and on children's experiences of smoking-related disease in their communities (section 6.7.1). The chapter concludes by considering children's agency as health promoters (section 6.7.2).

Quantitative data are presented from the children's and parents' surveys at each age (9, 10 and 11). The quantitative data were analysed using SPSS for Windows (version 9.0), with the strength of associations between variables measured using Chi-square tests. However, the statistics described below should be interpreted with caution since sample sizes in many cases are small, particularly with reference to children who have tried smoking and children with intentions to smoke. A logistic regression analysis was also performed in order to identify which variables were the most significant predictors of smoking behaviour during preadolescence. As the study progressed, new questions emerged from the data that had already been collected, and more measures were added to the children's questionnaire. Therefore, some of the analysis presented is based on data collected in 2000 and 2001 only.

Qualitative data from the children's questionnaires, the interviews, focus groups and the draw and write exercise are also presented but only from age 9 and 11. Qualitative data generated at age 10 is omitted from the analysis for two reasons. Firstly, the longitudinal study aims to explore and explain change over time. The analysis demonstrates that change over time is most significant and identifiable when there is a two year gap between data collection points. Secondly, a large volume of qualitative material was collected each year, and the focus on just two data points has allowed a more in-depth analysis of children's experiences at each age.

In Chapter 6, 'Q' indicates data from the children's questionnaire, 'I' signifies interview data, 'FG' represents data generated during focus groups, and 'DW' indicates data from the draw and write exercise. At age 11, each child chose his/her own pseudonym and these are used to report their talk throughout the chapter. Data from the children who were absent in 2001 (or whose identity could not be identified from the focus group transcripts) are labelled with their gender. 'Int' represents the interviewer's voice in the interview and focus group dialogues.

6.2   First Use Experiences

Three of the case study children reported that they had tried smoking by age 11, and this section introduces data on trying smoking drawn from the experiences of the wider cohort. It presents frequency data on the number of children that had tried smoking before going on to present children's accounts of their early experiences of smoking using qualitative data generated in the interviews and focus groups.

The smoking behaviour of the cohort is described in Table 6.1. Children who had tried smoking at least once were 'triers' and children who had tried smoking more than once were 'persistent triers'. The usual definition of regular child smoking in the UK is consumption of at least one cigarette a week (Thomas *et al,* 1993; Bolling, 1994), and children who were smoking at least once cigarette each week were classified as 'smoking

regularly'. Children who were currently wanting to try a cigarette were 'current intenders' and children who wanted to smoke as an adult were 'future intenders'.

Table 6.1: Smoking behaviour and intentions to smoke, 1999-2001

	Age 9		Age 10		Age 11	
	%	n	%	n	%	n
Triers	8	20	22	53	27	65
Persistent triers	1	3	7	19	12	28
Smoking regularly	-	-	1	2	3	6
Current intenders	3	7	5	12	6	15
Future intenders	3	7	3	7	2	4

In 1999, 8% of the sample (n=20) admitted that they had tried smoking, and three children had tried smoking more than once. The likelihood of child smoking increases with age (Thomas *et al,* 1993) and the proportion of children who had tried smoking increased over the next two years (see Table 6.1). Furthermore, by age 10 some of the children had begun to smoke regularly (1%) and by age 11, 3% were regular smokers.

However, this aggregated data may conceal gender differences in patterns of smoking uptake. Figure 6.1 shows that although rates of trying smoking for both boys and girls increased over time, boys were consistently more likely to experiment with cigarettes than girls. The statistical significance of gender as a predictor of smoking uptake is considered in section 6.3.

Figure 6.1: Proportion of children who reported trying smoking by gender
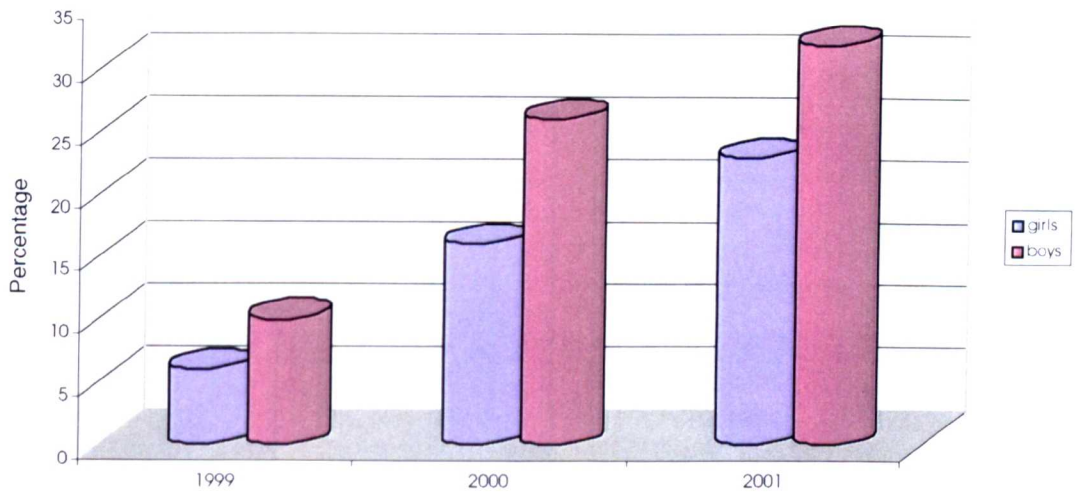
As Table 6.1 shows, a sizeable proportion of the cohort reported during the research that they had tried smoking. However, because smoking is an illicit behaviour for primary school children, many of these did not tell their families that they had smoked. Children may be very adept at concealing their smoking behaviour from their parents. A survey of secondary school children found that more than half of the regular smokers said that their families did not know they smoked (Bolling, 1994). Children's reports of trying smoking were compared with parental reports, and the analysis revealed that the majority of the children who participated in the LLSS successfully managed to hide from their parents that they had tried smoking (Figure 6.2). As the graph reveals, only a small proportion of triers' parents were aware that their children had tried smoking (8%, 1999; 29%, 2000; 20%, 2001). This suggests that children may smoke as a means to demonstrate their autonomy and their ability to make their own decisions without their parents' knowledge. Children may also conceal their early smoking behaviour from their parents in order to avoid discipline. The data from the parental questionnaires on children's smoking experimentation are also interesting because a small number of parents revealed that their children had tried smoking when the children had not reported trying smoking in their own questionnaires (n=2, 1999; n=0, 2000; n=1, 2001). This suggests that there may be a very small degree of under-reporting of smoking by the children participating in the study.

Figure 6.2: Parental awareness of triers' smoking experimentation
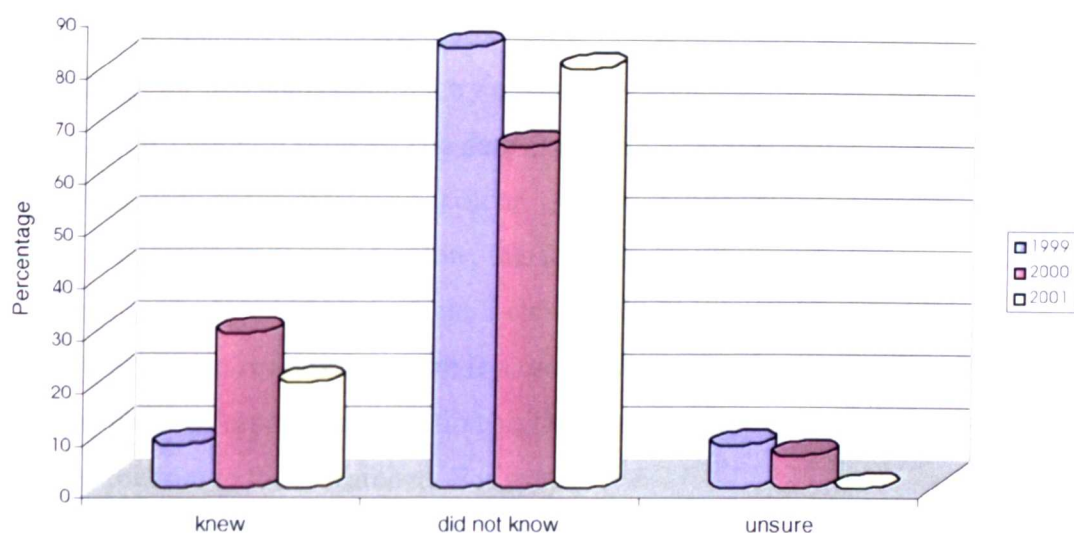
Quantitative data on the context of children's first use experiences were collected from the whole cohort using the children's questionnaires. Although this study is built on the assumption that children give reliable accounts of their own views and experiences, it should be noted that the data that describe past experimentation should be treated with caution because they are retrospective in nature, and therefore recall (memory) bias may have affected the children's accounts. It should also be noted that these are self-reported data, and should be treated with some caution. Nevertheless, children of primary school age have been shown to be able to accurately recall their first cigarette because the experience will have happened relatively recently (Bewley *et al*, 1974). This is particularly the case when data have been collected annually as with the LLSS.

Although the children were all asked to describe their first trial every time that data were collected, the quantitative data on first use that are presented in this part of the chapter only include the first reporting of experimentation with cigarettes. This means that if a child reported trying smoking in 1999 and then subsequently re-reported his/her first use experience in 2000 and 2001, only the description given in 1999 is included in the data. Thus the data presented for 2000 and 2001 only include children who had not previously reported trying smoking. This is because the earliest account is assumed to be the closest

in time to the child's first use and therefore the most accurate account. Therefore any effect of recall bias on the data collected is minimised.

Figure 6.3 shows the age at which children reported that they had first tried smoking. These data suggest that some children try smoking at a very early age – perhaps even before they begin primary school. The data also show that rates of experimentation with cigarettes increased as the children got older. Although the number of children who reported trying smoking at age 11 is low, this is may be because for many of the children only a short time had passed between their eleventh birthday and the 2001 data collection point. Figure 6.3 also reveals that there is a considerable time lag between the age at which some children report that their first smoking experience took place and the reporting of the trial to the researcher. For example, in 2001 some children reported for the first time that they had tried smoking, although they suggested that their smoking experience had happened as long ago as when they were aged 7, 8 or 9. Perhaps these children delayed reporting smoking until they were confident in the guarantees of confidentiality made during the collection of data, or perhaps they were unable to accurately recall the exact age at which their first trial had taken place.

Figure 6.3: Age at first trial
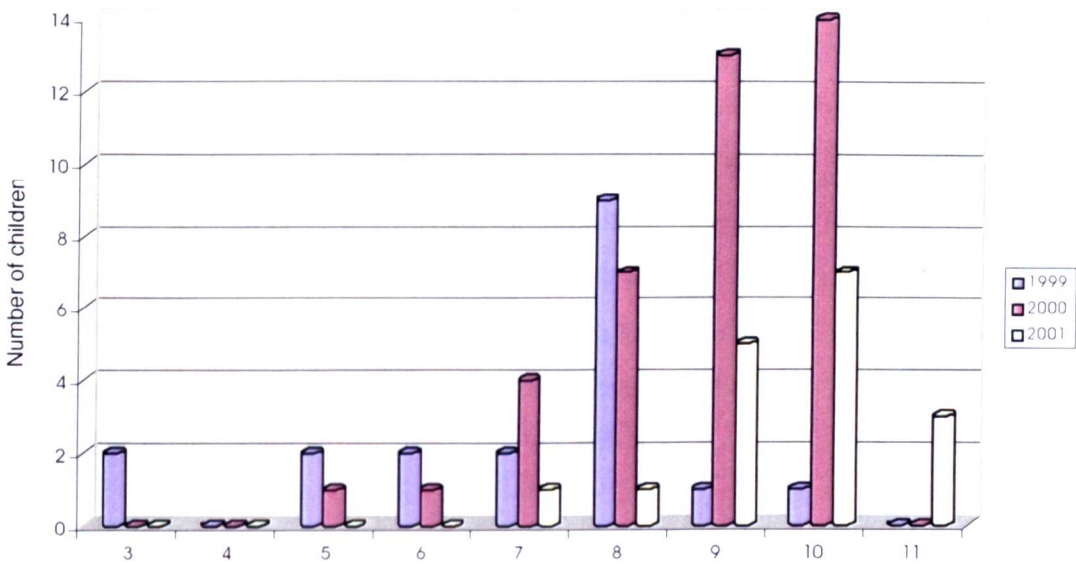
The source from which the children obtained their first cigarette is shown in Figure 6.4. The case studies revealed that some children have easy access to cigarettes at home, and it is interesting to note the many different means that children use to access cigarettes at an age when they would be unlikely to succeed in an attempt to purchase cigarettes from a shop. Although two children reported in 1999 and 2000 that they had been given their first cigarettes by their parents, it is likely that this had happened in an attempt to deter them from taking up smoking. Alternatively, if children have parents who are smokers, many know where their mother or father's cigarettes are kept and may have the chance to steal cigarettes. In this way it is important to consider how having a smoking parent is related to access to cigarettes for early smoking trials. Similarly, the data reveal that parents may give their children access to tobacco by leaving cigarettes unattended and lit in ashtrays, enabling children to quickly try their first puff. Some parents also ask their children to fetch their cigarettes or to light them, and in this way they give their children the opportunity to try smoking. Nevertheless, the data demonstrate that as the children got older they were less likely to steal cigarettes from their parents in order to try smoking, and more likely to be given a cigarette by a friend.

As Figure 6.4 shows, friends are the main source of cigarettes for children's first trials. The majority of the children who reported that they had tried smoking had been given

their first cigarette by a friend. Again, these data suggest that children who try smoking
have friends who are older than them. This is because same-age friends would be
unlikely to have access to a ready supply of cigarettes. However, older friends may have
been able to buy cigarettes either from shops or from cigarette machines. A few children
had also tried smoking by picking up lighted cigarette butts off the floor. This is perhaps
the easiest – but least appealing - way for children to try smoking if they have
unsupervised leisure time in public places to enable them to look for lighted butts on the
pavement. It also demonstrates the opportunistic nature of children's access to cigarettes
during preadolescence, and the lengths to which some children will go if they are
determined to try smoking.

Figure 6.4: Source of the first cigarette
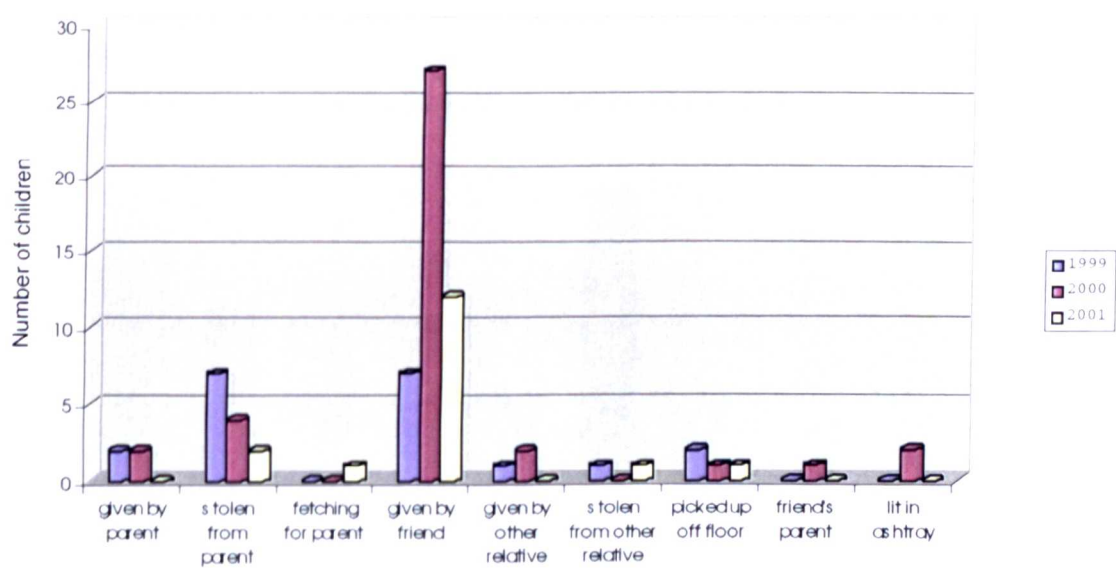
The case studies showed that children may try smoking in the company of friends who
are already smokers and the data presented in Table 6.2 reveal that few children smoked
their first cigarette alone. The number of children who shared their first smoking
experience with another person increased between 1999 and 2000 from 60% to 85%, and
then declined slightly to 76% in 2001. These changes in the social context of the first
trial may reflect changes in patterns of access to cigarettes, with children more likely to
be given their first cigarette by a friend, and less likely to steal it from a parent or pick it
up off the floor as they get older.

	1999		2000		2001	
	%	n	%	n	%	n
Smoked first cigarette alone	40	8	15	6	24	4
Smoked first cigarette with someone	60	12	85	34	76	13

The people with whom the children tried smoking are shown in Figure 6.5. While a small proportion of children shared their first cigarette with a parent or another relative, most children shared their first cigarette with a friend. This is unsurprising because if a child was given his/her first cigarette by a friend, then it is likely that he/she smoked the cigarette in the company of that same friend. Over time children became less likely to smoke with a parent and more likely to smoke with a friend, and this reflects the changes in patterns of access to cigarettes that have already been outlined.

Figure 6.5: Person with whom child smoked first cigarette
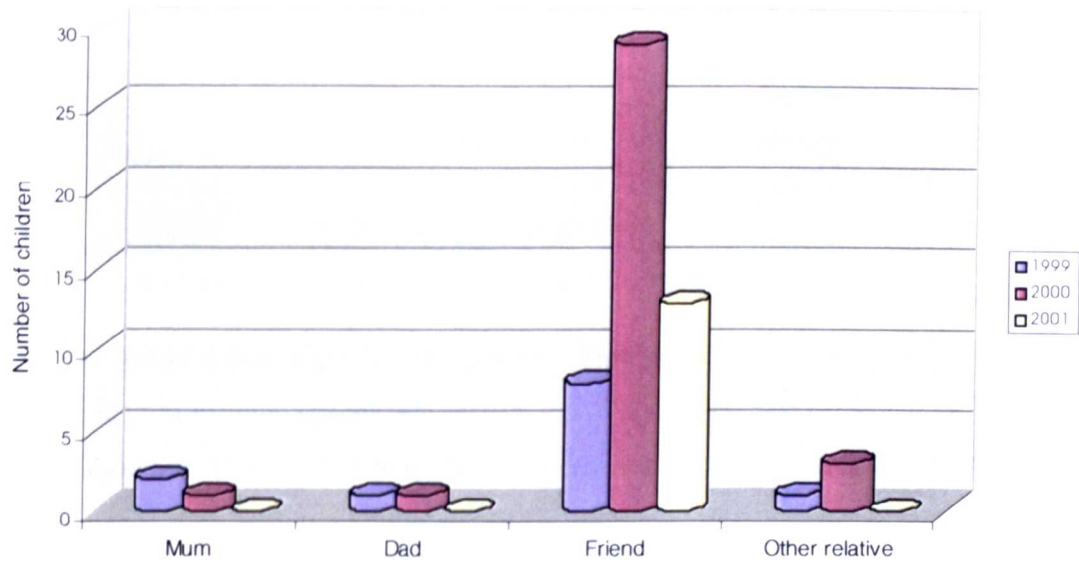
While a small proportion of triers smoked their first cigarette either at their own home or that of another relative or friend, it can be seen from Figure 6.6 that most children smoked their first cigarette outside, away from the protective gaze of adults. As already discussed, the majority of children who had tried smoking had kept their experimentation hidden from their parents. This is probably because they knew that their parents would

disapprove of their smoking and perhaps because they feared parental discipline. Therefore most children smoked outside, away from adults who might seek to intervene in their first trial. The number of children who reported smoking their first cigarette at their own home decreased from 5 to 1 between 1999 and 2001. Correspondingly, the number of children who smoked outside increased from 9 in 1999 to 28 in 2000, falling again to 13 in 2001. As children get older they have increasing access to unsupervised leisure time outside, and this may be reflected in patterns of smoking uptake.

Figure 6.6: Place where child smoked first cigarette
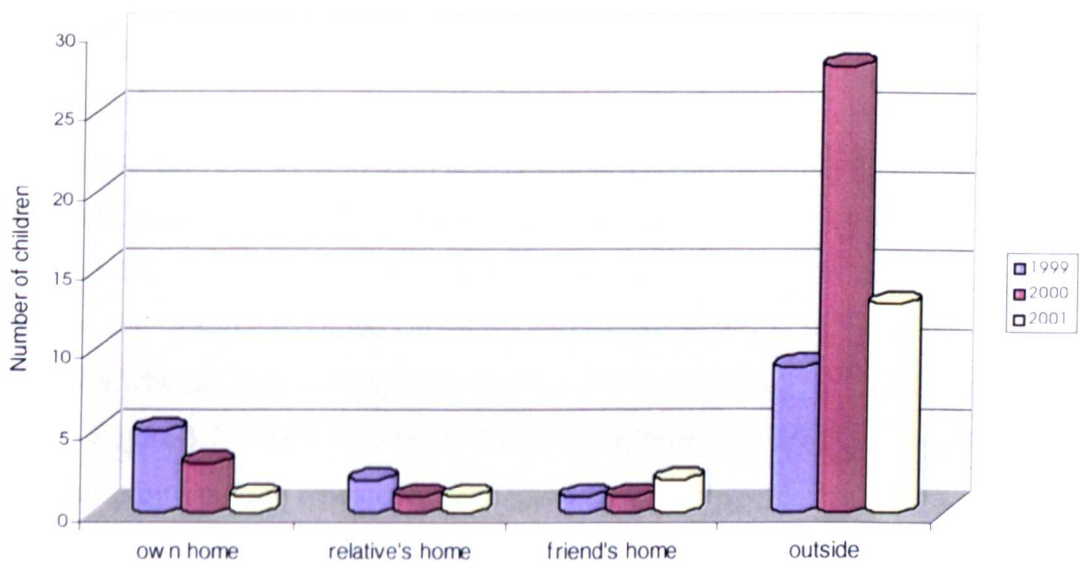
In 2001, the children described the places where they smoked outside and these give a fascinating insight into the spaces where preadolescents spend their leisure time. These places are shown in Table 6.3. These data show that children may spend their free time in hidden spaces such as down alleyways and in an empty house. They also show that children spend their time in open spaces such as parks, fields and a forest. Some children also spent their time in public spaces where other adults may be present, but perhaps not adults with responsibility for them, such as in the street, outside a pub and on a bridge. It is of concern that three children reported trying smoking on the railway.

Table 6.3: Outside spaces where children reported smoking their first cigarette (all children who reported trying in 2001, not just first report)

Outside Space	Number of children
In the street	6
Behind some flats	1
Outside a pub	2
Down an alley way	13
On the railway	3
On a bridge	1
In the park	8
On a field	2
In an empty house	1
In a forest	1

The experience of smoking the first cigarette may either deter or encourage the child to further experimentation (Hirschman *et al*, 1984). Although some children had only tried smoking once (57% of triers in 2001), 43% of the children who reported trying smoking in 2001 had smoked repeatedly. This suggests that for some children their first smoking experience does not act as a deterrent but as an introduction to further smoking. Therefore, the research explored children's perceptions of their first smoking experience, specifically whether they had enjoyed smoking the first time they tried. The results are shown in Figure 6.7. These data reveal that although many of the triers had persevered with tobacco by smoking repeatedly, few could describe their first experience of smoking as enjoyable. It is striking that so many children were unsure whether they had liked smoking or not, but maintained an ambivalence about the experience, yet still persisted in repeated trials. This suggests that children take up smoking not because they enjoy using tobacco, but in response to social pressures to smoke (see sections 6.4 and 6.5).

Figure 6.7: Child's enjoyment of first cigarette
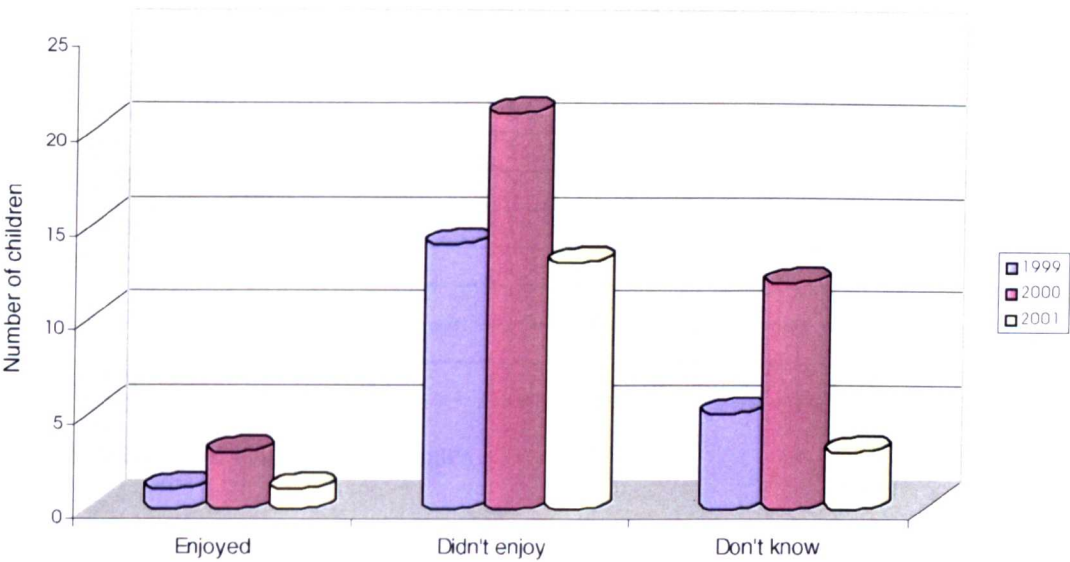
In 2001, all the triers were asked an open-ended question about why they had tried smoking. Of the 65 children who reported trying smoking, only 41 (63%) could offer an explanation of why they had tried. Perhaps this is because the experience took place a long time ago, or possibly children were unable to give an explanation because they had many different motives for trying. Nevertheless, it is interesting to consider how the motives of the children who had tried smoking compare with the discourses around smoking uptake that were familiar to the rest of the cohort (see section 6.4). Table 6.4 shows the motives reported by all the children who had tried smoking in 2001. It is striking that children are keen to emphasise their own agency in trying smoking, and curiosity was the biggest motive suggested (n=19). The influence of friends (which emerges so clearly from the qualitative data and the statistical analyses presented in section 6.3) is also mentioned by many children as a key influence on experimentation (n=14). It is interesting that two children suggest that they were 'forced' into smoking. Although many children in the cohort were fearful of being 'forced' into smoking, triers were unlikely to describe it is a reason why they smoked. Only one child said that she tried smoking because she was influenced to do so by her parents, which suggests that the influence of parents may be long-term and perhaps subconscious in contrast with the more immediate influence of a friend offering a cigarette.

Table 6.4: Reasons that children gave for having tried smoking (all triers in 2001)

Motive	Number of responses*
Curiosity	19
Influence of a friend	14
Was fetching cigarettes for relative	1
To deter child from future smoking	2
'Because I was very stupid'	1
Saw other people smoking	1
'Forced'	2
To be cool	2
Influence of parents	1

*Children could give multiple responses

The descriptions of first use experiences gathered from the questionnaires were supplemented by more detailed accounts given during the interviews and focus groups.

At age 9, Pete de Mar described how his aunt had given him a cigarette to try to deter him from taking up smoking in future. He reported that for the time being at least her strategy had been successful. At the time of the interview, Pete reported that he was resisting offers of cigarettes from friends. It would be fascinating to know his aunt's motive in trying to deter him from taking up smoking at such a young age. Perhaps she knew that he was already being offered cigarettes. Pete suggested that she wanted him to know that smoking harms health, but it is hard to know how this could be conveyed with just one cigarette. It is more likely that she had perhaps hoped that he would find the experience unpleasant:

> *Int*: So did your auntie give you the cigarette?
> *Pete*: Yes, she was just telling me not to taste it, not to take it off no-one because it is horrible.
> *Int*: So your auntie gave you a cigarette just because she wanted you to know that it was horrible?
> *Pete*: Yes, and it was bad for your health.
> *Int*: And how old were you when that happened?
> *Pete*: I was eight Miss, nearly nine.
> *Int*: Were you? And what was it like? Did you have a smoke of it? Did you have a puff of it?

Pete: Yes just a little bit.

Int: And what was it like when you tried it?

Pete: Horrible Miss and disgusting.

Int: Does it make you never want to try a cigarette or did you think I might like to try this again?

Pete: Yes, Miss. If my friends tell me to, I just say no and run away (I, 1999).

At age 9, Paul Brown described during a focus group how he had tried smoking a cigarette butt that he had picked up off the floor. The unappealing way in which he chose to access his first cigarette indicates that he was determined to try smoking. Paul's determination to smoke was also revealed when he explained that despite not enjoying his first trial, he would be prepared to persist with smoking:

Int: So Paul, you've tried one? Where did you get it from?

Paul: It was on the floor. Outside.

Int: And you tried a puff? What was it like when you tried it?

Paul: It was horrible.

Int: Why was it horrible?

Paul: It was just...

Boy: It had been on the floor?!!!

Paul: No! It was just, when I breathed in, I don't know, it was just horrible. When I breathed in I could feel stuff in my throat. I didn't like it.

Int: You didn't like it, but do you think you'd try it again?

Paul: Yes. Just one, two or three. No more.

Int: Why would you try it again if it was horrible?

Boy 2: Try one that hasn't been on the floor.

Boy 3: It's been on the floor and someone's puffed into it. They've smoked half of it and you're just picking it up...

Paul: You had to say that, didn't you? (FG, 1999)

At age 11, Margaret King explained how she had tried smoking when her mother gave her a cigarette to light. Her account reveals the way in which some parents give their children easy access to opportunities to experiment with cigarettes. It also shows that some parents enlist their children to help them to continue smoking in the context of ill-health. It would appear particularly dangerous to ask a child to light a cigarette from the cooker. Margaret's account shows firstly the extent of her mother's dependency on cigarettes and secondly how smoking was such a normal feature of her family life:

Int: Have you tried smoking?

Margaret: Yes.

Int: And what was it like when you tried?

Margaret: I didn't like it.

Int: How many times have you tried it?

Margaret: Only once. In the back kitchen when my Mum told me to go and light it off the cooker.

Int: Why did she tell you to do that?

Margaret: Because she had a sore back, and she had a big bump on her back. So she couldn't get up and my Dad wasn't there because he was going to get the food and the shopping.

Int: So what happened then?

Margaret: Nothing.

Int: She just gave it to you and said 'Can you go and light this off the cooker?'

Margaret: Yes. And then I gave it back to her.

Int: Did she know that you'd tried it?

Margaret: No.

Int: So why did you want to try it off your Mum's cigarette?

Margaret: Because I'd never tasted it (I, 2001).

Similarly, Bruce described how he had tried his father's cigarette that had been left lying lit in an ashtray. Again, a parent's carelessness with cigarettes gave him easy access to trying smoking:

Int: Have you ever wanted to try smoking?

Bruce: I have. I've done it once. But I've never done it since.

Int: How old were you when you tried smoking?

Bruce: I was seven. My Dad was smoking in the living room. He went out. I was hiding under the table and came up and had a bit and then just went back under the table so he didn't see me.

Int: So then you put it back in the ashtray?

Bruce: [nods]

Int: So did he know that you'd smoked? Did he catch you?

Bruce: No (I, 2001).

By contrast, Lee Pu got his first cigarette not from his parents but from friends. At age 11, Lee described how he had tried smoking while spending time with his friends who were smoking and drinking in their den. The den appears in his talk as a private peer-oriented space beyond parental control, where children engaged in illicit substance use. His account suggests that smoking is part of a wider pattern of substance use among preadolescents:

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Int: Where are you when it's smoky?

Lee: Sometimes at home. Sometimes in my mate's house or in somebody's den or something.

Int: ... What's the den? Tell me about the den.

Lee: Pieces of wood laid over each other, with like two pieces of wood for the roof and a cover on it so the rain doesn't go in.

Int: And who goes to the den?

Lee: Me and my mates.

...

Int: Have you ever wanted to try smoking?

Lee: I've only tried it once and I didn't like it.

Int: So what made you try it?

Lee: Just everybody was smoking in the den.

Int: But were they forcing you, or was it your choice to do it?

Lee: They were all forcing me, and I saw everyone else doing it and I thought 'They're all doing it, so why shouldn't I?'

...

Int: Do you think children who smoke are different from children who don't smoke? Or do you think it's all the same?

Lee: I reckon they're different because other kids, they just play on computer games or something, and these kids, they hang around on the streets and that, and just smoke or drink.

Int: How young are people when they try drinking do you think?

Lee: Well, when my Dad's drinking I always rob a can off him or something. So that's how I get it (I, 2001).

The next part of the chapter moves beyond children's own accounts of their first use experiences, to consider how experimentation with cigarettes during preadolescence is socially patterned.

6.3   The Determinants of Smoking during Preadolescence

The key issues that emerged from the case studies and from the qualitative and frequency data on first use were explored in the analysis of the quantitative data. The first part of this section presents cross-sectional univariate Chi-square (X^2) analyses. The second part presents a logistic regression analysis that shows how risk factors at age 9 can be used to predict experimentation with cigarettes by age 11.

6.3.1 Cross-Sectional Analyses

Table 6.5: Associations between sociodemographic variables and experimentation with cigarettes between the ages of 9 and 11

VARIABLE*	df	1999		2000		2001	
	df	X^2	p	X^2	p	X^2	p
Gender	1	1.136	0.287	4.46	**0.035**	2.052	0.152
Ethnic group	1	0.229	0.632	0.043	0.836	0.606	0.436
Smoking mother	1	8.16	**0.017**	11.899	**0.008**	15.359	**0.002**
Smoking father	1	3.688	0.158	3.567	0.312	10.669	**0.014**
Smoking brothers	1	2.944	0.086	22.397	**<0.001**	22.626	**<0.001**
Smoking sisters	1	0.996	0.318	6.863	**0.009**	9.801	**0.002**
Smoking friends	1	19.91	**<0.001**	41.267	**<0.001**	32.735	**<0.001**
Smoking best friend	1	0.057	0.972	30.086	**<0.001**	25.587	**<0.001**
Lives with a smoker	1	-	-	14.333	**<0.001**	17.943	**<0.001**
Exposed to ETS	1	-	-	2.219	0.136	3.436	0.064
Smoking-related disease	1	4.504	**0.034**	4.996	**0.025**	6.623	**0.010**
Lone parent	1	2.059	0.151	3.742	0.053	3.622	0.057
Occupational class	5	4.292	0.508	5.236	0.388	2.679	0.749
Low income	1	11.19	**0.04**	16.902	**<0.001**	2.289	0.130
Deprivation	2	-	-	2.555	0.279	5.992	**0.05**

*Statistically significant associations between variables and experimentation with cigarettes are highlighted in bold.

Analysis revealed that early experimentation with cigarettes is indeed socially patterned (see Table 6.5). Parental smoking emerged from the case study analyses as a key influence on trying smoking. The statistical analysis also showed that in terms of familial factors, each year children who had tried smoking were significantly more likely to have smoking mothers, although father's smoking was only associated with experimentation with cigarettes at age 11. Having a smoking brother or sister was associated with trying smoking in 2000 and 2001. Sharing a household with a smoker was also significantly associated with experimentation with tobacco each year.

The data presented in section 6.2 showed that friends were often the source of a child's first cigarette and often shared his/her first smoking experience. Therefore it is perhaps unsurprising that experimentation with cigarettes was strongly associated with having

smoking friends throughout preadolescence. Trying smoking was also associated with having a best friend who smoked at age 10 and 11.

At age 10, boys were more likely to try smoking. Ethnic group was not associated with trying smoking at any point. In terms of socioeconomic status, parent's occupational class was not found to be associated with trying smoking during preadolescence. Both of the case study children who lived in low-income households had tried smoking and this association was reflected across the wider cohort. Children living in low-income households were significantly more likely to have tried to smoke at age 9 and 10. Living in a deprived area was associated with trying smoking at age 11.

Although it has been postulated that exposure to passive smoke is linked with smoking uptake (see section 1.8), the children in this study were not more likely to try smoking if they reported spending time in smoky places (although smoking was associated with living with a smoker). This may be because children described themselves as exposed to ETS even if they only spent time occasionally in smoky environments, whereas if children live with a smoker it is likely that not only are they regularly exposed to passive smoke but also to smoking role models. In terms of smoking and health, it was surprising that, at each stage, knowing someone with smoking-related disease was associated with trying smoking. The impact of knowing someone with smoking-related disease on smoking uptake is discussed in the next section.

6.3.2   Risk Factors that Predict Experimentation with Cigarettes during Preadolescence

A logistic regression analysis was carried out to determine which risk factors at age 9 predicted subsequent experimentation with smoking at age 11. An initial model incorporating factors related to intentions, gender, ethnicity, familial and peer smoking was constructed by entering all the variables in a backwards stepwise procedure. Because the focus was on predicting subsequent behaviour, children who had already reported smoking at age 9 were excluded from the analysis. Therefore, the findings presented are for the group who had never tried smoking at age 9 (see Table 6.6).

Table 6.6: Logistic regression using variables at age 9 to predict smoking experimentation by age 11

Model	Odds Ratio (CI)	p
Being male	2.36 (1.04-5.36)	0.035
Having a smoking father	5.27 (2.18-12.74)	<0.001
Having a smoking brother	5.32 (1.36-21.18)	0.017
Having a smoking best friend	5.36 (1.04-27.66)	0.025
Knowing someone with smoking-related disease	3.13 (1.38-7.10)	0.004

The logistic regression model revealed that having a smoking best friend at age 9 was an important predictor of trying smoking at age 11. Children with a best friend who smoked were over five times more likely to report experimentation with cigarettes compared with children with a non-smoking best friend, after controlling for gender, paternal and fraternal smoking and for knowing someone with a smoking-related disease. The model also showed that children with a father or a brother who smoked at age 9 were also over five times more likely to have smoked at age 11 than children whose fathers or brothers did not smoke, after adjusting for the other variables.

Although gender was associated with trying smoking in the cross-sectional Chi-square analysis at age 10 only, being male emerged as an important independent predictor of experimenting with tobacco at age 11 in logistic regression. Thus gender predicted smoking when other variables were accounted for, with boys more than twice as likely to try smoking as girls. Whereas girls' smoking may be explained by familial or other factors, being a boy was a predictive factor in its own right.

The qualitative data gathered from the children has demonstrated that they are only too aware of the importance of familial and peer smoking in shaping their own tobacco use. This was borne out by the logistic regression analysis. Perhaps the most unexpected and interesting finding is that knowing someone with smoking-related disease is associated with subsequent experimentation with cigarettes. Children who knew someone who had been ill because of smoking were over three times as likely to have tried smoking, when

other factors were controlled for. However, the children who participated in the interviews and focus groups who reported knowing someone with smoking-related disease were frequently saddened and deeply personally affected by the impact smoking has on health (see section 6.7.1). For this reason, it is unlikely that knowing someone who is ill acts as a motivation to try smoking. Instead, perhaps children who know someone with smoking-related disease are exposed to broader community influences in terms of adults and friends who smoke and this community exposure to smoking role models predicts experimentation with cigarettes.

Variables which emerged in the model as having no predictive value were current and future intentions to smoke, mother's smoking status, ethnic group, having smoking friends and having smoking sisters. Of particular interest are intentions to smoke. The case study analysis suggested that in many cases current intention to smoke is not a useful predictor of behaviour and this was confirmed by the analysis of the quantitative data. Current intention may not be a useful predictor of experimentation with cigarettes because of the considerable time that elapsed between data collections which might fail to detect short-term changes in intention. Furthermore, if children perceive themselves to be coerced into smoking, then it is most unlikely that their smoking behaviour will be preceded by a positive intention to smoke (for an in-depth analysis of quantitative and qualitative data on current and future intention see Appendix K).

6.4   Beliefs about Why Children Smoke

All the children – including those who had not tried smoking themselves – were able to offer a wide range of explanations of why some children try smoking. This part of the chapter examines the discourses that the cohort used to talk about children's smoking behaviour and it considers how these reflect the findings from the case studies. The sections that follow present an analysis of children's conceptualisations of the process of smoking initiation that is structured by the key themes that emerged from the case studies. These themes are: the influence of parents (section 6.4.1) and friends (section

6.4.2), curiosity (section 6.4.3), the use of tobacco as a coping strategy (section 6.4.4) and concern about being bullied into smoking (section 6.4.5).

6.4.1 The Influence of Parents

At age 9, many of the cohort believed that children principally learn to smoke at home. Their discourses around the influence of parents on smoking uptake had three core elements. Firstly, parents may normalise smoking behaviour in the home by setting an example as an adult smoking role model. Secondly, the children of smokers may have easy access to cigarettes at home. Thirdly, parents may unconsciously teach their children how to smoke by demonstrating how to light up, often several times a day.

Some explained that children want to imitate people around them, and the importance of the modelling of parental behaviour emerged as a key theme in their talk. Perhaps the cohort suggested that children want to imitate parental smoking because children are generally encouraged by their parents to behave as they do. If these children – on the verge of adolescence - are encouraged by their parents to model other aspects of adult behaviour and to behave 'in a grown up way', maybe it is unsurprising that some children go on to model their parents' harmful behaviours too. Each year it appeared that many children were still uncritical of their parents' health choices and decision making:

> I think some children try smoking because their friends and family are smoking and all that and they might want to follow in their footsteps and start smoking (Emma Peters, FG, 1999).
>
> Their parents do and they want to be like their parents (Titch, Q, 1999).
>
> Children smoke because they see adults do it (Becky Sullivan, Q, 1999).
>
> They have seen their Mum and Dad smoking and they want to smoke too (Emily Mask, Q, 1999).
>
> They want to be like adults or their Mums and Dads and family (Marcus Barnes, Q, 1999).
>
> Their adults smoke and they want to be like them (Tim Mit, Q, 1999).

Some children smoke because they have seen their Mums and Dads smoke so that they think it is good to smoke (Ellie-May Campbell, Q, 1999).

Because if the adults are doing it then it must be OK (Julie Kelly, I, 1999).

Because their parents do and they say 'Always do the right thing' so it must be right if they do (Jamie Smith, Q, 2001).

[Children who smoke] probably learned when they were younger off their Mum and Dad, because they've started smoking in front of their kids and now they've grown up to smoke (Betty Willson, I, 2001).

Int: Where do you think they learned to smoke, these children in the pictures?
Becky Sullivan: Off their parents.
Int: How would they learn off their parents?
Becky: If the parents smoke, and they've grown up in the same house watching them (I, 2001).

In the same way, many of the cohort argued that it was the responsibility of adults to set a good example to children by not smoking. Some even suggested that if parents smoked, they did so because they wanted their children to take up smoking too:

They want their children to smoke (Clare Smith, Q, 1999).

Kids smoke because their Mum and Dad are setting an example to them (Boy, FG, 1999).

In addition to the role modelling of smoking behaviour, smoking parents could also enable their children to smoke by giving them access to cigarettes at home. Some of the children of smoking parents knew that they could have easy access to the cigarettes that they found around the house (see also the first use accounts presented in section 6.2):

[Children smoke] Because their Mums do [and] they see one lying around (Sarah Mathers, Q, 1999).

Furthermore, at age 11 a few children described exactly how parents transmit the smoking habit to their children. They suggested that children learn the mechanism of how to light and smoke a cigarette from repeatedly watching their parents smoke, mirroring

the explanation given by James in the case study analysis (see section 5.9.1). In this way parents may inadvertently teach their children to smoke:

> *Int*: [shows pictures of children smoking] Where do you think they learned to smoke, those kids in the pictures?
> *Tabby Morgan*: At home.
> *Int*: How would they learn to smoke at home?
> *Tabby*: If their parents smoke.
> *Int*: How would they learn from their parents?
> *Tabby*: If they sit and watch them.
> *Int*: If they sit and watch them, what would they learn to do?
> *Tabby*: How to puff one.
> *Int*: So your Mum and Dad smoke, would you say that you know how to do it because you've watched them?
> *Tabby*: Well, I've seen them do it loads of times, so yes (I, 2001).

> *Int*: [shows pictures of children smoking] Where do you think they learned to smoke, these children in the pictures?
> *Max S.*: From other people.
> *Int*: How would they learn from other people?
> *Max S.*: By watching them.
> *Int*: Do you mean by watching them they'd know how to light a cigarette and that kind of thing?
> *Max S.*: Yes.
> *Int*: So if your Mum smokes, would you know how to smoke from watching your Mum?
> *Max S.*: Yes.
> *Int*: You'd know how to light a cigarette and what she does and everything?
> *Max S.*: Yes (I, 2001).

Clare Smith suggested that if children were curious about trying smoking anyway they might deliberately observe how their parents smoked:

> *Int*: [shows pictures of children smoking] Where do you think they learned to smoke, these children in the pictures?
> *Clare*: If they've been wanting to smoke, they might have been watching their Mum and Dad if they smoke, or people in the streets.
> *Int*: How would they learn to smoke watching their Mum and Dad or people in the street?
> *Clare*: Just like watching them and seeing how they do it.
> *Int*: Now, your Mum smokes. Would you know how to smoke from watching your Mum smoke?
> *Clare*: Yes.

Int: So if you wanted to light a cigarette, you'd know from watching your Mum?
Clare: Yes (I, 2001).

This section has demonstrated that preadolescents believe that the influence of parents is of central importance to smoking uptake. At age 9, the role of parents in modelling smoking behaviour was the most important theme in their discourses. However, although parents remained an important influence on smoking uptake throughout preadolescence, by age 11, the emphasis in the children's accounts had shifted clearly to the role of friends in early smoking. This is the focus of the next part of this section.

6.4.2   The Influence of Friends

The influence of friends was a central theme in the cohort's accounts of smoking initiation from age 9. While some children talked about being bullied into smoking (see section 6.4.5), others talked about the role that friends play in smoking initiation with an emphasis on the importance of peer group membership. These children suggested that young people might start smoking to fit in with a peer group. At age 9, their talk shows that belonging to a peer group is a central concern to children in their final years at primary school, and how they are prepared to engage in risky behaviours to avoid being 'left out':

> Some children smoke because their mates smoke, so they want to do the same (Girl, Q, 1999).

> If their mates smoke they will not want to be left out (Boy, Q, 1999).

> Their friends might smoke and they want to fit in the gang (Amy Woods, Q, 1999).

> They might feel left out because their mates might smoke and they don't, and they might feel left out and they want to get back in (Billy Bob, I, 1999).

By age 11, the importance of family in children's discourses around smoking uptake had given way to the widespread belief that friends were the key influence on starting smoking:

> Because their friends smoke. Because their friends have persuaded them to (Rosie Billford, Q, 2001).

> I think so they can be cool in front of their mates and be popular (Jill Garden, Q, 2001).

> Sometimes they get in with the wrong crowd and they just do it (Marie Donovan, Q, 2001).

> If friends offer you a ciggy you may feel under too much peer pressure that you give in and have one or you could feel a chicken (Maggy Haniford, Q, 2001).

> *Int*: You said something about peer pressure. What does that mean?
> *Girl*: Friends might say 'Go on' but he says 'No' and they say they won't hang around with him any more. They're blackmailing him.
> *Int*: Why would his friends do that? Why would they want him to smoke?
> *Girl*: Because if they think they're all cool, they don't want some non-smoker hanging round with them as it will take the look off them, the smoking (I, 2001).

Being 'grown up' emerged as an important theme, and some children even suggested that perhaps friends were helping them to grow up by persuading them to start smoking:

> They want you to grow up and be a man, so they force you to smoke ciggies (Boy, FG, 2001).

6.4.3   Curiosity

Part of growing up is having new experiences and discovering new things. Many of the cohort had a significant number of smokers in their social networks (see the mappings which accompany the case study descriptions in Chapter 5). Each year, some of these children argued that smoking by friends and family could lead to curiosity that might make children want to try smoking for themselves. Some children explained that they were particularly keen to try smoking because it was not permitted for minors, and because they were unable to wait until they were old enough to legally purchase cigarettes:

They've seen adults doing it. They've seen every kid in the world doing it. So they think 'I wonder what that's like?' And they try one, and they like it. And they want to keep on smoking (Fitzy, I, 1999).

They want to see what it tastes like (Jenny Hill, Q, 1999).

[Children smoke] To know what it's like (Steven Owen, Q, 1999).

They might want to see what it's like. Because they can't wait until they're old enough (Bob Transit, Q, 1999).

Int: Why do you think they're smoking those people in the pictures?
Kevin Ferguson: Because they've seen other people smoking.
Int: Why would it make them want to smoke if they've seen other people smoking?
Kevin: Just to see what it's like (I, 2001).

6.4.4   Coping Strategy

Research with adults has documented how they use tobacco in order to cope, particularly in the context of material disadvantage (Graham, 1987; Graham, 1993). The present research with preadolescents found that as young as 9 years old, children know that smoking helps people to cope in difficult circumstances. It is interesting to consider how growing up with a smoking parent affects children's knowledge about smoking. In this instance, several of the children understood that their parents and other adults they knew used smoking in order to manage boredom:

I think adults smoke because they do it so they aren't bored (Mark Jenger, Q, 1999).

Sometimes they get bored and they smoke for something to do (Harriet Vaisey, Q, 1999).

They smoke because it is something to do in their life (Boy, Q, 1999).

[Adults smoke] when they are bored and they can't be bothered (Willa Wing, Q, 2001).

[Adults smoke] because they like it and it is something to do (Emin, Q, 2001).

[Adults smoke] Because they will be bored and [have] nothing to do (Peter Smith, Q, 2001).

In addition to dealing with boredom, from age 9, many children were also aware that adults use tobacco to cope with the stresses of everyday life. Some specifically mentioned that they knew this because of the way in which their parents used tobacco. The children suggested that tobacco has several different functions: that it keeps people calm, that it enables one to deal with nerves, to manage anger and to cope with stress. The cohort referred to the way in which adults use tobacco to deal with 'problems' – these included difficulties at work, the worry of caring for someone who is sick and the sense of loss associated with bereavement. They were even aware that this reliance on smoking as a coping strategy may prevent their parents from giving up:

My Mum and Dad said it calms you down (Boy, Q, 1999).

Adults smoke because they are nervous. And because they are angry (Jenny Hill, Q, 1999).

It relaxes them and it puts the pain and stress away (Courtney Owen, Q, 1999).

They might have bad nerves or they have problems (Boy, Q, 1999).

It might calm them down. It might relax them. It will make them feel good (Lucy Morgan, Q, 1999).

My Mum can't give up, because every time that something happens that makes her nervous she goes back on them (Rebecca Williams, I, 1999).

[Adults smoke] So they can get all the anger and stress out of them (Louise Wright, Q, 2001).

Some adults smoke because they get stressed out or they're sad and they think smoking will make them feel better and stop them being sad (Edward Jones, Q, 2001).

[Adults smoke] Because it can be relaxing. Because it can ease any pain (Lucy Morgan, Q, 2001).

It calms them down after a day's work (Paul Simson, Q, 2001).

I think it could be like someone is ill or they lost someone so it drives them to it (Rebecca Rattle, Q, 2001).

Int: Why do you think those adults in the pictures are smoking?
Clare Smith: They might have been under pressure.
Int: What do you mean when you say they might have been under pressure?
Clare: They might have had loads of bad problems. And they might have thought that cigarettes might take them away, and they might have forgotten about them.
Int: Why do people think that cigarettes take their problems away?
Clare: Because it's something else to think about instead of just all your problems and people who make your problems and that (I, 2001).

Some children even suggested that they were the cause of their parents' smoking, perhaps echoing their parents' rationale for lighting up. This suggests that some parents tried to justify their smoking at home in the context of their children's misbehaviour. Because the majority of the children intensely disliked their parents smoking, this must have been hard for them to accept:

[Parents smoke because] their children are naughty (Sarah Mathers, Q, 1999).

Int: Why would smoking calm their nerves?
Lee Pu: Because if people are shouting at their kids or something, then smoking will probably calm their nerves. Because my Mum always says it (I, 2001).

These beliefs about the way adults use tobacco had informed the cohort's knowledge about the function of smoking for young people. The discourses that the cohort used to talk about adult smoking were reflected in their beliefs about the function of smoking for children. At age 9, some children suggested that the use of tobacco as a coping strategy was not confined to adults, but instead that young smokers might also smoke in order to cope with problems:

[Children smoke because] They have problems at home (Girl, Q, 1999).

Children smoke because if they're sad at home they might smoke (Sally Ellis, Q, 1999).

One girl described how for some children smoking might serve the same function as a friend. This is an interesting simile and its use in her discourse represents a tremendous empathy with smokers. Perhaps this was because she knew that smokers use cigarettes to provide reassurance and calming in the same way that they might turn to a friend for support. Cigarettes could also serve a friend-like function because smokers spend a lot of time with them, because they have had an association with tobacco for a long time, and because they feel that cigarettes are always there for them. It is striking that a young child could already appreciate this symbolic function that smoking has:

> [in response to picture of child smoking] She looks a bit down and maybe sometimes when you are down you need a lot of cigarettes, because it is like a sort of friend (Girl, I, 1999).

At age 9, some of the cohort also suggested that children might smoke when they were bored or had nothing else to do in the same way that they knew that adults used tobacco to structure their time:

> [Children] just want to smoke for something to do because they don't have nothing to do (Sally Lock, Q, 1999).

> Children smoke because they have nothing to do, because they will be bored of doing not even one simple thing. Might just be for fun (Boy, Q, 1999).

The children had a much greater awareness of the function of smoking as a coping strategy by age 11. In 2001, they were much more likely to suggest that children might smoke in order to cope in stressful situations. This suggests that as the children got older they became more aware of how adults use tobacco. It also suggests that many did not distinguish between patterns of smoking behaviour by children and by adults. In their talk, smoking was seen as having the same functions for children: in relieving depression and stress, and as a source of calm. As in the discourse around adult smoking, the cohort identified certain situations in which tobacco could help children to cope: in response to family conflict, to difficulties at school and out of school – perhaps a reference to conflict with friends. It offers an insight into the turbulence of preadolescence that while still at primary school, the cohort referred to children experiencing depression:

[Children smoke] to get rid of bad things (Clare Smith, Q, 2001).

They think that smoking gets rid of their problems at home, school or out of school (Lucy Morgan, Q, 2001).

It could calm children down after bad times (Olivia Dixon, Q, 2001).

I think some children smoke when their Mum or Dad might have had a fight and they might feel depressed or sad (Helen Baxendaren, Q, 2001).

They might be going through a tough time so smoking would help them out of their depression (Girl, Q, 2001).

Because they are having a hard time at home (Jodie Rencsil, Q, 2001).

They might have been stressed and took the example of their parents (Billie-Jo, Q, 2001).

However, although this was a prominent theme in their discourse, none of the cohort actually reported that they smoked in order to cope. It is also interesting to note that none of the children who lived in the more affluent districts mentioned that children would use tobacco as a coping strategy. This may be because smoking rates were lower among their parents, and so they were less aware that either adults or children would smoke in order to cope. If children in affluent areas use different discourses around smoking from children who live in more deprived areas, further research is needed to determine whether smoking has different functions for children during preadolescence on the basis of their socioeconomic status. If deprived children are more aware of and experience more social stress, how does this impact on patterns of smoking uptake?

By age 11, for the first time a small number of girls suggested that people might smoke in order to help them control their weight. This is a key development in the context of high smoking rates among teenage girls in the UK. It is fascinating that all of the children who mentioned this were girls, and particularly that most of the girls who mentioned this aspect of the habit lived in the more affluent postcodes:

[Adults smoke to] Help them lose weight (Alice Liddel, Q, 2001).

[Adults smoke] Because they think it keeps their weight down (Becky, Q, 2001).

[Adults smoke] So they won't go fat (Girl, Q, 2001).

People think that it slims you down but it doesn't really because it stops your taste buds from working so you don't feel like any food (Rebecca Williams, I, 2001).

As this study continues it will be interesting to consider why it was predominantly the affluent girls who talked about the role of smoking in controlling weight and where they had learned this. Again, it is striking that the children's discourses on the function of smoking varied according to the prosperity of the area in which they lived. As the study progresses into adolescence it will be interesting to see how these different perceived functions of smoking for young people are reflected in different patterns of smoking initiation.

6.4.5 Bullying

Other studies have found that smoking is related to perceived peer pressure (see section 1.5.2). The issue of peer influence is closely related to the issue of status and 'image' within the peer group. Some children described pressure to smoke from friends because smoking was seen to be associated with grown up or adult status. Some children reported being 'forced' to smoke by peers. There is a fine line between friendly persuasion and coercion, and the term 'forced' seemed to cover both of these meanings in children's accounts. While some children described receiving encouragement from friends to try smoking, others gave graphic accounts from their own experience of being taunted and physically bullied into smoking by older children they barely knew. It is therefore interesting to consider how children construct accounts of their early smoking experiences, particularly because smoking is an illicit behaviour for preadolescents. Many children were fearful that in future they would be bullied into smoking - especially at secondary school. Children were more likely to describe bullying and peer pressure in their drawings than through the other methods used, and this demonstrates the strength of using the triangulation of different methods to yield a holistic understanding of children's perspectives.
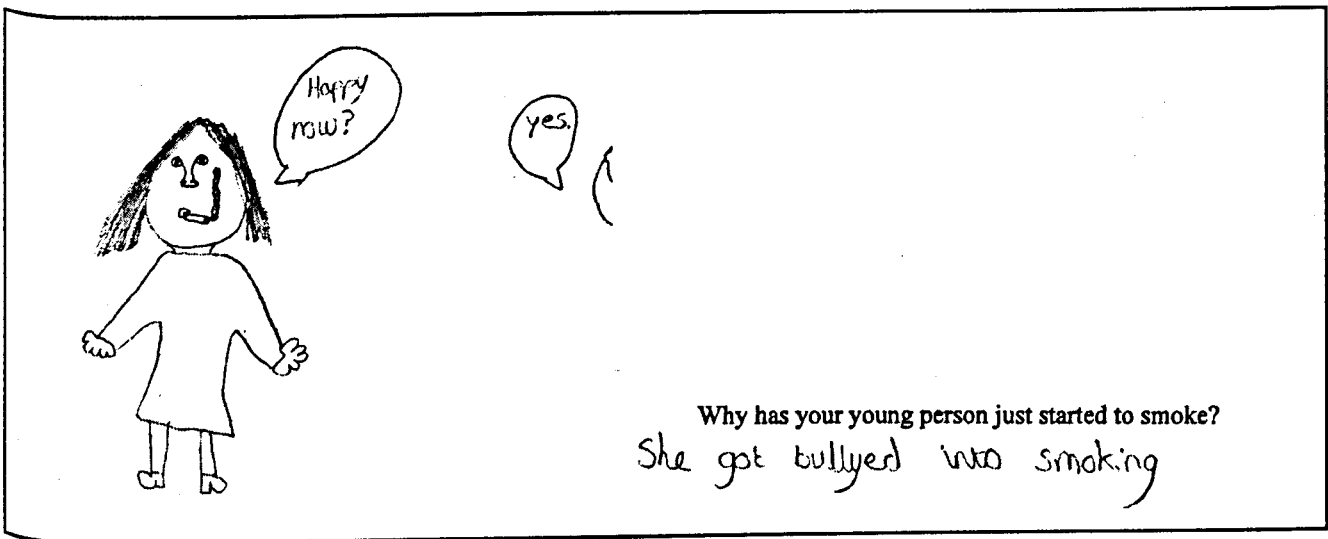
Figure 6.8: Betty Ann, DW, Box 4, 1999
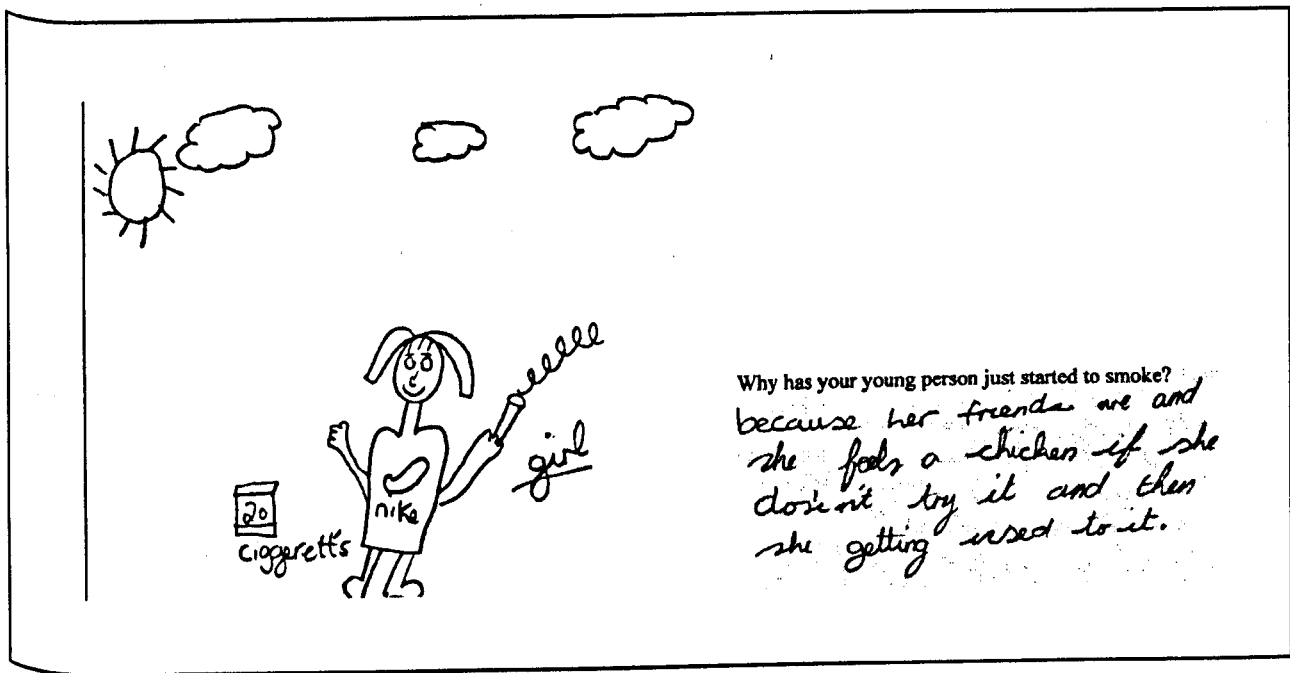
Figure 6.9: Hannah Clare, DW, Box 4, 2001

Why has your young person just started to smoke?

Her friends all smoke and said to her if she doesn't smoke they will beat her up so she did.

Girl

Figure 6.10: Olivia Dixon, DW, Box 4, 2001

girl
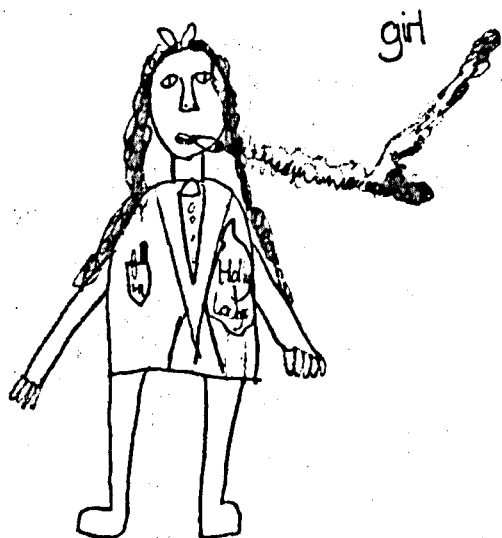
Why has your young person just started to smoke? *She has just started to smoke because her friends though she was a chicken so she bought some cigarettes.*

Figure 6.11: Paul Simson, DW, Box 4, 1999

At the ages of both 9 and 11, pressure from friends to smoke ranged from gentle persuasion to threats of exclusion from the friendship group. In Fitzy's account, he describes being 'forced' to smoke by his 'best friend'. The way in which he recalls his

experiences appears particularly contradictory. He suggests that he was being coerced into smoking to the extent that he had to run away, yet the person he was with was his best friend. Perhaps some of these accounts and talk appear to blend themes of friendship and of coercion because children deal with being encouraged to engage in a risky behaviour by denying their own agency in the situation. Alternatively, perhaps children used the word 'forced' to describe an unwelcome offer of a cigarette:

> They see their friends smoking it and maybe, you know, their friends have forced them. They say 'If you don't try a cigarette, then we won't be your friends' (Bruce, I, 1999).

> They are forced, bribed, people won't be their friends (Boy, Q, 1999).

> *Int*: Do you know any children who smoke?
> *Fitzy*: I know a mate of mine – my best friend. He smokes and sometimes he forces me to smoke. And I just get it and throw it on the floor and stamp it out and run away.
> *Int*: So even though your best friend smokes, it doesn't make you want to try smoking?
> *Fitzy*: He's forcing me...
> *Int*: Why do you think he wants you to smoke?
> *Fitzy*: Because he wants me to be like him.
> *Int*: Have you ever wanted to try smoking?
> *Fitzy*: No. I hate smoke! (I, 1999)

> Maybe their friends make them do it because they could say 'Have it or I am going to batter you' (Kirsty Dane, Q, 2001).

> Some children smoke because they are forced to smoke by gangs (Emma Spencer, Q, 2001).

Children who smoked were viewed as tough because they were engaging in an adult behaviour (see section 6.5), therefore young smokers occupied a high status in the peer group. Because early smoking was seen as unpleasant, children who could manage to smoke were seen as brave. This meant that smokers were seen as smoking to 'show off'. More importantly, non-smoking children often feared that the smokers would try and exercise power over them, and this reflects the findings of the case study analysis. In preadolescent culture, cigarette use was symbolic for some children of the exercise of power:

They think they're all good and they think that when they're walking down the street no-one's going to say nothing to them, and they're going to be scared of them and that for smoking (Andrew Woods, I, 1999).

[Children smoke] So they think they can bully other children (Annie-May Smith, Q, 2001).

Young smokers were also seen as rebellious, independent and autonomous because they were engaging in a forbidden behaviour, frequently without the knowledge of their parents. Some children suggested that young people might smoke in order to deliberately annoy their parents:

They think they're boss and hard just because they smoke, and their Mum doesn't know, and their mates aren't allowed to. But they still think they're boss of the street (Jennifer Alan, Q, 1999).

They think it is funny and exciting and annoys their Mum (Tiffany, Q, 1999).

Bruce: You get attention from it.
Int: How do you mean 'you get attention from it'?
Bruce: Kids know that it's naughty and dangerous and they want to follow that and look brave (I, 2001).

The examples of discourse presented above have shown that some children were worried that they would be physically forced into smoking. Other children also moved beyond discourse to give examples of the threat of physical violence from smoking bullies from their own experience. Fred Flint's account in particular shows that children were bullied by older children who smoked:

Fred Flint: I have been threatened to take a ciggie.
Int: Who threatened you?
Fred: These lads out of [name of secondary school], they robbed my bike and threw it in the canal. He said 'Take this ciggie and smoke it while we watch you or we will hang you over the bridge' because I live by a bridge. And they went to do it to me. And the police came down because my brother Gary has got a mobile phone and he was watching them.
Int: So why were they threatening to make you smoke?
Fred: Because they wanted to do something because I swore at one of them because they hit my sister (FG, 1999).

Int: Have you ever wanted to try smoking?
Clare Smith: I have once. I felt sick. I tried because this lad forced me when I was about 9, I think. And then I was with one of my friends – this friend in York – and he did the same to me. He held my nose so I'd have to open my mouth.
Int: So how many times has he made you smoke?
Clare: Twice.
Int: Was it the same lad both times?
Clare: Yes.
Int: And what did he do? He held your nose?
Clare: Yes. So I had to open my mouth.
Int: So why did he want you to smoke? Why was he forcing you to smoke?
Clare: He'd just do it for the fun of it and just to see if I would want to smoke and that.
Int: So where were you when this was happening?
Clare: Outside. I was in a park.
Int: And did you tell your Mum or anybody what had happened?
Clare: No (I, 2001).

At age 9 (and to a lesser extent at age 11), children were particularly concerned about name calling from peers who wanted to ridicule them into experimenting with cigarettes. Because smoking was associated with toughness, children who refused to try smoking were worried that they would be labelled as a chicken or a wimp:

> Their mates call them a bottler or a chicken (Girl, Q, 1999).

> Their friends call them a wimp and a chicken and bully them (Sarah Blanchard, Q, 1999).

> Some people might dare them. Call them names if they don't. Bully them (Lucy Morgan, Q, 1999).

> [Children] think it's cool and their friends say 'Go on, have a try'. And if you don't, they call you a chicken (Tiffany F, Q, 2001).

As the data demonstrate, the same themes reoccurred each year in the cohort's discourse around smoking onset. However, whereas at age 9 children were more likely to attribute smoking uptake to the influence of parents, by age 11 children were more likely to see the smoking behaviour of friends as the key determinant of smoking behaviour. This change represents a key shift in the cohort's perspectives on smoking and is reflected in higher rates of experimentation with cigarettes by age 11. It is interesting to consider

how the discourses which the cohort used to talk about smoking uptake were reflected in their understanding of the way adults used tobacco (particularly as a coping strategy). It is also important to consider how discourses (for example, around bullying) were reflected in actual personal experience or whether they were used to sustain the symbolic function that smoking has for preadolescents in conveying adult status. The chapter now turns to this theme of smoking as an adult behaviour.

6.5 Smoking as an Adult Behaviour

6.5.1 Preadolescent Discourses on Smoking as an Adult Behaviour

The continuation of the LLSS during preadolescence provided an opportunity to explore a finding from the original research that many children hold the view that smoking is bad for children but acceptable for adults (Porcellato, 1998). In the interviews, the children – who were all aware that smoking poses risks to health – were asked whether smoking was worse for adults or worse for children. The vast majority of the sample agreed that smoking was worse for children, and the responses to this question yielded some useful insights into the way preadolescents construct smoking as an adult behaviour.

Firstly, in the context of knowledge about the potential health consequences of smoking, many of the children argued that smoking was more acceptable for adults because they had already lived their lives. These children argued that because adults are already 'old' any disease (or even death) related to smoking, was not such a 'waste of life'. By the time people had reached adulthood, they were seen as having had 'a good life'. This discourse was most prominent in the children's talk at age 9:

> Adults smoke because they are older than children (Boy, Q, 1999).

> When you get older it is still not right to smoke, but it is in a way because you have had the rest of your life and if they die they have still had some sort of a life. And for young people, they are just making themselves sick and all that, and they have still got the rest of their life to go (Betty Willson, I, 1999).

At least if you are an adult and you start smoking about 30, that is probably a good time to start because at least you have lived 30 years of your life (Bill Bobby, I, 1999).

It's worse for children because they're younger and, you know, they're just risking their life. If you're an adult, you've had a proper life (Melinda, I, 1999).

Int: Do your Mum and Dad know that you've tried smoking?
Fitzy: Yes. They've found out. Eventually I told my Mum.
Int: And what did she say when you told her?
Fitzy: She just said 'Don't try it again'. Gave me a bit of a warning. Told me all the things that could happen.
Int: So why is it OK for your Mum to smoke, but she doesn't want you to smoke?
Fitzy: Because she hasn't got long to live. We've got a life to live.
Int: So why is it OK to smoke when you're an adult?
Fitzy: You haven't got long to live! (I, 2001).

Secondly, at the age of both 9 and 11, many of the cohort also argued that smoking was more acceptable for adults because they had bigger bodies than children. The vast majority of the children knew that early smoking was difficult to cope with, and they concluded that adults were physically better able to cope with inhaling the smoke because they had bigger lungs. This discourse was widely used throughout preadolescence:

I think that adults smoke because they are bigger (Margaret Jackson, Q, 1999).

Adults might have larger arteries, so it might take less time for the children to get blocked up (Penny Milton, I, 1999).

[Children] are only young and your heart's not as big as a grown up's (Pete de Mar, I, 2001).

[Children's] lungs and hearts are not as strong as adults' (Andrew Woods, I, 2001).

[Children] are too young and their lungs are smaller than grown ups and their lungs will fill up faster than the grown ups' (Margaret King, I, 2001).

This belief about the relationship between physical size and ability to smoke was reinforced by knowledge about the dangers of smoking for health. On the basis of these beliefs, at age 9 some preadolescents had concluded that smoking might prove

immediately hazardous to children's health, and this strengthened the view among the majority that smoking was only acceptable for adults:

> Because they're only little and they could get lung disease and they might die. But with grown ups, they mightn't die that easily because they've been smoking for a long time and they might not go into hospital and die (Maggie Magrath, I, 1999).

> Because they can catch a cough easily and they can just die in seconds because the smoke – it's bad (Fitzy, I, 1999).

> They only have little lungs and the smoke can go in their lungs easily and kill them (Girl, I, 1999).

> If they were under 5 they could die (Becky Jordan, Q, 1999).

> It can kill kids under age (Leanne Shaw, Q, 1999).

> *Int*: Why is smoking bad for children?
> *Girl*: Because we're not proper people, grown up yet.
> *Megan Smith*: And it can kill us. Straight away.
> *Jessie Crown*: And we've got little lungs and the grown ups have big lungs (FG, 1999).

However by age 11, when over a quarter of the cohort had tried smoking, and many children had friends who smoked, none of the children suggested that smoking might prove immediately hazardous. Instead, as puberty approached, some of the cohort were concerned that smoking might stunt their physical development:

> *Int:* Why is smoking bad for children?
> *Rebecca Williams:* Because their bodies are growing up and it interferes with the body growing up (I, 2001).

Lastly, because all the children knew that smoking was dangerous to health, some of the cohort argued that adults were the only ones who were sufficiently responsible to make such an important decision as to whether or not to take up smoking. These children argued that adults had the necessary education and years of life experience to enable them to make an informed choice about tobacco use:

> Adults know more things than children because they have more education, they've been through that level (Bruce, I, 1999).

Because [adults] are old enough for the responsibility and it's your fault if you are knocking twenty years off your life (Pete de Mar, I, 1999).

They know what they are doing (Philip Flack, Q, 1999).

Int: [shows pictures of children smoking] How old are the children in these pictures?
Tom Murray: 12 years old.
Int: Do you think they're old enough to smoke?
Tom: No.
Int: Why aren't they old enough to smoke?
Tom: Because they're not responsible enough yet to smoke.
Int: Why do you have to be responsible to smoke?
Tom: Because you need to know all the effects of smoking before (I, 2001).

Because many of the children knew that early smoking was unpleasant and difficult to master, at age 9 some also suggested that adults could smoke because they knew how to do it 'properly':

Children don't really know how to do it properly like adults (Michelle Whittingham, I, 1999).

Adults can smoke because they are older than us and they know how to handle cigarettes (Joseph Michaelson, Q, 1999).

However, by age 11, when many of the cohort had tried smoking and a few were beginning to smoke regularly, this discourse was not used. Perhaps this was because it was clear that children could also master smoking, and adults were not the only ones who could 'smoke properly'.

As the data above show, at age 11 many children continued to offer explanations of why smoking was associated with adulthood, particularly that adults could smoke because their bodies were bigger and stronger. However, among a few children there was a growing realisation that adults' bodies are unable to cope with the smoke too:

Children say they can handle it, but my Grandad died. He was about 55 when he died. And he was older than them and he couldn't handle it. So

children are definitely not going to be able to handle it (Billy Bob, I, 2001).

Because smoking was socially constructed as an adult behaviour by the preadolescents who participated in this study, at age 9 the cohort suggested that some children took up smoking as a means to demonstrate that they were grown up too. This suggests that the discourses held by preadolescents affect smoking initiation because smoking has a symbolic function in representing adult status. In this way, children may smoke to convey to their peers that they are mature and also so that they could exercise power over other children. Smoking was also used to represent autonomy:

They think they are adults and big boys (Pete de Mar, Q, 1999).

Children smoke because they like to feel grown-up (Lucy Smith, Q, 1999).

They think they're all brassy and cooler than other people (Girl, I, 1999).

Rebecca Williams: They see older people smoking and they think it makes them look good and older.
Int: So why does it make them look older?
Rebecca: Because they think 'Oh well, they must have been able to get them from the shop, so they must be old' (I, 1999).

They think they're brave in front of other children (Boy, Q, 1999).

They might think they're smart probably being the only kid in school who smokes (Mick Smith, Q, 1999).

They want to show off to their mates. They think they're big toughies (Boy, Q, 1999).

They think they're hard because their Mums and Dads smoke. So they think they will be Mums and Dads (Helen Baxendaren, Q, 1999).

They think they're like an adult themselves (Bruce Willas, Q, 1999).

Kayleigh Rudge: Because they smoke, they think they are adults.
Int: Why do people think they are adults? Why do children want to be like adults?
Girl 1: So they can boss other children around and they think they can play with whoever they want.
Kayleigh: They just want to do adults' things.
Int: Why do they want to do adults' things?

Girl 1: They want to be big and all that.
Girl 2: Because their adults might do it and they might want to do the things that their adults do.
Girl 3: Their Mum smokes, maybe the Dad smokes, maybe the brother smokes and the sister smokes so they smoke.
Girl 4: Because they might be left out (FG, 1999).

Fred Flint: Kids who smoke think they are big because they are smoking.
Int: Why do kids think it is big to smoke?
Fred: Because adults do it.
Piers de Mar: Kids who smoke think that they can be adults as well.
Int: So why do people want to be adults like that?
Piers: Because they can do whatever they want. Adults can do more things than kids (FG, 1999).

At age 11, many children continued to suggest that young people smoked in order to feel grown up. This shows that many of the cohort had a forward-oriented, developmental focus. Instead of being satisfied with their present age, many were keen to appear grown up and older than their chronological age. Some of the children suggested that this was because while children were restricted in the kind of activities they could engage in, older people could do whatever they chose:

> They think they're bigger when they smoke (Kerry Louise Brown, Q, 2001).

> [Children smoke] To act big. To be brave. To impress (Mark Jenger, Q, 2001).

> They might think and feel that they are grown up. They might feel important (Lisa Elliot, Q, 2001).

> When you smoke it makes you feel boss about yourself (Emily Mask, Q, 2001).

> [Children smoke] To try and be a grown up quicker (Jill Garden, Q, 2001).

> Some children smoke because they see adults doing it and so they want to be an adult so they smoke (Alan P, Q, 2001).

Int: [shows picture of children smoking] Why do you think those children are smoking?
Billy Bob: To make them look hard.
Int: Why does smoking make them look hard?

Billy Bob: Because adults do it and they think they're privileged as adults.
Int: What do you mean when you say 'privileged as adults'?
Billy Bob: Like they can do what adults can do and think they're better at it (I, 2001).

Ellie Gordon: They want to look good in front of their friends.
Int: Why would smoking make them look good in front of their friends?
Ellie: Because it's a big thing to smoke.
Int: What do you mean when you say 'it's a big thing'?
Ellie: Because you're brave from doing it because you could die (I, 2001).

6.5.2   Children, Smoking and the Law

As the section above shows, the cohort clearly associated smoking with adulthood and by age 11, 27% had tried smoking. Surprisingly, however, throughout preadolescence many did not know that the law only permits shopkeepers to sell tobacco to people over 16 years of age. Because smoking is a habit that children associate with adulthood, every child knew that there was a minimum age of purchase for tobacco products. Furthermore, every child knew that they were currently too young to buy cigarettes. However, even at the age of 11 there were few children who knew categorically that cigarettes could only be sold to people over the age of 16. Instead, many children guessed that cigarettes could be bought from a shop at either 16 or 18 years of age. Perhaps this was because the legal boundaries between adulthood and childhood are blurred in the UK, and people gain some responsibilities at 16 (for example, tobacco purchase and the age of consent) while others are not achieved until 18 (for example, voting and alcohol purchase):

> *Betty Willson*: You have got to be over 16 to smoke, but I don't think you should smoke anyway.
> *Int*: Why have you got to be over 16 to smoke?
> *Betty*: They just say it in the shop (I, 1999).

> *Girl*: There is an age when you can start smoking and it's at 16. When you go into pubs at 16 and you buy a pack of ciggies and your boyfriend's 18 and you get a lager or something. You'd like one but they don't know how old you are, because you've got to start drinking when you're 18.
> *Kerry Ann Burns*: I think that you should be able to start smoking when you're 18, like you can start going to driving lessons when you're 18, and

start drinking alcohol when you're 18. I think you should start smoking when you're 18 (FG, 1999).

Max S.: It's either 16 or 18 in England.
Andrew Woods: You've got to be 18 or over because they've worked it out, scientists, that you've got to be over 18. Because they've tried it on someone younger than 18 who got asthma, and when you're under 18 you're most likely to get asthma, but when you're over 18 you're not (FG, 1999).

Int: The children in these pictures, they're 12, aren't they?
Jenny Hill: Yes.
Int: Do you think they're old enough to smoke?
Jenny: No.
Int: Why aren't they old enough to smoke?
Jenny: Because in the shop it says on a big sign 'No tobacco is meant to be sold to people under 18' (I, 2001).

Children under 16 shouldn't be smoking. It is against the law. I am disgusted (Lucy Morgan, Q, 2001).

Int: Why aren't the children in the picture old enough to smoke?
Pete de Mar: Because on the box of cigarettes it says you've got to be, on some that aren't very strong, 16. And on the very strong ones, 18.
Int: So you need to be 16 to smoke the milder ones and 18 for the stronger ones?
Pete: Yes.
Int: So is there an age when it's OK to buy cigarettes in a shop?
Pete: Yes, 16 and 18 (I, 2001).

Perhaps there was also confusion around the minimum age of purchase because some of the cohort were aware that the legal age was blurred in practice, and that younger children were sometimes able to buy cigarettes either from shops or from people selling smuggled tobacco:

Jenny Hill: In shops it says it's illegal to sell tobacco to children under 18.
Lucy Morgan: As Jenny said, it says you've got to be 18, but some shops sell them to anyone just as long as they get the money.
Int: Do you know any shops like that?
Girl: I do, across the road from me (FG, 1999).

Int: What age have you got to be to smoke?
Lee Pu: 16 or over.
Int: Why have you got to be 16?

> *Lee:* Well, you can smoke when you're 16 because that's when you can start getting served in the shops. But [these children in the picture], they're smoking when they're 12, and yet you can't even get served in the shop.
> *Int:* So where do you think these kids get their cigarettes from when they can't even get served in the shop?
> *Lee:* They get someone to go into the shops or somebody will get ciggies from abroad and sell them.
> *Int:* So the person who gets ciggies from abroad, where would they sell them?
> *Lee:* At their home, or in the pub, or they'll be walking down the street selling them (I, 2001).

Because the children knew that smoking was an adult behaviour, for some smoking was a symbol of the transition from childhood into adulthood associated with leaving school and getting a job. Perhaps getting a job was also associated with autonomy from the control of parents and teachers and with (financial) independence:

> *Int*: [showing a picture of 12-year-olds smoking] Do you think they are old enough to smoke?
> *Rebecca Williams*: No, because they are only still in school (I, 1999).

> If I wanted to smoke, I would smoke when I had a job or something. But I don't want to smoke (Julie Kelly, I, 1999).

> 16 or 18. I know it's around that age. All things like getting a tattoo and drinking. It's all around leaving school because that's when you become an adult (Girl, I, 2001).

> You're only allowed to start when you're 18, because then you're like an adult – you can do what you want then really. These children [in the picture] are only 12. They should be living with their parents (Julie Kelly, I, 2001).

6.6 Addiction

6.6.1 Understanding of Addiction and the Cessation Process

Although other research has demonstrated that adolescents know that cigarettes are addictive (Goldman and Glantz, 1998), there has been little research into how children's understanding of the addiction process develops during preadolescence (Rugkåsa *et al,*

2001a). Because many of the children had parents who were current or former smokers, they were able to describe their parents' cessation attempts and the understanding this had given them of the addiction process. All the case study children knew in principle from age 9 that cigarettes are addictive and that this inhibits cessation among smokers, and they began to use the tem 'addiction' from age 10 onwards.

As with the case studies, at age 9 all the children in the cohort knew that it is difficult for adults to quit smoking. Many children explained that adults they knew had begun to smoke as children and were now unable to quit. However, few children used the word 'nicotine', and only a small minority used the word 'addiction'. Some knew that adults smoked because they were 'used to it' or because smoking was a habit:

> I think adults smoke because they can get addicted. My Mum says she smokes because she gets addicted (Max P, Q, 1999).

> Adults smoke because in the cigarette there is a kind of little drug and it makes them smoke. The little drug tastes nice (Lisa Elliot, Q, 1999).

> My family smoke because when they smoke they can't quit because they are used to it (Sarah Huch, Q, 1999).

> They tried it when they were children and they could not stop smoking (Emily Mask, Q, 1999).

> It's just a habit and it's dead hard to stop a habit (Billy Bob, Q, 1999).

> Adults smoke because in the cigarette there's a little drug and it makes the person get addicted to smoking when they first try smoking (Jessie Crown, Q, 1999).

> They smoke because nicotine is addictive (Alan P., Q, 1999).

> If you have been doing it for a long time you are sort of used to smoking and you have sort of got the habit of smoking (Julie Kelly, I, 1999).

At age 9, some of the children who were not smoking regularly could still offer an empathetic understanding of what it means to be addicted. Why are some children who do not smoke able to offer such an insight into addiction? In the same way that Chima described addiction in terms of the loss associated with giving up a favourite doll or toy

in section 5.8.1, these children used metaphors to describe the process using examples from their own experience. They compared smoking with their own pleasures and habits, such as chewing gum and eating sweets. One girl likened the loss associated with giving up smoking to that of losing a parent. This is an interesting analogy that conveys her understanding of the extreme sense of loss associated with giving up tobacco (which she compares to a familial bereavement), and also the dependency that smokers have on nicotine (because children are essentially dependent on their parents):

> When you have attached to it for a few years or for ages you stay to it like chewy. Like you have to take chewy everywhere if you like it (Pete de Mar, I, 1999).

> I believe that it is hard to stop because it is a very bad habit. Say I had to stop eating sweets or things with sugar in or I have got to drink water all the time and not drink anything else, that would be quite hard... Because you have got used to it and it is like taking something away that you have had for ages. Like say someone took your parents away, but not as bad as that (Girl, I, 1999).

However, as with the case studies, by age 11 the term 'addiction' was widely used and understood by the majority of the cohort:

> [Adults smoke because] When they were children they wanted to impress other people and now they are just addicted to it (Amy Woods, Q, 2001).

> They are addicted to the nicotine (Sarah Mathers, Q, 2001).

> *Int*: [shows pictures of adults smoking] Why do you think those adults are smoking?
> *Becky Sullivan*: Because they're addicted to it.
> *Int*: Why are they addicted to it? Why is smoking addictive?
> *Becky*: Because of the nicotine inside them (I, 2001).

> *Clare Smith*: [in response to pictures of adults smoking] They might be addicted to them and they might just not want to stop.
> *Int*: Why wouldn't they want to stop, do you think?
> *Clare*: They might just like having cigarettes and that.
> *Int*: What does it mean to be addicted to them?
> *Clare*: You've got to have them sometimes.
> *Int*: Do you know why cigarettes are addictive?
> *Clare*: Is it because of the nicotine?
> *Int*: That's it. What's nicotine?

Clare: A drug (I, 2001).

6.6.2 *Addiction and Smoking Uptake*

The previous section showed that by age 9 all the children understood that smoking is addictive, and by age 11 many were using the term 'addiction'. But how does children's knowledge of addiction affect their decision to experiment with cigarettes? As the cohort's understanding of addiction developed during preadolescence, by age 11 some children explained that the fear of becoming addicted to cigarettes deterred them from trying smoking:

> Everyone says one smoke gets you addicted (Rebecca Williams, Q, 2001).
>
> I don't want to get addicted to smoking (Josie Bloggs, Q, 2001).
>
> You could get addicted and never stop (Ellie Gordon, Q, 2001).
>
> You will be addicted to something that will kill you (Carl Corry, Q, 2001).
>
> If I smoke I could get addicted to them and may die (Jade Butler, Q, 2001).

Children may have been reluctant to try smoking in case they got addicted because at age 11, some children presumed that smokers could become addicted to cigarettes very quickly:

> *Int*: So how long do you think it takes after you start to get addicted?
> *Boy*: About a week (FG, 2001).

However, by the end of the study, some of the children who were smoking regularly suggested that they were addicted, perhaps because nicotine dependency was associated with adult regular smoking. Although it is most unlikely that these boys were addicted to nicotine if they were only smoking a couple of cigarettes each week, they were keen to communicate that they were dependent on tobacco:

> *Int*: You lads who smoke, would you say that you are addicted or not addicted?
> *Boy 1*: When you're in school because you can't have a ciggy, you're gasping.

Boy 2: Because we only have a couple a week, I would say Yes, in a kind of way. If we don't have any all week you go all dizzy (FG, 2001).

6.7   Smoking and Health

6.7.1   Experiences of Smoking-Related Disease

As the pilot study showed (see section 3.8), the health consequences of smoking were a key concern for preadolescents. Every child in the cohort had a good knowledge of the risks smoking poses to health, and many children spontaneously mentioned each year throughout the fieldwork that they knew someone who had been ill because of smoking. In this way, children's knowledge about the effects of smoking on the body was reinforced by their experiences of smoking-related disease in their families and communities. As the children got older, they were more likely to know someone who had been ill because of smoking (43%, 1999; 46%, 2000; 52%, 2001).

Figure 6.12: People with smoking-related disease
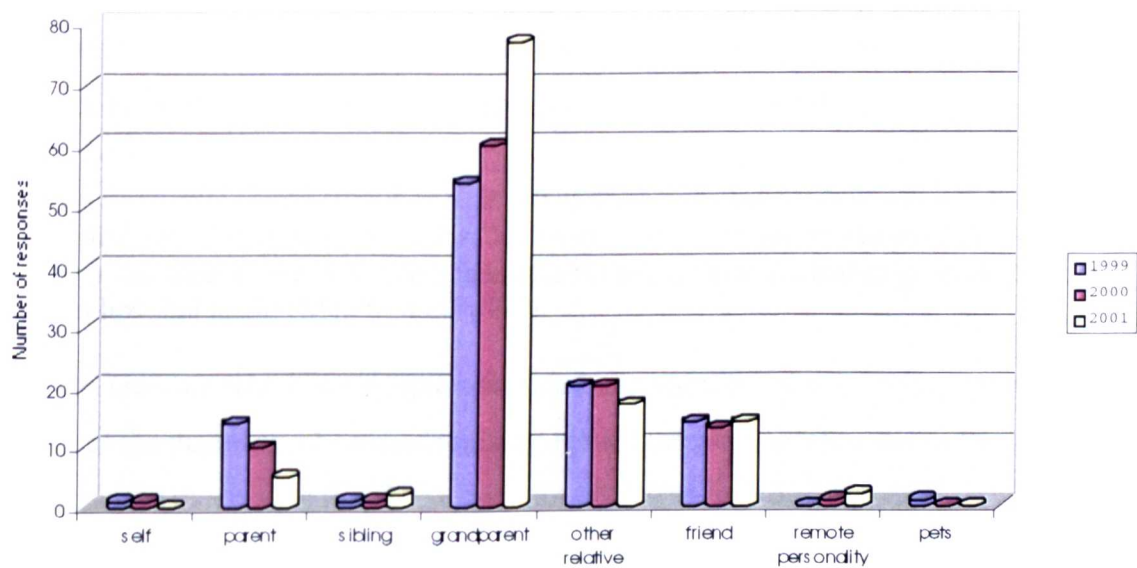
Some children reported that passive smoking had affected their own health by triggering asthma (see Appendix L for a discussion of the children's experiences of passive smoking and the effect of passive smoking on smoking uptake). However, the majority

of children who knew someone with smoking-related disease mentioned a grandparent or another relative (Figure 6.12). Some children described 'minor' ill effects on health such as coughing and lack of breath, whereas others reported knowing people with serious diseases such as cancer, emphysema and coronary heart disease (Figure 6.13).

Figure 6.13: Types of smoking-related disease described by the children
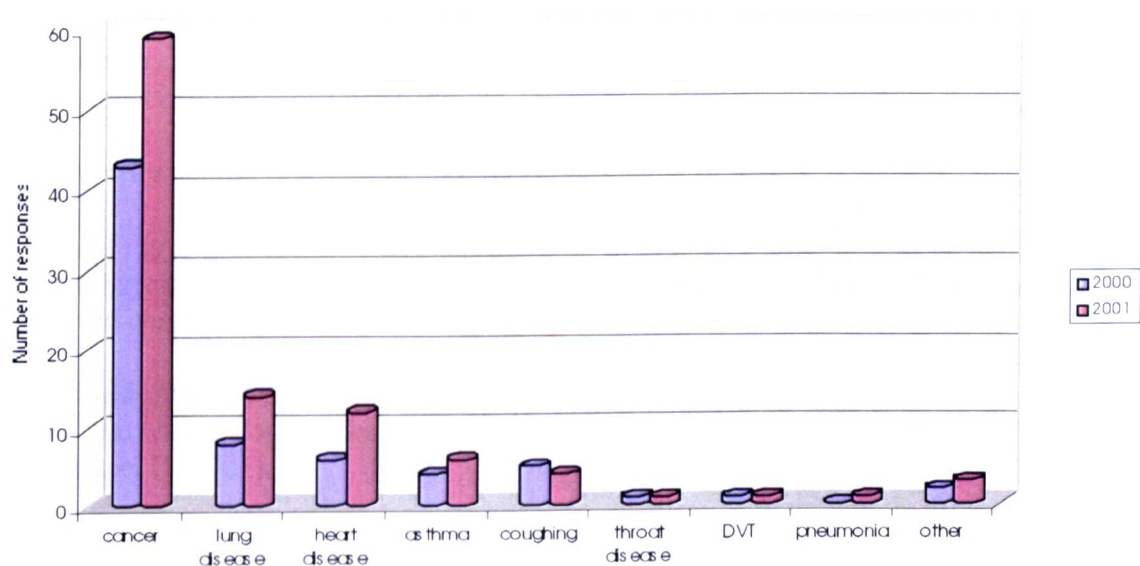
In the interviews and focus groups, many children talked unprompted about the experiences of people they knew who had been ill because of smoking:

> I do know that if you smoke you do get cancer. Because my Nan smoked a lot and she's been into hospital with cancer. She had to go for chemo but she's finished it. But now she's feeling a bit worse so she's had to go back into hospital again (Max S., FG, 1999).

Many of the children who knew people who smoked understood that smokers respond differently to the diagnosis of serious smoking-related disease. While some of the children reported that people they knew had quit on diagnosis, other reported bewilderment that some patients continued to smoke:

> My aunty: she was told she could lose her legs and she still smokes. And my Nan and Grandad died of smoking because they had cancer (Ellie Gordon, Q, 1999).

It was very clear from the children's accounts that some of the cohort had been deeply affected by their experiences of smoking-related disease among family members. Although the children were never asked about deaths from smoking-related causes, each year many children spontaneously mentioned that someone they knew had died from smoking:

> It was my Grandad who had cancer and died (Max P, Q, 1999).

> It was my Nan and she had cancer and smoking was not helping her with her cancer so she died (Amy Woods, Q, 1999).

> It was my auntie. She died in 1997 (Leanne Shaw, Q, 1999).

> It was my uncle. He used to smoke and he got lung cancer. He was ill for months and one day he was sitting down on his couch. I found out the next day he was dead (Paul Simson, Q, 1999).

> It could give you cancer and I don't want that because my Nan has had it and she was in hospital for ages. And she died. She was 69 years old (Toni Crosbie, Q, 2001).

Because the children had a good knowledge of smoking-related disease, some also worried that their parents and other relatives who smoked might become ill in future:

> I think it is horrible because people get sick and I hate my Mum and Dad smoking in case they get sick (Ellie-May Campbell, Q, 1999).

> I don't like smoking and don't like other people smoking like my Grandad because they could die (Rachel Kenfield, Q, 1999).

> I hate smoking. I have to put up with my Grandad smoking. I get really scared that something might happen to him (Melanie, Q, 1999).

> My father was ill because he smoked. I still think he might [have] a heart attack because he always smoked (Boy, Q, 1999).

> I feel scared in case something happens to my parents and I don't want them to die because of cigarettes because they might get lung cancer (Shauna Mally, Q, 2001).

6.7.2 Children as Agents of Health Promotion

Although the ways in which parental behaviour and attitudes influence children's smoking uptake have been widely documented (see section 1.5.1), there has been very little research into the impact that children have on parental beliefs and behaviour. Nevertheless, the scant evidence that is available shows that children are not afraid to tackle their parents about their smoking behaviour (Wilcox *et al*, 1981).

All the children who participated in this study were aware from age 9 that smoking harms health. Another study has found that preadolescents are aware of and are able to evaluate the risks that smoking poses to their parents' health (Riche and Thelen, 1990). On the basis of this knowledge, many of them took steps to give health and cessation advice to friends and family who smoked. However, although a few parents did give up smoking, many children reported disillusionment that their parents continued to smoke:

> *Int*: Who have you asked not to smoke?
> *Pete de Mar*: My Nan. Last year I said to my Nans, Grandads and my Mum and some of my aunties and one of my uncles. I said 'Don't give me nothing for Christmas, just stop smoking. That will be the best Christmas present ever'.
> *Int*: And that was last Christmas, was it?
> *Pete*: Yes. And they never... I always say to my Grandad 'Why can't you stop smoking?' And I always say 'I am going to break your cigarettes now'. And he says 'Break them and you will have to go and buy some more with your own money' (I, 1999).

> *Fitzy*: I've asked my family not to smoke.
> *Int*: And what did they say?
> *Fitzy*: They said 'I'll try not to smoke' and they do try, but they just can't. I say it to my Grandad and he still carries on smoking (I, 1999).

> *Megan Smith*: My Dad – I keep telling him to stop it and he says 'I'm going to pack in after this box' and then he buys another box! And I say 'Dad I thought you said you were packing in?' And he says 'It's just this other box'. And he gets more and he keeps on saying it. Again and again and again.
> *Int*: Sarah?
> *Sarah Huch*: I told my Dad and my Mum but my Mum goes 'Get my ciggies!' and I say 'No, I'm not getting your ciggies. And she's like that

'Get my ciggies now!' Because she can't go upstairs because she's got something wrong with her hips so I go upstairs to the bedroom [to fetch her cigarettes] (FG, 1999).

I've asked my Mum and my Nan because my Nan could die because she's got emphysema. And she had a heart attack... My Nan said she was going to try and pack up for Christmas for me, but she's tried before and she said it's really, really hard. She said she will for me. And I said it would be a lovely Christmas present for me (Jenny Hill, FG, 1999).

Int: Have you ever asked someone not to smoke?
Girl: Yes.
Int: Who have you asked?
Girl: My Mum. We've been talking about quitting and she says it's hard and you can't just ask someone to do it. It's not like giving up chocolate, it's much harder (I, 2001).

Int: Have you ever asked somebody not to smoke?
Carl Tanner: Yes.
Int: Who have you asked not to smoke?
Carl: My Nana and Grandad.
Int: And what did they say when you asked them?
Carl: They said 'We can't help it, it's addictive'. They said they're going to try and cut down but they just can't. It's very hard (I, 2001).

Research has found that having children is associated with smoking cessation in parents in both deprived and well-off families. Parents may be motivated to quit in order to protect their children from passive smoke, to present a positive non-smoking role model, to save money and as a result of direct pressure from their children (Jarvis, 1996). Some children even reported that their parents actively enlisted their help in making cessation attempts:

[My Mum] said every time me and my big brother, every time she tried to go for a ciggy, just say 'No' and take them away from her (Andrew Woods, I, 1999).

As the analysis presented in Appendix L shows, many of the cohort had a good understanding of the risks passive smoking poses to health. They also reported that being exposed to ETS affected their sense of well-being. Therefore, children who spent time in smoky environments reported taking steps to protect their own health from passive

smoking either by moving away or by asking the smoker (usually a family member) not to smoke near them:

> Smoking is horrible. When my Mum and Dad smoke in the living room I go into the next room and play on my computer (Billy Hatter, Q, 1999).

> Sometimes if it's too smoky I just say 'Mum, it's too smoky in here, I'm going up on my computer to get away from the smoke'. She goes 'Alright lad, you can go' (Fitzy, I, 1999).

> *Int*: Who have you asked not to smoke?
> *Betty Willson*: My Nan and aunties and uncles because we all, the kids, are sometimes in the living room and we are coughing and all that and when we come home all our clothes stink of smoke (I, 1999).

> *Girl*: Sometimes my Dad smokes in the car and I go 'Dad can you please stop smoking? It's going in my face'.
> *Int*: What does he say?
> *Girl*: He goes OK. He has got like a little ashtray in his car and he puts it out (I, 1999).

> *Int:* Is it smoky at your house, because your Mum smokes – doesn't she?
> *Rebecca Williams:* She doesn't smoke in front of me really. She usually goes in the yard and smokes out there, or in the kitchen.
> *Int:* Why does she go out there to smoke?
> *Rebecca:* Because I've told her that I don't like it so she goes out there (I, 2001).

> *Int:* Have you ever asked somebody not to smoke?
> *Betty Willson:* Yes.
> *Int*: Who have you asked?
> *Betty:* My Dad's mate. We were having our dinner and he lit a cigarette and I said to him 'Go outside with that'.
> *Int:* What did he say?
> *Betty:* He went 'Oh, alright'. And he just walked outside (I, 2001).

6.8   Conclusions

Chapter 6 has explored and developed the 'petite generalisations' (Stake, 1995) that emerged from the case study analysis presented in Chapter 5, in the context of quantitative and qualitative data generated by the wider cohort. Although it is not possible to generalise from the experiences of just five case study children, the findings

that emerge from the cohort analysis can usefully be applied to the experiences of other preadolescents in Liverpool.

Although three of the case study children tried smoking for the first time at age 11, a study of the smoking behaviour of the whole cohort revealed that some children try smoking at a very early age – perhaps even before they begin school. The data also revealed that rates of experimentation with cigarettes increased over time (from 8% at age 9 to 27% at age 11). Whereas the children who participated in the case studies had only tried smoking once, some of the other children in the cohort had gone on to try smoking repeatedly. Analysis of the children's perceptions of their early smoking experiences suggested that many of the triers continued to persist with acquiring the smoking habit despite reporting that they had not enjoyed their first trial. This suggests that preadolescents smoke not for enjoyment, but in response to a number of social pressures.

Cross-sectional analysis found that experimentation with cigarettes during preadolescence was socially patterned by familial smoking, peer smoking and by socioeconomic status. Analysis of the data using logistic regression to create a model of predictors of trying smoking during preadolescence suggested that paternal and fraternal smoking, best friend's smoking and knowing someone with smoking related disease at age 9 predicted experimentation with cigarettes by age 11. Being male was also a significant predictor of smoking uptake. However, the logistic regression analysis showed that expressing an intention to smoke at age 9 was not a useful predictor of smoking behaviour during preadolescence. This confirmed the finding from the qualitative case study analysis that suggested that intentions were limited in their usefulness to predict smoking uptake.

In addition to considering the determinants of smoking behaviour, Chapter 6 examined the discourses that the children used to talk about smoking onset. The findings from the analysis of baseline data at age 9 were validated by respondents in 2001. The children largely concurred with the researcher's interpretation of the data, and the exercise also

shed light on how the discourses that the cohort used changed during preadolescence. The results of the respondent validation exercise are explained in detail in Appendix M. Longitudinal analysis of the data revealed that the influence of parents which dominated their talk at age 9 gave way to an emphasis on the role peers play in smoking initiation at age 11. Key findings were that children know from age 9 that adults use tobacco to manage stress and boredom. By age 11, the children had appropriated these discourses around adult smoking and suggested that children might also smoke in order to cope. The study also revealed that children's discourses on the function of smoking were also patterned by socioeconomic status. The children who lived in the most deprived areas were more likely to use discourses around smoking as a coping strategy, whereas the perceived function of smoking in controlling weight was beginning to emerge in the discourse of the more affluent girls at age 11.

The idea that smoking is an acceptable adult behaviour emerged from the case study analysis and was considered in depth using data produced by the whole cohort. At age 9 children asserted that smoking was more acceptable for adults than for children because any smoking related disease is not such a 'waste of life', because adults have bigger bodies to cope with the smoke, because smoking could prove immediately hazardous to small children, because adults can make decisions and because they can handle cigarettes. By age 11, these views were still widely held, but – in the context of their experiences of knowing people with smoking-related disease - some children were beginning to realise that adults were also unable to cope with the smoke (see Appendix M). Because the preadolescents constructed smoking as an adult behaviour, in their culture tobacco use had become endowed with symbolic values that represented adult status in the peer group. This meant that children might start smoking to demonstrate that they were physically and mentally competent. Consequently, many of the cohort expressed anxiety that they might be bullied into smoking at secondary school by older children who were keen to demonstrate their elevated status among their peers.

The patterns of knowledge about addiction revealed by the case studies were confirmed by analysis of the data produced by the rest of the children. At age 9, the addiction

process was widely understood, and by age 11 the majority of the cohort used the term 'addiction'. Children's knowledge about the addictive nature of adult smoking was reflected in their behaviour in different ways. While some children argued that they were deterred from trying smoking for fear of addiction, others who were already smoking regularly saw addiction as a key feature of adult smoking that they aspired to emulate. In terms of smoking and health, the case studies showed that by age 9, every child had a good knowledge of the risks smoking poses to health. Data produced by the whole cohort revealed that many of the children had been deeply affected by experiences of smoking-related disease among their families and friends. Children's reporting of this increased between the ages of 9 and 11, and many of them expressed concern for the health of parents and family members who continued to smoke. Furthermore, children are often constructed as the targets for health promoters who seek to protect their health. However, this study showed that children can themselves be active agents of health promotion who seek to protect their own health from passive smoke and who also may promote the health of smokers by advising them to quit.

Chapter 7 will consider the relationship between the determinants of smoking during preadolescence and the discourses that the children use to talk about the habit. The chapter will also develop the theme of the social construction of smoking as an adult behaviour in depth in the context of the paradigm of the sociology of childhood. In considering the functions that smoking serves for children, the chapter will also consider why so many of the triers have persisted with smoking despite not enjoying their early experiences.

7 Discussion

7.1   Chapter Outline

This phase of the Liverpool Longitudinal Study of Smoking has examined emerging patterns of first tobacco use during preadolescence, in order to explore the relationship between intentions and behaviour, and to consider how children's experiences of smoking are shaped by the social context in which they live. This research built on the first phase of the LLSS (Porcellato, 1998) which had already tracked a cohort of approximately 300 Liverpool primary schoolchildren between the ages of 5 and 7. This thesis has presented baseline data collected at age 9 and it has used in-depth longitudinal qualitative and quantitative analysis to consider how children's experiences have changed during preadolescence at age 10 and 11. The analysis has examined how change has been experienced in the lives of individual children using a multiple case study approach. This unique qualitative longitudinal analysis has formed a key element of the study. The themes that emerged from the case study analysis were then explored and developed in the context of the experiences of the whole cohort.

The central themes that have emerged from the analysis of both case study and cohort data are that some children try smoking during preadolescence because the benefits that they perceive the habit to offer outweigh their knowledge of the future risks smoking poses to health. These perceived benefits are rooted in the social construction of both smoking and childhood in the UK. This chapter presents a discussion of the research findings and it considers how these reflect the results of other studies that have been carried out with this preadolescent age group and also with older children. In addition, it relates the findings of this study to the sociology of childhood literature in order to develop theory on children's experiences of smoking at primary school. The chapter opens with a discussion of smoking behaviour and its relationship to intentions to smoke during preadolescence (section 7.2). The next section reflects on the determinants of experimentation with cigarettes that have emerged from the research. It also considers

how these factors are reflected in the discourses that children use to talk about smoking uptake (section 7.3). The chapter then explores the importance of preadolescent discourses on the social construction of smoking as an adult behaviour and their impact on patterns of smoking uptake (section 7.4). The chapter concludes by considering how the findings of this phase of the LLSS are replicated by other longitudinal studies (section 7.5)

7.2 Smoking Behaviour and Intentions to Smoke

7.2.1 Smoking Behaviour during Preadolescence

In terms of smoking prevalence, the proportion of children who reported that they had tried smoking increased over time, and by age 11 over a quarter of the cohort had tried smoking (8%, 1999; 22%, 2000; 27%, 2001) and 3% were smoking regularly (at least one cigarette per week). Some children reported very early trials dating from the start of infant school, but most had tried smoking from age 8 onwards. Although in general surveys of smoking prevalence begin at secondary school, an existing cross-sectional study of smoking among 10 and 11 year olds in Liverpool found that 18% had tried smoking and 3% were smoking regularly (Dawson and Scott-Samuel, 1995). It is unlikely that child smoking rates in the city have increased by 50% since 1995, and instead this difference in smoking prevalence can possibly be explained by the longitudinal nature of the study. Perhaps the children who participated in the LLSS were not inhibited to report that they had tried smoking on the basis of their confidence in the confidentiality of the study and the rapport with the research team that has been built up over many years. The research has shown that children experiment with cigarettes for a number of reasons, and these are discussed in section 7.3. Qualitative data revealed that the majority of triers did not enjoy their first smoking experience and further research is needed to identify reasons why some children persist with smoking (43% of triers by 2001) despite the initial unpleasantness of the first trial, and why some children go on to become regular smokers.

The children in the cohort were at different stages of smoking experience in relation to the stage theory of smoking onset (Hirschman *et al*, 1984; Flay *et al*, 1998), and were making different transitions despite sharing the same chronological age (see section 1.4.2). At age 11, 12% (n=31) had progressed from being never-smokers in the *preparatory* stage to the second stage of *initial trial*. That is to say, they reported that they had tried smoking only once. A further 12% (n=28) had moved beyond this to the third stage of *experimentation* and were persisting towards acquiring the habit by making repeated attempts at trying smoking. In addition, 3% of the cohort (n=6) had progressed to the fourth stage of *regular smoking*. Analysis of the data would suggest that none of the cohort had reached the fifth stage of *addiction,* which is characterised by heavy daily use. However, the qualitative data revealed that although their weekly cigarette consumption was low, a few children used a discourse around addiction to describe their smoking behaviour. Perhaps this was because they aspired to patterns of adult smoking, which is characterised by nicotine dependency.

Lucas and Lloyd (1999) postulated that there are two pathways through early smoking experience: either the child makes his/her own decision to experiment with cigarettes based on curiosity or alternatively the child feels him/herself to be pressured or coerced into smoking by a group of peers. The results of the preadolescent phase of the LLSS give support to this view, although what this research adds is the finding that children's perceptions of coercion vary from child to child. The qualitative data showed that the children attached different meanings to the concept of being 'forced' to smoke. While some chose to present themselves as active social agents when recalling their early smoking experience, others denied their own agency and constructed their accounts to emphasise the role of peers. With regard to the first pathway, some children emphasised that they had deliberately initiated their first trials (James B, section 5.9.1; Margaret King and Bruce, section 6.2). The motive most frequently mentioned by triers when explaining why they had smoked for the first time was curiosity (n=19, see Table 6.4). Many of the accounts emphasised the opportunistic nature of the first trial and subsequent smoking, which were based on the ease of access to cigarettes. For example, children reported smoking lighted butts found on the floor and cigarettes left in ashtrays by family

members. Most triers recalled how they had smoked outside away from the protective gaze of adults. As the children got older, they had increasing access to unsupervised leisure time outside, and this gave them opportunities to smoke.

Other children who participated in this study suggested that they had followed the second pathway. Many of the accounts of first trials centred on peer pressure and the child's reluctance to try smoking (for example, Chima Chin, section 5.8.1; Lee Pu, section 6.2; Clare Smith, section 6.4.5). In 2001, the influence of friends and being 'forced' were key motives in explaining early smoking (n=16, see Table 6.4). The first trial was a social act for most of the children who had tried smoking and triers were likely to have smoked their first cigarette with a friend (Michell, 1990). Friends were also the main source of cigarettes for first trials, and this suggests that in many instances peers may initiate first use. The influence of friends on smoking uptake is discussed in more depth in section 7.3.2.

7.2.2   Intentions to Smoke

This study considered the usefulness of current intention to smoke to predict smoking during preadolescence. The concept of current intention to smoke measures the child's desire to experiment with cigarettes. This concept emerged from the first wave of the study (Porcellato, 1998). The case studies found that in two out of three cases (Maggie Magrath and Chima Chin) initial trial was not preceded by a positive current intention to smoke. However, in the case of James B, a positive current intention to smoke at age 10 predicted smoking at age 11. This suggests that current intention may have a limited usefulness in predicting subsequent smoking onset during preadolescence.

This finding from the case studies was explored using the quantitative data. Analysis using frequency data showed that the number of children who currently intended to smoke in 1999 (n=7) was much smaller than the increase in the number of triers in 2000 (n=33) (see Table 6.1). This suggests that in many cases first trial is not preceded by a change in intention to smoke. In 2000, the number of children who intended to smoke

(n=12) was exactly equal to the increase in the number of children who subsequently reported trying smoking in 2001 (n=12). However, analysis of the data using transition diagrams (see Figure K.1 and Figure K.2) that enabled individual children to be traced revealed that some of the children who tried smoking in 2001 had not currently intended to do so in 2000. This reinforces the finding that current intention is not necessarily a useful predictor of subsequent smoking behaviour. The diagrams also showed that children's intentions to smoke are unstable during preadolescence. Some children made transitions from susceptible to non-susceptible to susceptible and vice versa. Statistical analysis of the data confirmed this, and a logistic regression analysis found that current intention to smoke at age 9 was not a useful predictor of smoking by age 11. As Figure K.1 and Figure K.2 show, experimentation with cigarettes as reported in 2000 and 2001 was only immediately preceded by positive or ambivalent current intention to smoke in 17 out of 46 cases (37%). Perhaps in some cases current intention fails to predict trials because changes in intention occur only shortly prior to first use, and data were collected too infrequently to detect changes in intention. Alternatively, first use may not be preceded by a change in intention because children do not anticipate or 'plan' their initial trial (Blanton et al, 1997). Maybe children who follow the second pathway and try smoking as a result of perceived peer pressure or coercion would not necessarily intend to try smoking if they do not initiate their own first trial.

Another kind of intention emerged from this phase of the study. Analysis of the qualitative data showed that some children were planning to persist with smoking after their first trial, but often not planning to persist to adulthood (for example, Paul Brown, section 6.2). Perhaps the intention to persist to repeated trials could prove a useful measure of attitude and could help to explain the transitions that some of the cohort are already making from first trial to experimentation, regular smoking and beyond. This is an area that would merit further research.

Existing research is divided over whether future intention to smoke is a useful predictor of adult smoking status (see section 1.6). The findings from this study would suggest that, as with current intention, future intention to smoke during preadolescence is also of

limited usefulness in predicting adult smoking (Goddard, 1992). The proportion of the cohort who intended to smoke as adults remained extremely small throughout the study (3%, 1999; 3%, 2000; 2%, 2001), and actually declined as the proportion of triers increased (see Table 6.1). By 2001, more children reported smoking regularly than expressed a future intention to smoke – perhaps because these children intend to smoke only during adolescence but not during adult life. Although at age 11 only 2% of the cohort intended to smoke as adults, it is likely – on the basis of current adult prevalence rates in Liverpool - that in excess of 30% of these children will go on to smoke during adulthood (Crosier, 2001). This suggests that the predictive value of future intentions to smoke expressed during preadolescence is poor.

7.3 Determinants and Discourse

This part of the chapter discusses the determinants of smoking behaviour during preadolescence. It also considers how these research findings are reflected in the children's discourses around smoking onset. Although almost three-quarters of the cohort had no personal experience of trying smoking, they were still able to offer multiple and complex explanations of why some children do experiment with cigarettes. This finding parallels that of other studies which have found that by age 11 children are able to offer complex accounts of smoking onset that reflect the multiple causes of smoking (for example, Meltzer, 1984). However, the longitudinal design of the LLSS adds to this by using a case study method to reveal that children who try smoking during preadolescence offer more complex explanations than non-smokers even prior to their first trials. In many ways the cohort's discourses on smoking onset reflected the declared motives given by the children who had tried smoking (in section 7.2).

7.3.1 Family

This phase of the LLSS has shown that the family is of central importance in the child's decision whether or not to experiment with cigarettes, and this confirms the findings of a large number of other studies of smoking uptake (for example, Bewley *et al*, 1974; Green

et al, 1991; Doherty and Allen, 1994; Lloyd and Lucas, 1998). Statistical analysis revealed that trying smoking was associated with mother's smoking each year and with father's smoking at age 11. Experimentation with cigarettes was also associated with having siblings who smoked and with living with a smoker. A logistic regression analysis confirmed that paternal smoking is one of the most important predictors of smoking onset and children with a father who smoked at age 9 were five times more likely to have tried smoking by age 11. These statistical findings were reflected in the qualitative data. The case study analysis suggested that parental smoking strongly influences children's smoking behaviour during preadolescence. The three children who had parents who were either current smokers or who had recently quit (Maggie Magrath, Chima Chin and James B.) all reported that they had tried smoking by age 11. Conversely, the case studies also demonstrated that non-smoking parents may have a protective effect. Neither of the two children whose parents were ardent non-smokers (Sarah Blanchard and Bill Bobby) tried smoking at primary school. The case of Bill Bobby even suggests that having a non-smoking family may have a protective effect during preadolescence, even in the context of pressure to smoke – including offers of cigarettes - from peers. Study of the social context of the children who formed the case studies suggested that preadolescents may be polarised in terms of contact they have with smokers – the five children studied either had many smokers in their social networks or they had none. This suggests that some children come from families with barely any adult non-smoking role models. Because the study found that adult role modelling is central to the beliefs that preadolescents hold about smoking uptake, this may be highly significant for their future behaviour.

Children's discourses around the influence of family had three main themes. They described the role that parents play in setting an example of (acceptable) smoking behaviour; the easy access to cigarettes that the children of smokers may have at home; and how parents may unwittingly demonstrate to a child exactly how to light a cigarette several times a day. In the discourses that the children used to explain why some children start smoking, parents were seen as the most important influence at age 9. However, analysis of the children's talk suggested that by age 11 friends superseded family as the

central theme in children's accounts of smoking onset. This is in the context of adolescence as a transition from childhood to adult life as dependence on parents shifts to an emphasis on life outside the home.

Why are the children of smokers more likely to experiment with cigarettes during preadolescence? There are many factors that link parental tobacco use to smoking by children, to form the 'family circle' (Charlton, 1996). As the children's talk suggests, in many ways parents provide smoking role models, and socialise their children into smoking. Some children suggested that young smokers learn how to smoke by watching the ritual of their parents lighting up – and in this way parents may provide their children with knowledge of the mechanics of how to smoke. This unique qualitative finding supports and perhaps helps to explain the well-documented association between parental and child smoking. Despite many children's perception that their parents would disapprove of their attempts to smoke, smoking parents also provide a family environment in which smoking is acceptable. Several children suggested that while their parents might currently discipline them if they tried smoking, perhaps their parents would be more approving as they got older. This attitude would serve to reinforce the perception that smoking is an accepted part of adult life. (It would be interesting to know how parents construct their children's smoking as acceptable or unacceptable, and if smoking becomes more acceptable as the children get older.) Parental smoking is also of tremendous importance in giving young children easy access to cigarettes with which to experiment. Children know where their parents keep their cigarettes, and often cigarettes are left lying in ashtrays, which may give some children a fleeting opportunity for a puff of smoke. When cigarettes are such a common feature of family life, it is difficult for smokers to be vigilant and ensure that their children do not have access to tobacco.

7.3.2   Peers

The analysis of quantitative data found that experimentation with cigarettes at primary school is associated with smoking by friends, and this supports the findings of numerous other studies (for example, van Roosmalen and McDaniel, 1989; Bolling, 1994; Eckhardt

et al, 1994; Barber *et al*, 1999). A logistic regression analysis also demonstrated that the role of best friends is particularly important in smoking initiation and children with a smoking best friend at age 9 were more than five times more likely to have tried smoking by age 11. As suggested in section 7.2, this is because preadolescents frequently smoke their first cigarette with another child.

At age 11, the emphasis in the cohort's explanations of smoking onset shifted away from parents to the role played by friends, and this mirrors the findings of other research with young teenagers (Eiser *et al*, 1989; Distefan *et al*, 1998). The children highlighted the importance of group membership and not wanting to feel left out. Because preadolescents associated smoking with adult status (see section 7.4), some children explained that friends helped you by making you smoke so that you could grow up and look cool. The discourses that the children used to talk about the role of friends in smoking uptake suggested that they perceived two kinds of peer pressure. Some children described gentle persuasion from close friends, whereas others talked about bullying and physical intimidation. Confusingly, many of the children used the term 'forced' to describe any kind of pressure from peers (see section 7.4). There is also evidence to suggest that some children described themselves as having been 'forced' to smoke to deal with the contradictions that they felt. Because smoking is an illicit behaviour for preadolescents, perhaps some were therefore keen to emphasise the role that friends had played in encouraging them to smoke in order to absolve themselves of the responsibility of having made a decision that they knew had the potential to harm their health. The qualitative data showed that friends who smoked were likely to be older than the children who participated in this study. This means that they were more likely to be able to access a ready supply of cigarettes. It also meant that some children feared intimidation from older – physically stronger – adolescents. While a few children gave accounts of being bullied into smoking, many others expressed anxiety that they would be bullied to smoke in future, especially by the older teenagers with whom they would come into contact at secondary school. This finding is corroborated by research with older children which suggests that while many children may anxiously anticipate being bullied into smoking, in practice few children who have tried reported that they were coerced into their first

trial (Michell, 1997b). This concern about peer pressure is rooted in preadolescents' construction of smoking as an adult behaviour (see section 7.4).

7.3.3 Socioeconomic Status

Many studies have found an inverse relationship between adult smoking prevalence and socioeconomic status. Adult smoking is inversely associated with occupational class and it is also related to living in a household in receipt of means-tested benefits and with living in a deprived area (Marmot, 1996; Scott-Samuel and Platt, 1998; Lader and Meltzer, 2001; Richardson and Crosier, 2001). The research evidence on the social patterning of smoking during adolescence is not so conclusive, but several studies have found an inverse relationship between smoking behaviour and socioeconomic status (for example, Johnson *et al*, 1982; Green *et al*, 1991; Conrad *et al*, 1992; Hagquist, 2000; Boreham and Shaw, 2001; Sweeting and West, 2001). However, there has been little research carried out in the UK into the social patterning of smoking uptake during preadolescence. This phase of the LLSS filled this significant gap by using multiple measures of socioeconomic status to give a full picture of children's social position. These measures included parental occupational class, receipt of means-tested benefits and Townsend deprivation scores derived from postcode data. Qualitative data analysed using a case study approach showed that both of the children who lived in low-income households (Maggie Magrath and Chima Chin) had tried smoking. Although analysis of the cohort data revealed no association between child smoking and occupational class, statistical analysis confirmed that experimentation with smoking during preadolescence was associated with living in a low-income household in at age 9 and 10 and with living in a deprived area at age 11. Perhaps this was because children who live in deprived areas are exposed to more smoking role models because adult smoking prevalence is associated with deprivation. However, it is likely that the importance of parental modelling does not completely account for the association between child smoking and low income (Johnson *et al*, 1982), and further research is needed to explore why smoking during childhood is associated with poverty.

Although socioeconomic status has emerged as an important determinant of smoking during both adult and childhood, the cohort did not mention the relationship between smoking and disadvantage in their talk. However, the children did use discourses around the functions that tobacco has as a coping strategy and to control weight, and the use of these discourses varied by socioeconomic group and over time. Research has found that smoking among adults may be as a response to their poverty and as a means of coping in the context of material disadvantage (Graham, 1987; Graham, 1993; Marsh and McKay, 1994; Eriksen *et al*, 1997; Stronks *et al*, 1997; Dorsett and Marsh, 1998). Other studies have found that adolescents are aware of the way adults use tobacco for positive effect, and that teenagers also smoke to manage their emotional state and to counter boredom (Hirschman *et al*, 1984; Isohanni *et al*, 1991; Trevett and Bolling, 1997; Balch, 1998; Barber *et al*, 1999; Kegler *et al,* 2000). However, this is the first study to consider preadolescents' discourses around smoking as a coping strategy. In response to an open-ended question about why adults smoke, from the age of 9, children suggested that smoking helps people to cope in difficult circumstances: both to manage boredom and to cope with the stresses of everyday life. This knowledge about the way adults use tobacco had informed the cohort's beliefs about the function of smoking for young people. Although none of the children participating in the LLSS reported smoking in order to cope, some children suggested that young smokers might smoke in order to deal with their problems. The number of children who expressed this belief increased during preadolescence, and at age 11 the cohort was much more aware that children might use tobacco as part of a coping strategy than at age 9. Children are more likely to live in poverty than adults (Qvortrup, 2000) and further research is needed to consider why and how children experience social stress. Further work is also needed to identify whether preadolescent discourses around how some children smoking as a coping strategy is reflected in patterns of tobacco use, and how these questions relate to socioeconomic status.

The use of this discourse on smoking as a coping strategy during preadolescence was socially patterned. Although this discourse was used by many of the children who lived in the most deprived quartile (for example, Maggie Magrath), none of the children who

lived in the more affluent districts included it in their talk. Perhaps this is because parental smoking rates were lower in the more prosperous districts and they were therefore less aware that adults and consequently children would smoke in order to cope. However, it also emerged that children who live in more affluent areas may use different discourses to describe the positive functions that they perceive smoking to offer. In 2001, a small number of girls suggested that people might smoke in order to help them control their weight – these were mostly girls living in the more affluent postcodes. These key findings suggest that children in affluent areas use different discourses around smoking from children who live in more deprived areas. Because children's motives and beliefs about the positive functions of smoking are central to smoking uptake, further research is needed to determine whether smoking has different functions for children during preadolescence on the basis of their socioeconomic status. In this way, the discourses that children use around smoking may be of central importance in shaping their behaviour. This is because children may start or continue with smoking because they perceive that it offers them positive benefits. This supports the findings of another study that found that children who smoke are more likely to believe that smoking calms the nerves, whereas nonsmokers are more likely to believe that people smoke to show off (Charlton, 1984).

7.4   The Social Construction of Childhood and Smoking in the UK

This phase of the LLSS has explored the reasons why some children try smoking and how experimentation with cigarettes is related to the social construction of both childhood and smoking in the UK. This part of the chapter will explore these central themes and consider how discourses around smoking in the UK are related to patterns of smoking behaviour during preadolescence in the context of the key tenets of the sociology of childhood (see Chapter 2).

7.4.1   The Social Construction of Childhood

The 'new paradigm' of the sociology of childhood was discussed in Chapter 2. In summary, sociological theories of childhood have emphasised that the experience of being a child in the UK in the twenty-first century is socially constructed and culturally specific. The fact of children's physical immaturity has been translated into a range of characteristics that distinguish childhood in contemporary society. Childhood in the UK is characterised by structural vulnerability that keeps children socially dependent on their parents. Children are notably subject to the authority of their parents at home and to that of teachers at school. Because children are constructed as 'innocent' and 'vulnerable', parents and policy makers often seek to protect them from being corrupted by adult society. Therefore, children are not considered sufficiently rational or competent to participate in many legitimate adult activities. These ideas will now be explored in relation to tobacco use.

7.4.2   The Social Construction of Smoking

Smoking in the UK is constructed as an adult behaviour. The sale of tobacco products is restricted to adults over 16 years old, and these legal restrictions on tobacco purchase are simultaneously reinforced by social norms which construct smoking as an activity that is only suitable for adults. The goal of legal restrictions that ban the sale of cigarettes to children is to protect their health. However, while the aim may be to protect children from tobacco, the unintended outcome is that for many young people smoking is a way to demonstrate maturity and adult status. When children do not conform with stereotypes of childhood innocence, perhaps by taking part in an activity which is not permitted at their specific age – such as smoking - they risk being labelled 'deviant'. Arguably, children who smoke are deviant not only because they are challenging social norms around smoking by obtaining cigarettes unlawfully, but also because early smoking may lead to illegal drug use.

The prevailing discourse around child smoking is based on public health concerns. It constructs child smoking as highly undesirable because of the future risks young smokers pose to their health, and argues that child smoking must be prevented. This discourse derives not from children's present experiences but from a preoccupation with the health consequences of smoking experienced in adult life. It is interesting to consider how the discourses that adults use to talk about tobacco use during childhood inform research and subsequent interventions. For example, the LLSS has been funded with the ultimate aim of promoting health across the lifecourse by developing interventions to prevent smoking among children. Does this reflect the children's own concerns about smoking? This research has given a unique insight into preadolescents' concerns. The study has shown that many children in their last years at primary school are anxious about passive smoking and the impact that it has on their health. They are also worried about smoking-related disease, and about the health of smokers in their families and communities. In addition, many children who have not yet tried smoking are anxious that they may be bullied into doing so at secondary school. Clearly, these concerns are not reflected in a narrow health education approach, and alternative strategies on smoking, children's health and well-being are also needed. These will be discussed in Chapter 8.

7.4.3 Socialisation and Developmental Theories

Theories of socialisation seek to explain how children internalise and adapt to society by examining how cultural norms are passed from generation to generation. This phase of the LLSS suggests that smoking parents do transmit the habit to their children. The results of the study have shown that there are several reasons why the children of smokers are more likely to experiment with cigarettes. Firstly, smoking parents demonstrate to their children from an early age that smoking is an acceptable behaviour by providing a smoking role model, and indeed demonstrating the mechanics of how to light and smoke a cigarette. Secondly, parents may subconsciously teach their children the benefits of smoking by using tobacco to relax, as part of leisure, to cope in difficult circumstances, and to relieve boredom. Thirdly, the children of smokers may have easy access at home to cigarettes with which to try smoking. Fourthly, by exposing their

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children to passive smoke both at home and in other settings, parents may increase their children's tolerance of tobacco smoke. However, whereas socialisation theories construct children as passive, this research has found that in many ways children are active in choosing or rejecting tobacco use. Although parents may normalise smoking in the home, children are active in acquiring and smoking cigarettes without their parents' knowledge. Children also actively choose to use smoking to improve their status among their peers. In addition, this research reflects critiques of socialisation theory by focusing very deliberately not solely on the child's 'becoming' an adult smoker, but instead on what smoking means to preadolescents in the present.

Developmental theories postulate that children are both biologically and cognitively immature as they progress towards adulthood. In this way, childhood has come to be associated with incompleteness and incompetence, and 'childish' is often used as a pejorative term intended to convey immaturity. Other sociological research has found that preadolescents have internalised this dominant discourse of child development (Kelle, 2001). Because adult status is associated with both physical and mental competence, children frequently 'want to be older' and may strive to appear older than their chronological age. The LLSS has shown that in this way, some children seek to demonstrate their physical competence by showing that their bodies are strong enough to cope with inhaling cigarette smoke. One of the central themes of children's construction of smoking as an adult behaviour that has emerged from this research is that smoking is more acceptable for adults because they have bigger bodies to enable them to cope with the smoke. The most important outward sign of childishness is the immature body, and by smoking perhaps some children seek to demonstrate that their bodies are physically strong. Adulthood is also typically associated with mental competence. Some members of the cohort argued that adults could decide to smoke because they have the necessary life experience to make important decisions. The consequence of this is that smoking can also be a signifier of mental competence, and children may smoke to demonstrate that they are able to evaluate risks and make their own decisions in the context of the knowledge that smoking harms health.

However, the children who participated in this study responded to prevailing discourses around child development in different ways. The social construction of smoking as adult behaviour simultaneously discouraged some children from experimenting with cigarettes, while actively encouraging others to try. Some children who expressed an interest in smoking as an adult in future years, argued that they did not currently smoke because they were not yet sufficiently physically mature. Some children also suggested that they were as yet not capable of taking decisions that affect their health – these children denied their autonomy and argued that they were not competent to make such important choices. In this way, the construction of smoking as an adult habit serves to delay experimentation by some children – at least for a time. In summary, while some experimented with smoking to demonstrate their maturity, others - who had perhaps been better socialised - argued that children should not smoke because they are both physically and cognitively incompetent. This shows that children may use the same discourse to construct their identities in relation to smoking in diverse ways.

7.4.4   Smoking and the Negotiation of Social Transitions

Many – if not all – societies are stratified by age, and cultural customs are used to distinguish one group from another (Ennew, 1986; James and Prout, 1997). The function of these customs is to enhance the differences in status between each group. Modern society is notably structured on the basis of age-based transitions, for example, the move from primary to secondary school, from education into work, and from work into retirement. Nevertheless, in Western societies, the transition from childhood to adult status is now quite complex, as increased life expectancy means that adolescence has become a separate life stage. However, at the same time, the rites of passage from childhood to adulthood have become less well defined, and this promotes identity confusion because the status boundaries around adolescence are unclear and fragmented. As the age of puberty falls, and the age of beginning work is postponed there is less distinction between the roles played by children and those of adults. Because many young people delay entering the labour market (Roberts, 1983; Roberts, 2001), the period of transition between childhood and adulthood has been extended over time. Adulthood

is no longer defined by physical maturity, but instead relies on a process of social transition.

It is at this time that the adolescent struggles to establish his/her own identity, between the conflicting demands of family and peers. Because most smokers take up the habit during childhood (Charlton, 1984; RCP, 1992; McGee and Stanton, 1993; Balch, 1998), it is possible that smoking initiation is connected with the nature of childhood and adolescence, and the unsteady transition from dependence to self-reliance and responsibility. It has been suggested that children may use smoking to help them negotiate identity (Aloise-Young and Hennigan, 1996) and status during this crucial transition from childhood and adulthood:

> Some values incorporated in childhood are wise prohibitions limited only to childhood, and a major task of adolescence is to differentiate those prohibitions that are appropriate only to childhood from those appropriate to adulthood. Indeed, casting off the prohibitions of childhood is a necessary part of psychological maturation. Identifying appropriate limits for the adolescent is difficult under the best of circumstances, let alone when a culture is offering mixed and contradictory messages. Our culture has, historically, established smoking as a childhood prohibition and an acceptable adult behaviour. Thus, smoking becomes a natural avenue for children to assert their maturity (Bhatia *et al*, 1993: 278).

In this context, some children seek to negotiate their status by challenging the social norms and cultural customs that demarcate the boundaries of adulthood. This means that some children may engage in activities which are not permitted at their age as a strategy of resistance to the age-based stratification of society, and the way in which this operates as an ideology of control to restrict children's autonomy. The data presented in this thesis show that the sample are aware of the exercise of adult power in their lives, and that they seek to resist this by engaging in age-prohibited behaviours. Therefore some children attempt to use smoking as an outward sign of adult status because the act of smoking is endowed with symbolic meaning in children's culture. Because smoking is prohibited for children, they may use tobacco to demonstrate autonomy and independence from adult control (Gilpin and Pierce, 1997). As the data presented in Chapter 6 show, children who use tobacco are viewed by many of their peers as grown

up, brave, physically mature, tough and rebellious. Because 'the child' is socially constructed as a person who is not yet a physically mature adult, and smoking is seen by children as a very physically demanding activity, those children who engage in smoking perceive it as an ideal signifier of adult strength and resilience. The tough impression of those who manage to acquire the habit is reinforced by the belief that many children hold at age 9 that smoking is dangerous for and even fatal to young children. Furthermore, because preadolescents know that early smoking is experienced as unpleasant, children who can manage to smoke are seen as brave. Children may smoke despite legal and parental prohibitions in order to demonstrate that they are rebellious (Balch, 1998), and they may hide their smoking behaviour from their parents to represent their own private existence outside parental control. In this way, it has been argued that smoking may be functional for children during adolescence in preparing them for independence and the responsibilities of adult life (Franzkowiak, 1987).

Social constructionists have noted that people use discourse to mediate social relationships (Bury, 1986). Children's knowledge about smoking is socially produced and the discourses that they use to talk about tobacco mediate their experiences in two ways. Firstly, the discourses that preadolescents use around tobacco affect patterns of smoking uptake. This is because children may take up smoking either because they believe that in future years it will help them to manage stress and boredom, or because they seek to use smoking to help them negotiate status and identity during adolescence. Secondly, the discourses shape the nature of the relationship between smoking and non-smoking children. The qualitative data presented in Chapters 5 and 6 showed that the use of tobacco as an outward sign of elevated status in the peer group impacts on the relationships that young smokers have with their peers. Although a few of the children gave personal accounts of being bullied into trying smoking, many of the children from the whole cohort used discourses which expressed fear and anxiety that young smokers would seek to demonstrate their status in the peer group by the physical exercise of their power. Because some children smoked to demonstrate that they were physically strong, other children expressed concern that this would be translated into physical intimidation. It is fascinating that this perceived high status which smoking has in the culture of

preadolescence is precisely the opposite of its meaning in adulthood. In adult culture, smoking is now usually constructed as socially unacceptable behaviour and is associated with disadvantage (Marsh and McKay, 1994). Furthermore, in children's culture, smoking may give a child high status among his/her peers, but conversely the young smoker is constructed by adults as deviant. This contradiction may represent a dual advantage to young smokers who wish to communicate to their peers that they are rebelling against adult authority.

7.4.5 Structure and Agency

One of the key tenets of the paradigm of the sociology of childhood is the importance of the relationship between structure and agency. This research has considered how structural factors shape children's lives (see the discussion presented in section 7.3). In contrast with developmental and socialisation theories on childhood which have constructed children as passive, the sociology of childhood aims to emphasise children's agency. This study has shown that children are active social agents, some of whom choose to take up smoking and many of whom actively promote health. Firstly – and in the context of structural and parental influences - some children actively use discourses around smoking to demonstrate that they possess some of the symbolic qualities that preadolescents attribute to smokers. Although some children emphasise the role peers play in smoking uptake (see section 7.3.2), many triers emphasised their own agency in their accounts of smoking initiation. Secondly, while children are frequently constructed as in need of smoking prevention education and may be the targets of other health promotion initiatives, this study has shown that children play an active role not only in promoting their own health, but also that of others. Many children endeavour to protect their own health from passive smoke and others play a key role in encouraging both friends and family members to give up smoking. Although children undoubtedly should receive health education, researchers have largely ignored the contribution they can also make to health promotion. It is a unique and important finding from this study that children also have an important role to play in smoking cessation and in promoting the health of others.

7.5   Other Longitudinal Studies of Smoking during Preadolescence

7.5.1   Research in New Zealand and the United States

As outlined in section 1.10.2, there have been few studies carried out into children's experiences of smoking during preadolescence. In New Zealand, the Dunedin Study used quantitative techniques to assess changes in children's smoking between the ages of 9 and 15 years (Stanton *et al*, 1991; Stanton and Silva, 1991; Stanton *et al*, 1994). The study found that smoking behaviour at age 9 did not predict continued smoking at age 15. However, smoking at age 15 was found to be predicted by smoking behaviour at age 11 and 13. The research suggests that not trying smoking by age 9 is not protective against later smoking during adolescence because many of the adolescents who were smoking at age 15 had not tried smoking by age 9 (Stanton *et al*, 1991). Another aspect of the research was an exploration of whether academic achievement predicts smoking uptake. The study found that low academic achievement was related to changes in boys' smoking behaviour between the ages of 9 and 13, and to changes in girls' smoking behaviour between the ages of 9 and 11 only (Stanton and Silva, 1991). Although this was a longitudinal study, the third paper presents only a cross-sectional analysis of the sociodemographic characteristics associated with smoking by 15 year olds: low socioeconomic status, having a part-time job, changing address and being of minority ethnic origin (Stanton *et al*, 1994).

Another longitudinal study of smoking uptake during preadolescence was carried out in Washington, USA (Dinh *et al*, 1995). The study used checklists to assess children's perceptions of smokers and non-smokers between the ages of 10 and 12. Questionnaires were also used to measure participants' smoking behaviour. The research found that between the ages of 10 and 12, children's perceptions of smokers became more positive. In the same way, children's perceptions of non-smokers became more negative. These perceptions of smokers and non-smokers were then analysed to see if they were associated with smoking onset. The study revealed that 10-year-olds who thought smokers were 'healthy', 'cool' or 'good at sports' were more likely to have taken up

smoking by age 14. Furthermore, children who perceived non-smokers to be 'uncool' were also more likely to be smoking regularly by age 14. However, differential perceptions of smokers and non-smokers at age 12 were not found to predict smoking at age 14.

The final longitudinal study was carried out in North Carolina (Jackson, 1998; Jackson *et al*, 1998). This research used annual surveys to collect quantitative data from a cohort between the ages of 8 and 10. The aim of the study was to assess whether susceptibility to smoking is a useful predictor of subsequent first trial during preadolescence (Jackson, 1998). The surveys used four items to measure susceptibility (short and long-term intentions, normative expectations and ambivalence), and found that susceptibility was an important predictor of smoking initiation. (This conflicts with the findings of the LLSS, as presented in Appendix K.) The research also considered the role of parents and peers in smoking onset (Jackson *et al*, 1998). Analysis revealed that parents and friends who smoke do influence children to start smoking, especially in combination with low behavioural self-control and poor adjustment to school.

7.5.2 Research in Northern Ireland

When this phase of the LLSS was being designed in 1999, a review of the longitudinal studies described above revealed the clear need for a longitudinal study of smoking uptake in the UK. There was also a significant lack of research that used qualitative methods to explore children's experiences of smoking during preadolescence. However subsequently, after all the data had been collected and much of the analysis and theoretical development presented in this thesis had been carried out, two papers were published that described a longitudinal study into smoking and preadolescence in the UK (Rugkåsa *et al*, 2001a; Rugkåsa *et al*, 2001b). These papers presented baseline qualitative data from the first year of the study, which had been carried out with 10-11 year olds in Northern Ireland. The research also used an epistemological framework drawn from the sociology of childhood and had been informed by the first phase of the LLSS (Porcellato, 1999). Because the population studied, data collected and conclusions

drawn were very similar to those of this phase of the LLSS, the rest of this section will be devoted to an in-depth discussion of the methods, sampling frame and results of this study in comparison with this phase of the LLSS.

As described, although the Northern Ireland study is a longitudinal study, the only results published so far have been cross-sectional and do not consider change over time. In terms of method, the research used only interviews (in comparison with the triangulated method used by the LLSS) with 85 children at youth clubs (as opposed to schools) in Northern Ireland. The sample for the LLSS was designed to reflect the range of socioeconomic conditions found in the city of Liverpool in order to compare the different trajectories experienced by children from different socioeconomic groups. By contrast in Northern Ireland the researchers only interviewed children attending youth clubs within economically deprived areas, because smoking among adults has been shown to be associated with poverty. Whereas practically all children attend primary schools and the sample for the LLSS can therefore be said to be representative of all the children in the city, it is possible that the children who attend youth clubs do not reflect the lifestyles and behaviours of all the children in an area. This means that the findings from the LLSS are perhaps more applicable to a wider population that those of the Northern Ireland study which draws on a very limited sample.

In terms of findings, the papers published focus on addiction (Rugkåsa *et al*, 2001a) and on how children use smoking as a symbol with which to negotiate status (Rugkåsa *et al*, 2001b). In many ways, the findings from this research independently corroborate the results of the LLSS. At age 10-11, the smoking prevalence figures they report correspond almost exactly: 24% had tried smoking (LLSS: 22%, age 10; 27% age 11) and 3% were smoking regularly (LLSS: 1%, age 10; 3% age 11). Any small differences with the LLSS may be explained by the difference in the socioeconomic composition of the sample. The Northern Irish study found no gender differences in smoking experiences or attitudes to smoking. Rugkåsa *et al* (2001a) found that their participants knew that adults use tobacco as a coping strategy, particularly to calm nerves and to relieve depression. They also found that whereas children knew that adults were addicted to smoking, the

preadolescents did not suggest that children could become addicted to smoking and were therefore vulnerable to nicotine addiction. Their analysis diverges from that of the LLSS because they suggest that children differentiate between child smoking and adult smoking:

> Addiction was rarely mentioned in relation to smoking among children, and the ability cigarettes have to 'calm down nerves' was never applied to child smoking (Rugkåsa *et al,* 2001a: 593).

Rugkåsa *et al* (2001a) compared the results of their interviews with 10-11 year olds with focus group material generated by 16 year olds. They concluded that:

> Tobacco addiction may thus have some positive aspects that for young people could have communicative value if displayed. Though this appears *not* to be the case among 10-11 year olds, 16 year olds interviewed in the pilot focus groups expressed their addiction in some detail... If their smoking habits are taken seriously, they have appropriated an adult form of behaviour. The sociocultural image of addiction may therefore be used in a negotiation of their social status (Rugkåsa *et al,* 2001a: 599) [original italics]

These findings contrast with those of the LLSS that reveal that children of 9 to 11 years old absorb and seek to assimilate adult discourses around smoking behaviour. Thus, many of the cohort suggested by age 11 that children might also smoke to manage stress and to counter boredom, and children who were smoking regularly were keen to suggest that they might be addicted (in contrast with just the Northern Ireland 16 year olds). For the Liverpool children, smoking was an adult behaviour and some children aspired to all these different aspects of the adult habit.

The researchers in Northern Ireland agreed that children associated smoking with adulthood, and with physical and mental maturation. The findings of their study similarly showed that children smoke to 'look big', to achieve group membership and to negotiate status with their peers. The discourse that the Northern Irish children used to explain why smoking was an adult behaviour was strikingly similar to the discourse used by the Liverpool children. Rugkåsa *et al* (2001b) found that smoking was appropriate for adults because they can make their own decisions, they have the necessary knowledge, they

need to smoke as a coping mechanism, and that adults have mature bodies that are strong enough to tolerate the smoke. As with the LLSS – and informed by the same theoretical framework - the Northern Irish researchers also conceptually situated smoking during preadolescence and the teenage years in the context of the unsteady transition between childhood and adulthood:

> Unlike many other societies, Western Europe has few institutionalised rituals with which to mark the transition from childhood to adulthood. For a relatively long period of time a young person's status may appear unclear and negotiable. Different forms of symbols and symbolic action may help initiate and bring about negotiation over the individual's status. Smoking, perceived as exclusive to the adult world, could be one such symbol and may represent a potent means of transforming one's status or identity (Rugkåsa *et al*, 2001b: 136).

However, Rugkåsa *et al* (2001b) made a very important point that had not emerged during the analysis of the Liverpool data. They noted that children smoke to emulate adults but that of course children are not trying to negotiate status with adults, but with their peers, because early smoking is frequently kept secret from parents and other adults.

In the LLSS, the implications of this were that many children expressed concern about peer pressure, and the findings from the Northern Ireland study supported this to an extent:

> Appropriating symbols from the powerful world of adults is believed to empower the smoker to 'boss people around' (Rugkåsa *et al*, 2001b: 138).

However, Rugkåsa *et al* (2001a) observed that while never-smokers believed that children may smoke as a result of peer pressure, children who had tried smoking were less likely to emphasise the role of peers and instead to assert the role of their own agency in their early smoking experiences:

> Peer pressure seems to be frequently anticipated by children and adults alike, without consistent support in research (Rugkåsa *et al*, 2001a: 597).

> The importance of peer pressure in relation to smoking uptake may be something adults rather than children identify as a direct cause (Rugkåsa *et al*, 2001b: 133).

By contrast, the LLSS found evidence that children who have tried smoking often emphasised the role that peers played in their initial trials. This is a significant area of difference between the two studies and may perhaps be explained by the use of a triangulated method for the LLSS which enabled interview data to be confirmed by qualitative data generated in questionnaires and focus groups, thus yielding a fuller understanding of children's views and experiences.

7.6   Conclusions

This chapter has considered the determinants of smoking during preadolescence and the way these are reflected in children's discourses around smoking uptake. The analysis revealed that many of the cohort were able to offer multiple and complex explanations to account for smoking trials, despite not having any personal experience of trying smoking. Statistical analysis had shown that smoking by parents and siblings were associated with experimentation with cigarettes, as were living with a smoker and having friends who smoked. These findings were reflected in the discourses that the children used to explain smoking initiation although, between the ages of 9 and 11, the emphasis of the children's talk shifted away from familial influences to the role of peers. The study also showed that children were more likely to have tried smoking if they lived in a low-income household or a deprived area. Although the children did not acknowledge the association between smoking and disadvantage in their talk, the discourses that they used were patterned by socioeconomic status. Children who lived in deprived areas suggested that some preadolescents smoke as a coping strategy, while a few of the girls who lived in affluent areas described the perceived function that smoking has in controlling weight.

The analysis has also considered how the social construction of smoking as an adult behaviour affects patterns of smoking onset. While the preadolescent construction of smoking as an adult habit served to deter the majority of the cohort from trying smoking, some children used the discourse around smoking as an adult behaviour to demonstrate that they were adult. For these children smoking represented a rite of passage into adult

life. Interpretation of data in the context of theories drawn from the sociology of childhood showed that legal restrictions which aim to protect children's health may have the unintended consequence of making smoking more attractive to young people, by presenting tobacco use as an intrinsic part of adulthood. Some children smoke to demonstrate that they are mature, and smoking is a metaphor for adult status in the peer group. This means that smoking can be used by preadolescents to negotiate their position among their peers, and to communicate autonomy and independence, in the context of the unsteady transition from childhood to adolescence and beyond. Because the childish body is an outward symbol of immaturity, some children also smoke to convey that they are physically strong. By preadolescence, the entire cohort had a good knowledge of the risks smoking poses to health, and therefore some children may smoke to demonstrate that they are competent to make difficult decisions and to take risks.

These findings were confirmed by cross-sectional research with the same age group carried out in Northern Ireland (Rugkåsa *et al*, 2001a and 2001b). However, the LLSS offers several advantages over the Northern Irish study. Firstly, its data are drawn from a sample of children who represent the range of socioeconomic conditions in the city (rather than solely from children who live in disadvantaged areas), it uses multiple methods in a triangulated design (rather than just interviews) and it is school-based (thus facilitating easy tracking of the cohort, in comparison with a youth-club setting). These advantages to the research design of the LLSS led to key differences in the findings between the two studies. Importantly, the LLSS showed that preadolescents absorb and seek to assimilate adult discourses around smoking behaviour. The Liverpool children suggested that children might smoke to manage stress and to counter boredom, and regular smokers were keen to suggest that they might already be addicted to tobacco. The LLSS also found that children in Liverpool placed a much greater emphasis on the role of peers in first trials than was reported by the researchers in Northern Ireland. Furthermore, while this phase of the LLSS has used a longitudinal design to examine change during preadolescence, to date the Northern Irish study has only published cross-sectional findings.

In conclusion, this research has shown that some children go on to persist with acquiring the smoking habit despite not enjoying their early smoking experiences (Michell, 1990). Analysis of the discourses that the children used to talk about smoking has revealed that some preadolescents perceive that smoking offers many benefits. Children associated smoking with adult status, popularity, group membership, relief from boredom and a means to cope with stress. By age 11, 15% of the cohort (n=34) had either tried smoking repeatedly or were already smoking regularly. This demonstrates that for a significant minority of primary schoolchildren, these perceived benefits constitute a motive strong enough to outweigh the unpleasantness of first use and to overcome concerns about health risks and addiction. Children's accounts of their own first trials revealed a fascinating insight into how preadolescents deal with the contradiction of choosing to engage in a behaviour that they know is likely to harm their health. In several cases, children dealt with this contradiction by denying their own agency, and many of the accounts of first use placed a heavy emphasis on the role of peers. A key finding of this study therefore is that preadolescents see smoking as offering many functions, and the advantages of these perceived benefits are strong enough to outweigh the unpleasantness of first use and health concerns.

8 Summary and Conclusions

8.1 Chapter Outline

This thesis has described the development of the LLSS during the key phase of preadolescence. This final chapter opens with a summary of the thesis (section 8.2). The chapter then goes on to identify the key findings that have emerged from the study, and the contribution that the research has made both to knowledge about children's experiences of smoking (section 8.3) and also to carrying out research with children using participatory methods in a longitudinal design (section 8.4). Because reducing smoking rates among young people is a central objective of government tobacco policy, the next section looks at the implications of the findings for policy (section 8.5). The chapter closes by outlining the recommendations for further work (section 8.6).

8.2 Summary of the Thesis

This thesis examined children's experiences of smoking during preadolescence. The central aim of the research was to understand how children's early smoking careers developed between the ages of 9 and 11. The research used a multi-method child-centred triangulated design to generate quantitative and qualitative data on the determinants of early smoking and also on the discourses that children use to talk about tobacco. Baseline data collected at age 9 (in 1999) were compared with data collected at age 10 (in 2000) and at age 11 (in 2001) in order to identify key elements of change. These data were analysed longitudinally using a case study approach that identified individual trajectories and emerging themes. The case study analysis also used a comparative method to identify and explain the relationship between views, intentions and behaviour, and how these were shaped by the social context (particularly the familial smoking habits and socioeconomic conditions) in which the children lived. These 'petite generalisations' (Stake, 1995) were then explored and developed in the context of data generated by the whole cohort. The key determinants of smoking during preadolescence were identified using statistical analysis, and a model of predictors of smoking at age 11 was constructed

using logistic regression. The data were also analysed to explore the discourses that preadolescents use to talk about both smoking uptake and the nature of smoking as an adult behaviour. The implications of these discourses for smoking onset were then discussed in the context of the new paradigm of the sociology of childhood, and the contribution of the study to sociological theories of childhood was defined. The chapter will now conclude with reference to the original contribution made by the study, implications for policy and recommendations for further work.

8.3   Children's Experiences of Smoking

This research is the first longitudinal study in the UK to have tracked the experiences of smoking of a cohort of children during preadolescence. A central aim was to examine how children's early smoking careers develop between the ages of 9 and 11. In summary, in terms of smoking behaviour, the majority of the cohort remained never-smokers throughout the period of the study (73%, n=174). However, the proportion of children who reported that they tried smoking increased over time, from 8% (n=20) in 1999 to 27% (n=65) in 2001. Of these triers, 43% (n=28) had tried smoking repeatedly by the time they left primary school and at age 11, 3% (n=6) of the cohort were smoking regularly. The longitudinal design has provided a unique way of tracking the smoking careers of preadolescents over time. In the same way, diagrammatic modelling of the relationship between intentions and behaviour during preadolescence revealed that children's intentions are erratic during preadolescence and are limited in their usefulness to predict behaviour. The case study analysis of qualitative data also showed that there is a complex relationship between views, intentions and behaviour during preadolescence.

This phase of the LLSS is also the first study in the UK to explore the social patterning of smoking during preadolescence. The research considered the determinants of early smoking to show that experimentation with cigarettes at this age is indeed socially patterned. Children who smoked typically had older friends and a parent who smoked, and lived with a smoker either in a low-income household or in a deprived area. A logistic regression analysis showed that factors at age 9 could be used to predict trying

smoking by age 11. The key factors that emerged in a model to predict smoking included paternal and fraternal smoking, being male, knowing someone with smoking-related disease (community exposure to tobacco) and having a smoking best friend.

The study also considered how the discourses that the children used to talk about smoking developed between the ages of 9 and 11. The analysis of qualitative data revealed that children have absorbed the social construction of smoking as an adult habit in the UK and that the cohort did not differentiate in the discourses that they used to describe child and adult smoking. Adult smokers were seen as using tobacco as a coping strategy and as addicted. By age 11, many of the cohort talked about how some children might also smoke in order to manage stress and to counter boredom. Similarly, some of the cohort feared that children could become addicted to tobacco very quickly and this acted as a deterrent from trying smoking. Because the study has shown that children smoke to demonstrate that they possess adult capabilities, conversely a very small number of children who were smoking regularly sought to convey that they were addicted to tobacco already. It is likely that this is because addiction is a central feature of tobacco use that distinguishes adult smokers from preadolescents who are only just beginning to experiment with cigarettes.

Another key finding of the study is that children as young as nine years old may smoke in order to negotiate status in anticipation of the transition into adolescence and beyond. As the discussion presented in Chapter 6 showed, smoking may be considered a metaphor for adult status in the peer group, symbolising physical strength and mental competence, bravery, independence and autonomy. This means that the preadolescent construction of smoking as an intrinsic part of adulthood and as a means to negotiate status affects relationships between children who smoke and others who do not. Concerns around peer pressure to smoke were founded on the perceived attributes that smoking gives to children, especially the use of tobacco as a symbol of physical strength. Because all the children knew that smoking is a behaviour that harms health, some emphasised the role of peer pressure in their accounts of first trials perhaps to deal with the contradiction of engaging in a behaviour which they know has the potential to harm health. Conversely,

other children emphasised curiosity and the role of their own agency in their accounts of their initial trials.

Sociologists in the area of childhood have suggested that there is a need for research which considers how children use strategies of resistance to the exercise of adult power (James and Prout, 1997 – see section 2.3.3), and this study also fills that significant gap. Certainly, the study has contributed to the new social studies of childhood in theoretical terms by considering how preadolescents experience and seek to negotiate social transitions. It has also considered how the social construction of smoking as an adult behaviour which aims to protect children's health may actually encourage children to smoke to demonstrate that they too have adult status.

8.4   Longitudinal Research with Children

The LLSS used a unique multi-method design which triangulated several participatory techniques in order to give a full picture of children's experiences of smoking. This methodology was originally developed by Lorna Porcellato to assess children's perspectives on smoking during the early years, as part of the first wave of the study (Porcellato, 1998).

This preadolescent phase of the study has contributed to the development of the research method in a number of ways. Firstly, all the methods were updated to reflect the growing capabilities of the cohort. Secondly, the children's questionnaire, focus group schedule and parent's questionnaire were substantially redesigned to reflect the new focus on social context of this stage of the study. Because children generally begin to smoke during preadolescence, the emphasis of the research shifted to exploring children's first use experiences. The questionnaire also showed that preadolescent children can describe their own ethnicity and that postcode data can usefully be collected from this age group, enabling the improved analysis of children's socioeconomic status and the collection of new data on ethnic origin. The focus group schedule showed that participatory techniques developed with adolescents can also work well with this younger age group.

The parental questionnaire was redesigned so that in this phase of the study it constituted a significant data source that added an extra dimension in triangulation with the children's data. Because the research aimed to explore the social patterning of smoking among preadolescents, the parental questionnaire was used to collect data on parents' economic activity and socioeconomic status. However, a limitation of the study was the uneven rate of return of parental questionnaires which affected the usability of much of the parental data. Because the parents from the schools situated in the most deprived areas were much less likely to return their questionnaires, the affluent children were over-represented in the data on socioeconomic status with the exception of deprivation scores derived from postcode data. This phase of the study also showed that respondent validation techniques can be used successfully with preadolescents if findings are presented in simple and appropriate language.

This phase of the LLSS has also contributed to the development of qualitative longitudinal research design and analysis. A literature review found few longitudinal studies that had been carried out using qualitative methods to track individuals over time. Therefore, methods of qualitative data analysis were blended with a case study approach to create a unique longitudinal case study method. This innovative method of analysis proved extremely useful in allowing an in-depth exploration of how the experiences of individual children changed over time, while taking into account their social context. The use of a case study approach to examine longitudinal qualitative data was central to the process of identifying areas of similarity and difference in comparative terms in two key ways. Firstly, comparison of the data generated by each child was compared with the same child's data for the preceding year. This revealed how the knowledge and beliefs of each child changed over time. Secondly, a cross-case comparative analysis was used to consider how children's experiences differed in relation to their social status. This cross-case comparison led to the development of 'petite generalisations' (Stake, 1995) the applicability of which were then explored and developed in the context of quantitative and qualitative data generated by the whole cohort.

8.5   Implications for Policy

This research is very timely in the light of recent targets set by the government to reduce smoking prevalence rates among children (DoH, 1998). There is widespread agreement that successful tobacco control policy must be evidence-based (Samet *et al*, 1998). Therefore, this research has the potential to form a useful foundation for policy because it has yielded an understanding of the processes that determine children's early smoking careers. This phase of the LLSS has also offered a unique insight into the way that children think about smoking. If policies that aim to prevent smoking are to be successful, then it is vital that they are grounded in children's lived experiences and acknowledge the importance of their perspectives.

Although there is currently perhaps the political will to intervene to reduce child smoking rates, the questions of when and how to intervene are difficult ones. As discussed in section 1.4.2, stage theorists argue that young people take up smoking in phases, and therefore interventions should be designed to prevent them making the transition from stage to stage. While primary prevention involves preventing early trying and experimental use, secondary prevention aims to get experimenters or regular users to quit (Flay *et al*, 1998). Other academics in the field have also suggested that interventions should be targeted to the two year period between initial trial and establishment of regular smoking (Baugh *et al*, 1982). The implication from these studies is that preadolescence represents a key time to intervene in the development of children's smoking careers. At age 11, the majority of children have never tried smoking and primary prevention measures must continue to be taken to ensure that these children remain non-smokers (Charlton, 1984). However, by 2001 just over a quarter of the cohort had tried smoking and some were at the stage of experimentation or even regular smoking. These children require secondary prevention interventions to either encourage them to quit or to deter them from further trials. Because by preadolescence children are at different stages in their smoking careers, it is important to target effective and realistic interventions that relate to their own experiences of tobacco, diverse as these may be. This study has given

an insight into how children view tobacco, and also how their experiences vary by socioeconomic group and according to parental smoking behaviour.

So, if preadolescence represents an ideal time to engage in primary and secondary smoking prevention, what kind of interventions should be carried out? Although the findings from the first phase of the LLSS (Porcellato, 1998) have already been used to develop schools resources (Tacade, 2002), the findings from the preadolescent phase of the study have much wider implications for the prevention of smoking uptake. It is anticipated that resources for schools based on evidence collected from the children using a participatory approach such as the LLSS will prove an effective primary prevention tool. However, school-based interventions have so far been unsuccessful in preventing uptake among older children (Altman *et al*, 1999; Aveyard *et al*, 1999). This may be because children who smoke are not only more likely to be absent from school, but they are likely to hold anti-school values which means that they may be unreceptive to school-based health education programmes (Banks *et al*, 1981). The findings from this phase of the research have shown that by age 11 children are already well-informed about smoking, and well aware of the risks smoking poses to health. Thus, interventions which aim to prevent smoking uptake must take a broad approach which goes beyond health education to take account of the multifactorial nature of smoking onset.

Some factors that contribute to smoking uptake are more amenable to policy intervention than others. For example, while it is theoretically relatively straightforward to use tobacco control policy to raise the price of cigarettes, to introduce health education initiatives, to ban tobacco advertising and to restrict smoking in certain places, it is very difficult to intervene in individual factors which perhaps represent the most important influences on smoking uptake, such as the role played by family and peers (Townsend *et al*, 1994). Nevertheless, smoking prevention programmes must be targeted at both the individual and the community level if they are to be effective (Samet *et al*, 1998). This study has shown that social pressures and structural factors are central to the reasons why children take up smoking. Therefore it is important that interventions tackle the root

causes of smoking, which may well be linked to the nature of adolescence in the UK and also to the deprivation that is associated with smoking by parents and their children.

The government's tobacco policies centre on <u>Smoking Kills</u> (DoH, 1998) (for details of the strategy, see section 1.9). This section considers the strategies set out in the White Paper to reduce smoking rates among young people in the context of the results that have emerged from this research, and suggests additional implications for policy which draw on these findings.

Although the government acknowledges that children take up smoking for a wide range of reasons (DoH, 1998), the policies to reduce smoking rates among children and young people focus very narrowly on access to tobacco products through shops and vending machines. The strategy to reduce child smoking prevalence set out in <u>Smoking Kills</u> has four main strands:

1. Minimal tobacco advertising in shops
2. Tough enforcement on under age sales
3. Proof-of-age cards to prevent the sale of tobacco products to minors
4. Strong rules on the siting of cigarette vending machines to prevent their use by children.

Although it is possible that these measures - if fully implemented - may reduce smoking rates among older children, this study has shown that preadolescents do not obtain their cigarettes from shops or from vending machines. Younger children who are not yet smoking regularly may steal their first cigarettes from parents or they may smoke butts picked up from the street. However, many children are given their first cigarette by older friends. Therefore these measures may be useful in breaking the chain of supply in which older children buy cigarettes from shops or machines and then give or sell them on to younger children. In addition, while measures to strictly enforce the legal restrictions on the sale of cigarettes to minors may not prevent experimentation, they may prevent children from making the transition from experimental to regular smoking, which

requires easy access to a ready supply of cigarettes. It is vital that the law is strictly enforced if it is to be meaningful in restricting young people's access to cigarettes rather than merely symbolic in defining smoking as an adult behaviour. Some of the children who participated in the LLSS in 2001 were able to describe shops that sold 'loosies' (single cigarettes) to children, and none of the children who had tried smoking repeatedly suggested that they found it difficult to access cigarettes.

However, the study has also found that although many children have tried smoking, surprisingly by the age of 11 some children are still unaware of the exact age at which the sale of cigarettes is permitted to children. Although the cohort have known from their early years at school that there is a minimum age of purchase for cigarettes (Porcellato, 1998), the findings of this phase of the research have shown that many children still need to be made aware that the law applies to children *under 16*. Furthermore, although the law that restricts of the sale of tobacco products to minors is intended to protect children's health, the findings of the research have shown that the law contributes to children's belief that smoking can be used to demonstrate adult status. In this way, it protects some children from smoking while simultaneously encouraging others to start. Nevertheless, this finding should not be interpreted as a call for the law on tobacco sales to be changed. The law does successfully protect many children from smoking. However, legal restrictions on sales must be supplemented by significant media campaigns. These must challenge the supremacy of marketing by tobacco companies in shaping children's perceptions and the symbolic associations that tobacco has for preadolescents. Reducing children's access to cigarettes is not enough to prevent them smoking. In addition, it is vital to change the meaning and significance that smoking has for children. The chapter now goes on to consider the role of government policy on tobacco advertising.

Some of the other policy initiatives that the White Paper sets out, which are targeted either at adults or at the whole community, may also cut smoking rates among children:

1. End tobacco advertising

2. Improve smoking cessation services
3. Reduce smoking levels in public places.

The findings from this study support the proposed ban on tobacco advertising and promotion. Other research has shown that marketing produced by the tobacco industry seeks to reinforce children's perceptions that smoking is an adult behaviour by presenting tobacco as an entry into the adult world (for example, Aitken *et al*, 1985; Amos, 1992; Goldman and Glantz, 1998). Analysis of the children's talk has clearly shown that preadolescents are aware that children use tobacco to negotiate status as they approach adolescence and the subsequent transition to adulthood. In simple terms, children take up smoking because they believe it is an intrinsic part of adulthood. Tobacco advertising also normalises smoking behaviour and conveys to children that smoking is socially acceptable. Although the findings from this study give weight to the proposal to end tobacco advertising, the government has been disappointingly slow to introduce this ban. However, recent developments at the time of writing (March 2002) suggest that the Bill will shortly be debated in the House of Commons (DoH, 2002; Kmietowicz, 2002). Although there is some evidence that smoking rates among young people have started to fall (see section 1.3.2), this phase of the LLSS has shown that by age 11 over a quarter of children have already tried smoking. Several studies have found that cigarette advertising promotes smoking among children (for example, Aitken *et al*, 1986; Best *et al*, 1988; Nelson and While, 1992; Charlton *et al*, 1997; Jensen Arnett and Terhanian, 1998). Therefore, it is vital that the ban on tobacco advertising is introduced as soon as possible. Furthermore, this must be a total ban because studies have found partial advertising bans to be ineffective in reducing cigarette consumption (Laugesen and Meads, 1991; Jha and Chaloupka, 2000).

In order to reduce smoking rates among adults, the government has substantially increased its investment in smoking cessation services, with a special emphasis on providing services through Health Action Zones (DoH, 1998). Although the emphasis of these services is of course smoking cessation and not prevention, this study has shown that parents play a central role in smoking uptake. Therefore, reducing smoking

prevalence and consumption among parents should contribute to a reduction in rates of smoking uptake among their children (RCP, 1992; Derzon and Lipsey, 1999). This is because if a child does not have parents who smoke then he/she is not exposed to adult smoking role models in the home and will not grow up thinking that smoking is a normal part of adult life. Furthermore, the children of non-smokers do not have easy access to cigarettes at home and are not exposed to passive smoking (exposure to passive smoke increases children's tolerance of nicotine and makes them more likely to continue smoking past initial trial). A key finding from this phase of the LLSS has been that preadolescents are aware that adults use smoking to manage stress and that they have absorbed these ideas to suggest that children may also need to smoke in order to cope. Thus, children who are not exposed to adult smokers both at home and in the community will be less aware of the positive effect functions of smoking and perhaps therefore less likely to be attracted to the habit and to believe that smoking is necessary to cope with life.

In acknowledgement of the risks that passive smoking poses to health, part of the government's tobacco control strategy is to work with the hospitality industry to implement the Public Places Charter set out in Smoking Kills (DoH, 1998). The Charter is designed to encourage pubs, bars and restaurants to introduce a written policy on smoking and to introduce non-smoking provision wherever possible. The issue of passive smoking is especially significant for children because other research has shown that not only does ETS harm children's health, but it may also predispose them to taking up smoking (see section 1.8). Although some of the children who participated in the LLSS reported exposure to ETS in pubs and restaurants (2000: 11%, n=29; 2001: 11%, n=27), the number of children affected was small in comparison with those exposed to passive smoke in their own homes and in the homes of other relatives (2000: 44%, n=113; 2001: 51%, n=121). In addition, while most children probably make only a brief occasional visit to a pub or restaurant, it is likely that the children of smokers will spend many hours each day inhaling secondhand smoke at home. While several children reported that their parents did take some steps not to smoke near them, many of these

measures appeared symbolic rather than effective in protecting children's health (see Appendix L).

Although the steps the government is taking to encourage the hospitality industry to move closer to smoke-free status are welcome, smoking in public places is not the main concern of preadolescents and it does not pose the greatest risk to their health. While it is relatively easy to regulate smoking in public places, and impossible to regulate smoking in the private sphere, perhaps measures could be taken to encourage smokers to protect the health of children more effectively at home. Parents can minimise the effects of ETS on their children by not smoking in the house or car, by not smoking while children are present, by not permitting visitors to smoke and by ensuring that their home is well ventilated (Swann and Wright, 2001). Although a few of the cohort reported that their parents always smoked in the garden, these children were in the minority. Others reported that their parents would move to the other side of the room or even merely wave the smoke away. It is important that parents are well informed about the risks that passive smoking poses to their children's health and well-being. A component of the government's tobacco strategy aims to change attitudes to tobacco (DoH, 1998), and health education campaigns targeted at adults could usefully convey this vital information about children's health.

Lastly, policies which aim to prevent smoking universally focus on what adults can do to protect children. Teachers are exhorted to teach pupils about the risks tobacco poses to health, shopkeepers are obliged to keep the law that prohibits the sale of cigarettes to children, and even parents are perhaps encouraged to protect their offspring from passive smoke and not to allow them easy access to cigarettes. However, scant attention has been paid to the role that children already play in promoting health with regard to smoking. The findings from this study have clearly demonstrated that children want to be actively involved in health promotion. The participants in the LLSS already take steps to protect their own health from passive smoke and they endeavour to promote smoking cessation among their relatives and peers. Further evaluation is therefore needed to consider how children can be resourced as active agents in their communities to promote both their own

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health and that of friends and family. While the existing literature focuses on the negative impact that peers and parents may have in influencing children to start smoking, research is needed to explore how children can counter this by engaging in health promotion in their own right.

8.6 Recommendations for Further Work

8.6.1 Within the LLSS

Work is already underway on the third phase of the LLSS, which will continue to track the cohort at secondary school. There are several recommendations that have emerged from the preadolescent phase of the study that will usefully inform the development of the adolescent wave of the research.

The preadolescent phase has considered the transition from never having smoked to first trial and then to experimentation. At age 11, only 3% of the cohort were smoking regularly. However, it is anticipated that the proportion of children who smoke regularly will increase during the teenage years. As the cohort enters adolescence, the next wave of the study should therefore focus on the transition from experimentation to regular smoking. Not all children who experiment with cigarettes go on to become regular smokers (McNeill, 1991; McGee and Stanton, 1993). Therefore, research is required to explore why some children make the transition to becoming regular smokers, whereas others try smoking either once or repeatedly, yet do not progress further. Furthermore, the move to secondary school has been identified as a key time during which children take up smoking (Santi *et al*, 1990-1991), and the longitudinal data set which spans primary and secondary schooling will enable the research team to explore the significance of that transition for smoking onset.

Because the cohort has now been participating in the research for seven years, during adolescence it would be useful and interesting to compare smoking rates among the cohort with those of a matched control group. This comparison could be used to assess

whether long-term participation in the research has inadvertently produced the Hawthorne effect (Banks *et al*, 1978; Bowling, 1997). That is to say, whether participation in the study has affected the cohort's views and smoking behaviour so that they are no longer representative of the population from which they were sampled in 1994. Although the research has been conducted in a value-neutral way and every care has been taken not to impart information to the children, it is possible that annual participation in the study may have caused children to think more about smoking than they would otherwise have done, and this may have contributed to behavioural or attitudinal change. It would therefore be prudent to compare the data generated by the cohort during adolescence with those of a control group to see if any change of this kind has occurred.

Although the sociology of childhood has proved to be a useful epistemology with which to interpret the data on children's smoking during preadolescence, future work could also include an element of theoretical triangulation. Theoretical triangulation seeks to enhance understanding by using two different epistemologies to interpret a body of data in order to increase the power of explanation (Denzin, 1989). Although much of sociological theory around childhood acts as a critique of psychological ways of knowing, it would be interesting to consider how a psychological perspective could shed light on the sociological interpretations of the data presented in this thesis. During adolescence, other studies have shown that smoking is associated with low self-esteem (Minagawa *et al*, 1993; Barber *et al*, 1999). Therefore, an example of this theoretical triangulation could be to use self-esteem data to add another dimension to explanations of why some children become regular smokers during adolescence and others do not. Further research could also consider whether changes in children's views and discourse during preadolescence reflect or refute developmental changes described by child psychologists.

In addition, further work could compare the data produced during preadolescence (1999-2001) with that produced during early childhood (1994-1998). This is a unique longitudinal data set that has tremendous potential for further analysis. For example,

statistical modelling could be used to explore whether factors at age 5 and 7 predicted smoking at age 11. The scope of the longitudinal qualitative case study method presented in this thesis could also be extended retrospectively to include data generated by the case study children during the early years. This analysis would yield a fascinating insight into individual children's trajectories into smoking from infancy to adolescence.

8.6.2 Further Research

Although this research has implications for the continued development of the LLSS, its findings can also be used to generate recommendations for further research into children's experiences of smoking. A central finding has been that the social construction of smoking as an adult behaviour in the UK shapes patterns of smoking onset among preadolescents by simultaneously encouraging some children to experiment with cigarettes while deterring others from making an initial trial. Because social constructionism is central to understanding children's smoking, it would be useful to compare the construction of smoking in the UK with norms around smoking in other countries in the context of rates of smoking uptake. These findings could enhance knowledge about smoking uptake and also have implications for policy transfer. For example, in France, children are able to legally purchase cigarettes from shops at any age, yet adolescent smoking rates exactly match those in the UK (9% in 1998) (Corrao *et al*, 2000). What implications does this comparison have for policies that restrict the sale of cigarettes to children? Do legal restrictions impact significantly on child smoking prevalence rates? What other measures could also be used to reduce child smoking prevalence?

Further work is also required to investigate the social patterning of both children's smoking behaviour and their discourses around smoking during preadolescence. In particular, it has emerged from this study that preadolescents from disadvantaged areas perceive that some children may smoke in order to manage stress and to cope with life in the same way that studies have shown that adults use tobacco for positive effect. Further research is required to understand how children experience social stress and to discover

how they use coping strategies to manage their emotional state and to deal with boredom. This phase of the study has shown that smoking during childhood is associated with poverty, therefore further research is needed to uncover why children from deprived areas are more likely to smoke than those who live in relative affluence. This understanding could then be used to develop interventions which take account of the structural pressures that operate on children, and also that act on these social pressures.

8.7   Conclusions

The preadolescent phase of the LLSS has examined the determinants of smoking during preadolescence. Qualitative methods have been employed to explore the discourses that children use to talk about tobacco and smoking uptake. Triangulation has then been used to identify how children's talk is socially patterned, and how the determinants of smoking are reflected in their discourse. An innovative longitudinal case study approach has also considered how individual children's trajectories into smoking develop during preadolescence. All of these things are unique to this research.

The study has revealed that patterns of smoking behaviour are socially patterned during preadolescence by familial and peer smoking, and particularly by socioeconomic status. The research has also demonstrated that some children take up smoking as they negotiate the social transition to adulthood, in order to show that they are physically strong and mentally competent. Analysis of the children's talk has shown that preadolescents who live in more deprived areas suggest that some children need to smoke in order to cope with social stress, and that more affluent girls are already beginning to identify smoking with weight control while still at primary school.

However, the challenge now is to develop primary prevention measures to protect the majority of children who are still non-smokers when they leave junior school from trying smoking during adolescence. In addition, the research has shown that a significant group – over a quarter – of the cohort had tried smoking by age 11. Innovative secondary prevention initiatives are urgently required to prevent these children – many of whom

have tried smoking repeatedly, and a few of whom are already smoking regularly – from becoming (or continuing as) regular smokers during adolescence and beyond into adulthood. As already discussed, the interventions required must move beyond a narrow focus on health education to tackle the structural and social pressures which this study has shown shape patterns of smoking during childhood. This presents a great challenge to researchers, health promoters and policy makers, but it is essential that these steps are taken to protect the health and well-being of children both now and in the future.

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Appendix A: Letter to Parents

Dear Parents

As you know, your child .... has been participating in the Smoking Research Project since 1995. This research is unprecedented in Liverpool and has raised significant interest on a national level. The project is now entering its second phase, and so I am writing to give you some information about the project, and to invite your child to take part for the next three years.

The aim of the Smoking Research Project is to develop an understanding of children's views about smoking as they move through their early years at school. So far, the response to the project has been amazing, and over a thousand children have taken part across the city of Liverpool. What we hope to do now is to track a selected group of these children for the next three years as they move from primary to secondary school.

The form of the research will remain much the same. In the classroom, the children will complete questionnaires and a drawing exercise. In addition, some of the children will be interviewed either in groups or by themselves. Because your child has already taken part in the project, we sincerely hope that they will continue to participate in the next stage. We are already very grateful for the co-operation of your child and their school and we hope that this will continue into the future.

With this letter you will find a consent form, and also a brief questionnaire about yourself and your family. I would be very grateful if you could return these to me in the envelope provided. You should note that any details you provide will remain strictly confidential, and will be kept on a database for future use. If you have any concerns or questions, or require any further information, please do not hesitate to contact me at the School for Health.

Thank you for your help and co-operation.

Yours sincerely

Beth Milton

Encs.

Appendix B: Parents' Consent Form

Parents' Consent Form for Smoking Research Project

By completing this form you are acknowledging that your child has / has not received parental permission to participate in this study.

Name of parent / guardian ....

Name of child ....

Name of school ....

I have read and understood the information sent to me about the smoking and children research project.

Please sign the appropriate statement below:

- I give my consent for the child named above to participate in the smoking research project.

Signature .... Date ....

- I would like further information about the study before I give my consent.

Signature .... Date ....
Contact telephone number ....

- I do not give my consent for the child named above to participate in the smoking research project.

Signature .... Date ....

Please return this form to Liverpool John Moores University in the enclosed envelope together with the questionnaire.

Please note that if you do NOT return this form, your child will automatically be included in the questionnaire survey, the drawing exercise and the group work.

Thinking about Smoking Workbook 2001

These questions are about you, your family and friends, and what you think about smoking.

Sometimes you will need to write a number or a word. Sometimes you will need to write more.

Please write in the spaces, like this:

....

Or put a tick in one box for each question, like this:

Yes ☐   No ☐

It is very important that what you write is your own work, so do not look at what other people are writing.

No one will see your answers except me, so please be as truthful as possible. There are no right or wrong answers, we just want to know what you think.

When you have finished, please put your workbook in the envelope. This is so that no-one else will see your answers.

I would like to take part in the Thinking about Smoking activity. Please write your name here:

Name .... Date.............................

About you:

We're going to start with some questions about you.

1. **I am a**   Girl ☐   Boy ☐

2. **How old are you?**   I am ……. years old

3. **When is your birthday?** ………………………………………………

4. **What is your postcode?** ………………………………………………

5. **What is your ethnic group?**

White English ☐	Chinese ☐
White Scottish ☐	Indian ☐
White Welsh ☐	Pakistani ☐
White Northern Irish ☐	Bangladeshi ☐
White Irish ☐	African-Asian ☐
White European* ☐	Asian Other* ☐
White Other* ☐	Mixed Ethnicity* ☐
Black Caribbean ☐	Other* ☐
Black African ☐	
Black Other* ☐	

* please write here ………………………………………………………

6. **What is your country of birth?** ………………………………………

About smoking and you:

Now I'd like you to answer some questions about smoking.

7. **Have you ever tried to smoke a cigarette?**   Yes ☐   No ☐

If you ticked Yes, answer only the blue questions.
If you ticked No, answer only the red questions on the next page.

Answer these questions if you have tried a cigarette.

8. **How many times have you tried to smoke a cigarette?**

   1 time ☐   2 – 5 times ☐   More than 5 times ☐

9. **Have you smoked a cigarette in the last week?**

Yes ☐   No ☐

These questions are about the first time you tried to smoke a cigarette.

10. **How old were you the first time you tried to smoke a cigarette?**

   I was ……. years old

11. **Where did you get your first cigarette?**

   Mum or Dad gave it to you ☐   Brother or sister gave it to you ☐

   Stole it from Mum or Dad ☐   Stole it from brother or sister ☐

   Friend gave it to you ☐   Picked it up off the floor ☐

   Somewhere else…………………………………………………………..

12. **Did you smoke it by yourself or with someone else?**

   By myself ☐   With someone else ☐

13. If you smoked it with someone else, who did you smoke with?

Mum ☐   Dad ☐   Brother ☐   Sister ☐   Friend ☐

Someone else ....

14. Where did you smoke it? ....

15. Why did you try smoking?

16. Did you like smoking the first time you tried?

Yes ☐   No ☐   Don't Know ☐

17. Do you want to be someone who smokes when you are older?

Yes ☐   No ☐   Don't Know ☐

Answer these questions if you have never tried a cigarette.

18. Have you ever wanted to try a cigarette?

Yes ☐   No ☐   Don't Know ☐

19. Why?

20. Do you want to be someone who smokes when you are older?

Yes ☐   No ☐   Don't Know ☐

21. Why?

22. What do you think about children who smoke?

About other people:

These questions are for everybody to answer, whether you have tried a cigarette or not.

23. Does your Mum smoke?

Yes ☐   No ☐   Used to smoke ☐   Don't Have a Mum ☐

24. Does your Dad smoke?

Yes ☐   No ☐   Used to smoke ☐   Don't Have a Dad ☐

25. Do you have any brothers?

Yes ☐   No ☐

26. If you have brothers, how many do you have?

I have ……… brother(s)

27. If you have brothers, how many smoke?

…………….. brother(s) smoke

28. If you have brothers, how many used to smoke?

…………….. brother(s) used to smoke

29. Do you have any sisters?

Yes ☐   No ☐

30. If you have sisters, how many do you have?

I have .... sister(s)

31. If you have sisters, how many smoke?

.... sister(s) smoke

32. If you have sisters, how many used to smoke?

.... sister(s) used to smoke

33. Do you have any friends that smoke?

Yes ☐   No ☐

34. How many of your friends smoke?

.... friends smoke

35. Does your best friend smoke?

Yes ☐   No ☐   Don't Know ☐

36. How many smokers live in your house or flat?

.... smokers live in my house or flat

37. Why do you think that some <u>children</u> smoke? Please write as many reasons as you can:

38. Why do you think that some <u>adults</u> smoke? Please write as many reasons as you can:

39. What do <u>you</u> think about smoking? Please write as many things as you can:

40.Are you ever in a smoky place?

Yes ☐   No ☐

41.Where?

42.How do you feel when you are in a smoky place?

43.Do you know anybody who has been ill because of smoking?

Yes ☐   No ☐

44.Who was it? What was wrong with them?

Thank you for filling in the workbook.

Please put it in your envelope and seal it down.

Appendix D: Ethnicity Question for Children's Questionnaire, 2001

Personal Communication from Professor Martyn Barrett:

Hi Beth - Thanks for your message. I'd have thought 11 year olds would be aware of their own categorization in terms of the standard census type categories. But these don't always accord with their own subjective self-categorizations (e.g. the category of Indian might be split for them into Punjabi, Gujarati, etc., or into Hindu, Muslim, Sikh, etc.), which might be where problems arise. I suspect you'd do best to present a list of categories for them tick one, but to leave an "other" option for them to fill in, which you could then reclassify for your own analysis purposes accordingly.

Awareness of ethnicity develops from as young as four years of age onwards, so I wouldn't have thought 11 year olds would have problems. I've just had to thrash out a set of categories for children for a project I'm involved with, and a member of the Steering Group for the project was Paul Ghuman, who has written extensively on ethnic minority kids, and he advised us on the appropriate breakdown of the ethnic minority categories. Our list is as follows:

White English [ ]
White Scottish [ ]
White Welsh [ ]
White Northern Irish [ ]
White Irish [ ]
White European [ ] (specify):
White Other [ ] (specify):
Black Caribbean [ ]
Black African [ ]
Black Other [ ] (specify):
Chinese [ ]
Indian [ ]
Pakistani [ ]
Bangladeshi [ ]
African-Asian [ ]
Asian Other [ ] (specify):
Other [ ] (specify):
Mixed ethnicity [ ] (specify):
Ethnicity information not available [ ]

Hope this helps.

Martyn

P.S. I myself have only used questionnaires with secondary school aged kids - we use interviewing for 5-11 year olds. It would probably be wise for you to pilot the questionnaire with a small sample of primary kids before starting any major data collection, just in case they do have difficulty with the questionnaire format.

****

Professor Martyn Barrett
Department of Psychology

Appendix E: Draw and Write Invitations and Instructions

	Instructions to Draw and Write	**Permitted Reminders to the Children**	**Beware**
<u>Box 1</u>	Draw a person smoking a cigarette. Think about the smoke and where the smoke is going. How does your person look and feel? Write where the smoke is going. Write how your person looks and feels.	Draw as quickly as you can. Don't spend too long on drawing the background. It is the people and what they are doing that we want to see. Don't call out, just whisper to me. If you need some help, I will write it for you.	Don't give any hints, suggestions or reminders. Write down exactly what the child says even if it does not make sense.
<u>Box 2</u>	This time draw a person who has been smoking for a long time. How can you tell from the INSIDE of the person's body that your person has been smoking for a long time? Write down how you can tell.	Remind again: How can you tell? Emphasise <u>inside</u> of person's body.	Don't indicate with your voice any disapproval.
<u>Box 3</u>	In this box draw a person who is trying to stop or give up smoking. Think about how your person looks and feels. Write down how your person looks and feels. Think about why your person wants to give up smoking. Write down why your person wants to give up smoking.	Encourage and help as before. Remind them that there are two parts to the question.	Don't suggest any words, or disapproval.
<u>Box 4</u>	Draw a young person who has <u>just started</u> to smoke. Why has your person started to smoke? Write down why your person has started to smoke and say if it's a boy or a girl.	Emphasise words 'just started'.	Check that they (or you) have written 'Boy' or 'Girl'.
<u>Box 5</u>	Draw your self and draw someone offering you a cigarette. What are you really thinking? What do you say out loud to them? Write what you think in your head. Write what you say out loud.		

THINKING ABOUT SMOKING

Draw and Write Workbook

On each page in this workbook you will find a box. In the box you are going to do a drawing and then you are going to write about what you have drawn.

Please draw as quickly as you can. Don't spend too long on drawing the background. It is the people and what they are doing that we want to see.

Remember, it is important that you think about your own work, and don't look at what other people are doing.

Box 1

Draw

Write   **Where is the smoke going?**

How does your person look and feel?

Box 2

Draw

Write   **How can you tell from the inside of the person's body that your person has been smoking for a long time?**

Box 3

Draw

Write   **Why does your person want to give up smoking?**

How does your person look and feel?

Box 4

Draw

Write   **Why has your young person just started to smoke?**

Box 5

Draw

Write   **What do you say out loud?**

What do you think in your head?

Appendix G: Focus Group Schedule

Talk about smoking, but also about other topics. Focus group: ideal to talk about culture & social interaction – stay off contentious topics. Use Shucksmith & Hendry (1998) method of selecting one person, and then letting them choose 4-5 other friends.

Introduction and Ground Rules:

- Make name badge.

- Here today to talk about smoking.
- Important to listen to what others have to say, and only to talk one at a time. Respect – all have something important to say. Tape.

- Icebreaker: Say name and favourite TV programme (1999), food (2000) or thing to do on Saturday (2001).

Questions:

1. Card game

- Each answers question from card, then throw open to discussion (agreement / differences).

Questions: Have you ever asked someone not to smoke? Who?
What do your Mum and Dad think about smoking?
What would your Mum or Dad do if they found out you were smoking?
What would you do if someone offered you a cigarette?
How do you feel about other people smoking near you?
Why do some children try smoking?
Do you think children who smoke are any different from children who don't smoke?
Do you know anyone who smokes?
Is there an age when it is OK to smoke?
Is it easy or hard to stop smoking?

Appendix I: Semi-Structured Interview Schedule

- Start with introductions. Explain about the tape recorder.

Show pictures of adults smoking

- What can you see?

- Why do you think they smoke?

- What do your Mum and Dad think about smoking? Do they smoke? Have they ever tried to quit?

- Does anyone else in your family smoke? (grandparents) (visitors / parents' friends: last resort)

- If yes, why do you think they smoke?

- Where do you see people smoking (apart from at home)?

- Are you ever in a smoky place? How do you feel?

- Is it easy or hard to stop smoking? Why?

- What can happen to people who smoke?

Show pictures of children smoking

- What can you see?

- Why do you think these children are smoking?

- Where do you think they learned to smoke?

- Do you know any children who smoke?

- What about you? Have you ever wanted to smoke?

- How old are the children in these pictures?

- Are they old enough to smoke?

- Is there an age when it is OK to smoke?

- Are children who smoke different from children who don't smoke in any ways?

- [You said smoking is bad for people. Do you think it is worse for grown ups or children. Why?]

- Have you ever asked someone not to smoke? Who?

- What do you think about smoking?

- Is there anything else you'd like to say?

Mapping of family and friends (2001 only)

- Who do you live with?
- Who else do you spend time with?
- Who else is in your family?
- Is there anyone important who is not on the map?

SMOKING AND CHILDREN RESEARCH PROJECT

Parents' Questionnaire

As part of our study, I would be very grateful if you would take a few minutes to complete this questionnaire. It is only with your help that we will be able to understand how children develop their views on smoking in the context of the family. This information will be used to improve the health of school children in Liverpool.

Some of the questions below are about you and your child. There are also questions about your partner and the rest of your family.

- Please tick the boxes, or write in the spaces provided.

- Your responses will remain <u>completely confidential</u>.

- When completed, please return the questionnaire to school in the envelope provided.

Section A - About your child:

These questions are about the child who is taking part in our study.

1. **Child's name:** ....

2. **My child is:**

White	☐	Indian	☐
Chinese	☐	Pakistani	☐
Black-Caribbean	☐	Bangladeshi	☐
Black-African	☐	Mixed ethnicity	☐
Black-other*	☐	Any other ethnic group*	☐

    * please describe ....

3. **Child's country of birth:** ....

4. **To your knowledge, has your child ever tried a cigarette?**

    Yes ☐   No ☐   Don't Know ☐

Section B - About you:

5. **I am:**   Female ☐   Male ☐

6. **My age:** .... years

7. **My country of birth:** ....

8. **I am the child's:**

    Mother ☐   Father ☐   Other * ☐

    * please describe ....

9. **I am a lone parent:**   Yes ☐   No ☐

10. **What do you do during the week? Please tick all that apply.**

Employed full-time	☐	Unable to work due to long-term sickness or disability	☐
Employed part-time	☐		
On a government employment or training scheme	☐	Retired from paid work	☐
Unemployed	☐	Looking after home or family	☐
In education	☐	Other*	☐

    * please describe ....

11. **My occupation is:** ....
    (if unemployed, retired, or otherwise not in work please give <u>most recent occupation</u>)

12. **The main tasks I undertake in my job are:** ....
....
....
....

13. **Are you (or your household) entitled to any of the benefits listed below?**

    Working Families' Tax Credit (Family Credit), Income Support,
    Housing Benefit, Jobseeker's Allowance, Council Tax Benefit.

    Yes ☐   No ☐   Don't Know ☐

14. **How would you describe yourself?**

I am a:	**Smoker**	☐	*please go to Question 15.*
	Ex-smoker	☐	*please go on to Question 21.*
I have:	**Never smoked**	☐	*please go on to <u>Section C</u>.*

15. **<u>If you are a smoker</u>, how many cigarettes and cigars do you usually smoke each day? Please write the number in the boxes.**

    ☐ Cigarettes   ☐ Cigars

16. **Which brand do you usually smoke?**

....

17. How old were you when you started smoking?

....

18. Why did you start?

....

19. Does your smoking affect your health? How?

....

20. Have you tried to quit? How?

....

Now go on to Section C.

21. If you are an ex-smoker, how long ago did you quit?

....

22. Why did you stop smoking?

....

23. Did you use anything to help you quit?

....

Now go on to Section C.

Section C – About your partner:

Please complete this section if you have a partner who shares your home. If you are single, please go on to Section D.

24. My partner is: Female ☐   Male ☐

25. My partner's age: .... years

26. My partner's country of birth: ....

27. What is your partner's relationship to your child?

Mother ☐   Father ☐   Step-mother ☐   Step-father ☐

Other* ☐

* please describe ....

28. What does your partner do during the week? Please tick all that apply.

Employed full-time	☐	Unable to work due to long-term sickness or disability	☐
Employed part-time	☐		
On a government employment or training scheme	☐	Retired from paid work	☐
Unemployed	☐	Looking after home or family	☐
In education	☐	Other*	☐

* please describe ....

29. Occupation: ....
(if unemployed, retired or otherwise out of work, please give most recent occupation)

30. The main tasks your partner undertakes in their job are: ....
....
....
....

31. Is your partner a: **Smoker**   ☐   *please go to Question 32.*
                         Ex-smoker   ☐   *please go on to Question 38.*
Have they: **Never smoked** ☐   *please go on to Section D.*

32. If your partner is a smoker, how many cigarettes and cigars do they usually smoke each day? Please write the number in the boxes.

☐ Cigarettes   ☐ Cigars

33. Which brand do they usually smoke?

   ....

34. How old were they when they started smoking?

   ....

35. Why did they start?

   ....

36. Does their smoking affect their health? How?

   ....

37. Have they tried to quit? How?

   ....

Now go on to <u>*Section D*</u>.

38. **<u>If they are an ex-smoker</u>**, how long ago did they quit?

   ....

39. Why did they stop smoking?

   ....

40. Did they use anything to help them quit?

   ....

Now go on to <u>*Section D*</u>.

Section D - About other people:

These questions are about other people in your family or at home.

41. Does your child have any brothers?

No ☐ go to question 42

Yes ☐ please complete the details below <u>for each brother</u>

Brother 1:	age	Smoker ☐	Ex-smoker ☐	Never smoked ☐
Brother 2:	age	Smoker ☐	Ex-smoker ☐	Never smoked ☐
Brother 3:	age	Smoker ☐	Ex-smoker ☐	Never smoked ☐
Brother 4:	age	Smoker ☐	Ex-smoker ☐	Never smoked ☐
Brother 5:	age	Smoker ☐	Ex-smoker ☐	Never smoked ☐

42. Does your child have any sisters?

No ☐ go to question 43

Yes ☐ please complete the details below <u>for each sister</u>

Sister 1:	age	Smoker ☐	Ex-smoker ☐	Never smoked ☐
Sister 2:	age	Smoker ☐	Ex-smoker ☐	Never smoked ☐
Sister 3:	age	Smoker ☐	Ex-smoker ☐	Never smoked ☐
Sister 4:	age	Smoker ☐	Ex-smoker ☐	Never smoked ☐
Sister 5:	age	Smoker ☐	Ex-smoker ☐	Never smoked ☐

43. How many smokers live in the same house as your child altogether?

....

44. To your knowledge, do any of your child's friends smoke?

Yes ☐   No ☐   Don't Know ☐

Section E – Any Comments?

45. Do you have any other comments?

Please use this space if there is anything you wish to add.

- Thank you for completing this questionnaire.
- Please return it to school in the envelope provided.

Appendix K: Intentions to smoke

Current Intention to Smoke

This study uses two measures of children's intentions to smoke: current and future intention (Porcellato, 1998). The concept of current intention is used to measure whether the child is planning to try a cigarette at the time of the research. The concept of future intention relates to the child's intention to smoke as an adult.

Table 6.1 shows that the proportion of children who reported that they currently wanted to try smoking was small (1999: 3%, n=7; 2000: 5%, n=12; 2001: 6%, n=15). The appendix now goes on to explore the statistical associations between sociodemographic factors and current intention to smoke.

Table K.1: Associations between sociodemographic variables and current intention to smoke between the ages of 9 and 11

VARIABLE*		1999		2000		2001	
	df	X^2	p	X^2	p	X^2	p
Gender	2	4.220	0.121	0.264	0.876	3.278	0.194
Ethnic group	2	3.598	0.165	0.880	0.644	2.157	0.340
Smoking mother	2	5.700	0.223	4.872	0.56	3.543	0.738
Smoking father	2	16.10	**0.003**	11.986	0.062	11.585	0.072
Smoking brothers	2	4.166	0.125	0.122	0.941	1.152	0.562
Smoking sisters	2	4.166	0.125	2.299	0.317	2.157	0.340
Smoking friends	2	4.983	0.083	19.972	**<0.001**	22.582	**<0.001**
Smoking best friend	2	17.75	**0.001**	12.717	**0.048**	5.316	0.256
Lives with a smoker	2	-	-	0.246	0.884	1.384	0.500
Exposed to ETS	2	-	-	0.833	0.659	0.163	0.922
Smoking-related disease	2	0.961	0.618	0.339	0.844	6.765	**0.034**
Lone parent	2	1.400	0.497	5.878	0.053	1.517	0.468
Occupational class	10	11.504	0.320	13.103	0.218	5.402	0.863
Low income	2	1.251	0.870	0.276	0.871	0.749	0.688
Deprivation	4	-	-	1.932	0.748	1.403	0.844

*Statistically significant associations between variables and current intention to smoke are highlighted in bold.

In comparison with trying smoking, fewer factors were statistically associated with current intention to smoke (see Table K.1). Possibly this is because there were fewer children in the cohort who currently intended to smoke in comparison with the number of children who had already tried smoking. In terms of familial factors, father's smoking was associated with wanting to try a cigarette at age 9, but not subsequently. Maternal and sibling smoking were not associated with currently wanting to smoke at any point during preadolescence. Similarly, living with someone who smoked was not associated with a positive current intention to smoke between the ages of 9 and 11.

The central finding which emerged from this analysis was that currently intending to smoke was consistently associated with having either smoking friends (in 2000 and 2001) or a smoking best friend (in 1999 and 2000). This relationship between wanting to try smoking and having a smoking peer group would suggest that peers exert a considerable influence on preadolescents' views on smoking initiation. Perhaps having smoking friends is also associated with current intention to smoke because the children who want to take up smoking may already have been offered cigarettes and opportunities to smoke by their peers.

Many of the sociodemographic variables analysed were not statistically related to current intention to smoke. Neither gender nor ethnic group were found to be statistically associated with wanting to try smoking. Wanting to experiment with cigarettes was not associated with any of the measures of socioeconomic status (occupational class, benefit status or deprivation) either. Furthermore, children who were exposed to secondhand smoke were not more likely to want to try smoking. However, knowing someone with smoking-related disease was associated with trying smoking in 2001 only.

In 1999, the children who participated in the interviews were asked to explain their intentions towards smoking. The children gave a wide range of justifications for their negative intentions to smoke which ranged from fear of future illness to dislike of passive smoking and concern that their parents would be angry:

Int: Why haven't you wanted to try?
Becky Sullivan: I have heard that it could give you cancer and you could die of it and I don't want to die of it (I, 1999).

Int: Have you ever wanted to?
Tabby Morgan: No.
Int: Why not?
Tabby: Because you see people coughing and getting ill and stuff and it puts you off (I, 1999).

Int: Why have you never wanted to try?
Rebecca Williams: Because when my Mum smokes all the smoke gets in my face and it's horrible (I, 1999).

Int: Why don't you fancy it?
Matt B: Just when I stayed in my Nan's for a couple of days I already had a cough when I was out (I, 1999).

Int: Have you ever wanted to try a cigarette?
Girl: No. Because I would be killed – my Mum would kill me! (I, 1999).

By 2001, these data were collected from the whole cohort using the children's questionnaires. The motives of the children who wanted to smoke were similar to the reasons given by the children who had already tried smoking. They centred on curiosity, the influence of friends and the importance of group membership:

Because so many people smoke I wonder what it is (Toby, Q, 2001).

Because I don't know what it is like (Toni Crosbie, Q, 2001).

Because I have seen other people do it. I don't want to become a smoker, I just want to try one (Maggy Haniford, Q, 2001).

Because my friends are doing it (Timothy O'Leary, Q, 2001).

Because all my mates are doing it (Sophie Larkhill, Q, 2001).

Next door tried when we were on holiday and I felt left out (Girl, Q, 2001).

My Nan and aunties all smoke but my Mum and Dad don't smoke. I sometimes feel left out (Lisa Gerrard, Q, 2001).

The members of the cohort who did not want to try smoking explained that *they were* concerned that smoking would harm their health (perhaps because they knew people who

had been ill because of smoking), or compromise the fitness levels required to participate in sport. Some children also did not currently want to smoke because they believed they were too young:

> I know it might kill me one day (Kerry Louise Brown, Q, 2001).

> I have asthma and it is not good for your health (Louise Simpson, Q, 2001).

> I have seen how ill people get by smoking (Kayleigh Rudge, Q, 2001).

> Cigarettes killed both my grandads (Naomi Redcross, Q, 2001).

> I do boxing and it will ruin it for me (Mick Smith, Q, 2001).

> It will slow me down in running and I really like running (Bob Williams, Q, 2001).

> It is dangerous and unlawful to smoke at my age (Cara-Elizabeth Brimage, Q, 2001).

The literature suggests that children who lack a strong negative current intention (that is to say, they report a positive intention or are unsure) are susceptible to smoking (see section 1.6). Conversely, children who display a strong negative intention to smoke are non-susceptible. Although there were few participants in the LLSS who had a positive current intention to smoke, there were several more who lacked a strong negative intention to smoke, and were therefore susceptible to smoking (see Table K.2). While the proportion of children who had already tried smoking or who currently intended to smoke increased each year (1999: 20%, n=49; 2000: 34%, n=84; 2001: 38%, n=92), the number of children with a clear negative intention to smoke decreased over time (1999: 80%, n=198; 2000: 66%, n=172; 2001: 62%, n=147). Therefore, this shift in attitude demonstrates that by age 11 the cohort as a whole was more susceptible to taking up smoking.
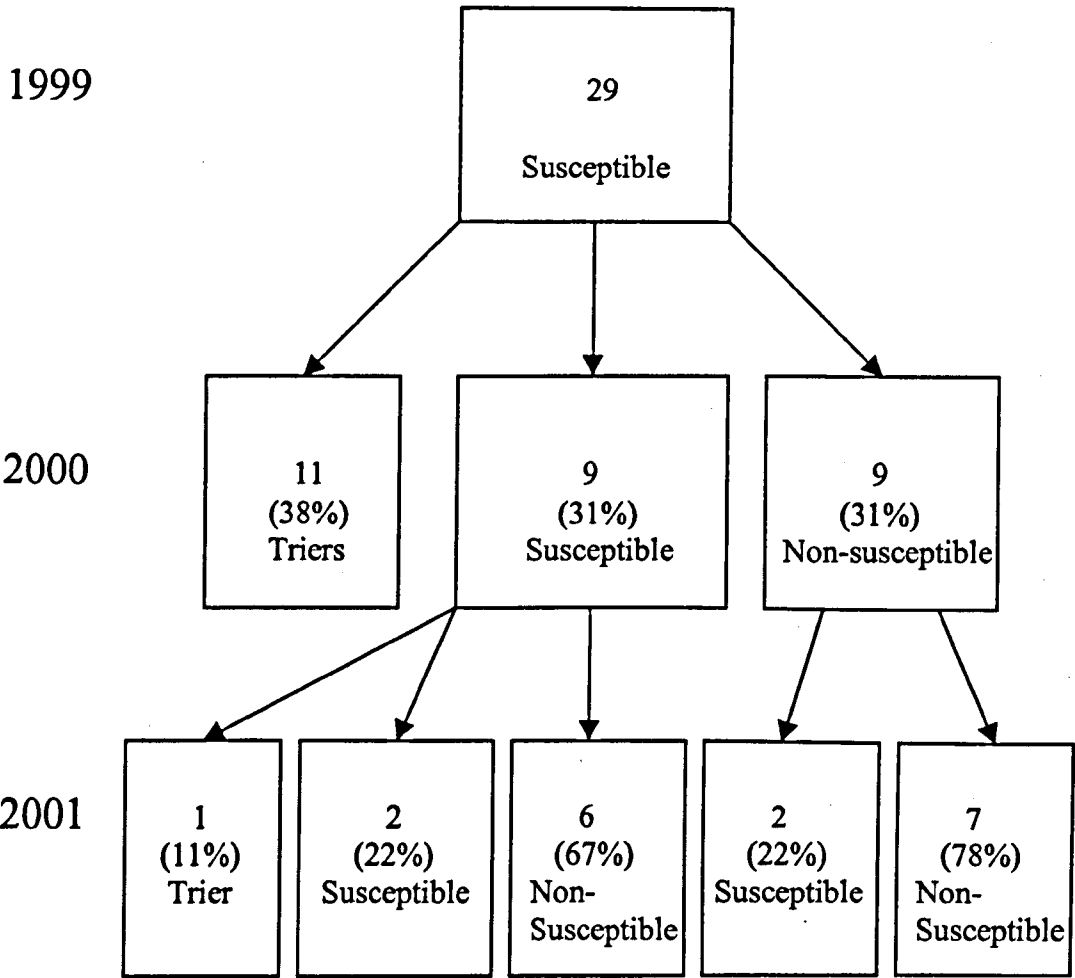
Table K.2: Current intentions of children who had never tried smoking (1999-2001)

Susceptibility	Current Intention	1999		2000		2001	
		%	n	%	n	%	n
Susceptible	Positive	3	7	5	12	6	15
	Ambivalent / Unsure	9	22	7	19	5	12
Non-Susceptible	Negative	80	198	66	172	62	147

NB: Columns do not total 100% because children who had already tried smoking were excluded (1999: 8%, n=20; 2000: 22%, n=53; 2001: 27%, n=65).

The longitudinal design of the study enabled the tracking of each individual child's intentions during preadolescence, and the relationship between intentions and subsequent smoking behaviour. Figure K.1 displays these data in diagrammatic form. It considers how the smoking experience of the children who were susceptible to smoking developed over the course of the study. The diagram shows that of the children who were susceptible in 1999, 38% (n=11) went on to try smoking in 2000. A further 31% (n=9) remained susceptible in 2000, but of these nine only one actually tried smoking in 2001.

It is interesting that there were two children who wanted to try smoking every year, but by 2001 had still not tried smoking. Perhaps these children will have tried smoking by the next data collection point when they are at secondary school. The diagram also shows that children's intentions to smoke vary over time. Of the 29 children who were susceptible to smoking in 1999, the following year nine of these (31%) were not susceptible to smoking – that is, they had a strong intention not to try smoking. However, while seven of these remained non-susceptible, by 2001 two children were again expressing a current intention to smoke or were unsure whether they might like to try smoking.

The experiences of these children are contrasted with those of the children who were non-susceptible to try smoking in 1999 (that is, children who did not report trying smoking and who expressed a clear intention against wanting to try smoking) – see Figure K.2.

<u>Figure K.2: Diagram to show how the intentions and behaviour of children who were non-susceptible to trying smoking at age 9 developed during preadolescence</u>
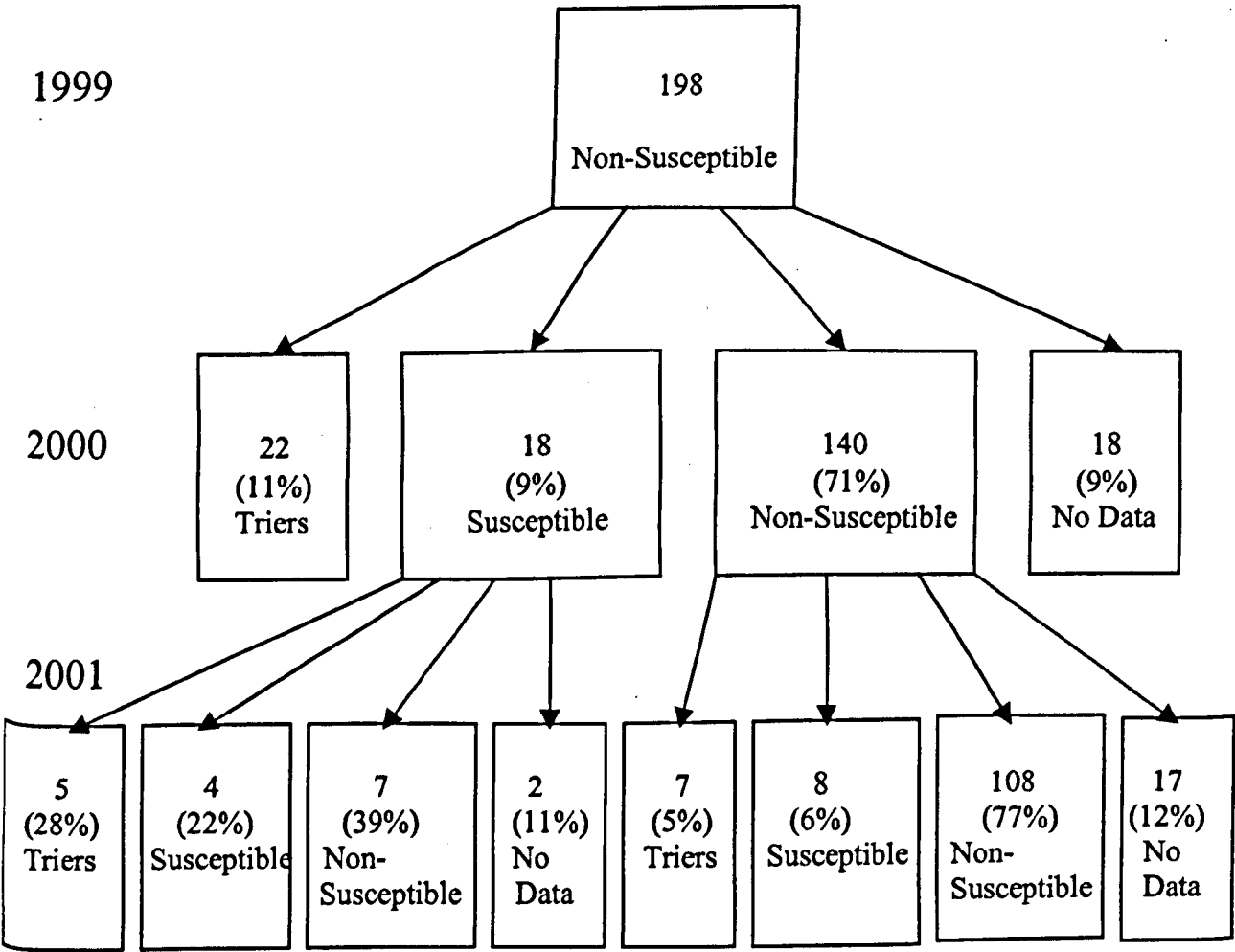
NB: Children in the 'No data' boxes were absent from school during data collection.

1999

198
Non-Susceptible

2000

| 22 (11%) Triers | 18 (9%) Susceptible | 140 (71%) Non-Susceptible | 18 (9%) No Data |

2001

| 5 (28%) Triers | 4 (22%) Susceptible | 7 (39%) Non-Susceptible | 2 (11%) No Data | 7 (5%) Triers | 8 (6%) Susceptible | 108 (77%) Non-Susceptible | 17 (12%) No Data |

As Figure K.2 shows, experimentation with cigarettes was not always preceded by current intention to smoke. Of the 198 children who expressed a clear negative intention against trying smoking in 1999, 22 (11%) went on to try smoking in 2000. A further 18 children (9%) went on to express a current intention to smoke, and of these five (28%)

335

tried smoking and four (24%) remained susceptible to smoking in 2001. Further research is needed to consider why children's intentions to smoke may be unstable during preadolescence and also to consider why children make the transition from susceptibility to smoking to non-susceptiblility and vice versa at different points in time.

Future Intention to Smoke

Only a small minority of children anticipated that they would smoke during adulthood, and the number of children who wanted to smoke as adults decreased slightly over time (1999: 3%, n=7; 2000: 3%, n=7; 2001: 2%, n=4). It is intriguing that as the children got closer to adulthood, and even as the proportion of children who had tried smoking increased and some children began to smoke regularly, the cohort were less likely to intend to smoke as adults. For example, in 2001, 2% of the cohort wanted to smoke as adults, but 3% were already smoking regularly. Perhaps the children who are already smoking anticipate that they will smoke during adolescence but not continue into adulthood. If these children who are trying smoking and even smoking regularly do not intend to smoke as adults, then further research is needed to consider how they view their own smoking futures as they enter adolescence.

The chapter now goes onto explore the statistical associations between sociodemographic factors and future intention to smoke.

Table K.3: Associations between sociodemographic variables and future intention to smoke between the ages of 9 and 11

VARIABLE*		1999		2000		2001	
	df	X^2	p	X^2	p	X^2	p
Tried smoking	2	24.094	<0.001	12.101	0.002	20.146	<0.001
Smoking regularly	2	-	-	4.118	0.128	13.836	0.001
Current intention	2	44.134	<0.001	76.148	<0.001	10.336	0.006
Gender	2	0.300	0.861	3.715	0.156	2.307	0.315
Ethnic group	2	22.147	0.076	2.624	0.269	1.245	0.537
Smoking mother	2	10.47	**0.033**	8.500	0.204	5.195	0.519
Smoking father	2	8.877	0.064	10.275	0.114	20.928	**0.002**
Smoking brothers	2	9.80	**0.007**	2.651	0.266	14.796	**0.001**
Smoking sisters	2	3.457	0.178	0.726	0.696	2.145	0.342

Smoking friends	2	9.79	**0.007**	8.609	**0.014**	11.288	**0.004**
Smoking best friend	2	6.790	0.147	9.635	0.141	21.249	**<0.001**
Lives with a smoker	2	-	-	5.851	0.054	4.690	0.096
Exposed to ETS	2	-	-	2.102	0.350	1.634	0.378
Smoking-related disease	2	0.652	0.722	0.726	0.696	1.634	0.442
Lone parent	2	2.549	0.280	1.016	0.602	0.001	0.971
Occupational class	10	7.659	0.662	9.033	0.529	1.339	0.931
Low income	2	2.006	0.735	3.582	0.466	0.072	0.788
Deprivation	4	-	-	10.011	**0.040**	5.456	0.244

*Statistically significant associations between variables and current intention to smoke are highlighted in bold.

The statistical associations between future intention to smoke and the sociodemographic variables under study are shown in Table K.3. Although only a few children expressed an intention to smoke in future, children who wanted to be a smoker when they were older were consistently more likely to have already experimented with cigarettes between 1999 and 2001. Children who wanted to smoke as adults were also likely to already be smoking regularly in 2001. This would suggest that even at age 11, a few children have embarked on a smoking career that they anticipate will last into adulthood. For children who had not yet tried smoking, each year there was a statistically significant association between currently wanting to try a cigarette and intending to smoke when older.

In terms of familial factors, maternal smoking was only associated with future intention to smoke in 1999, and paternal smoking was associated with wanting to smoke as an adult only in 2001. Children with brothers who smoked were more likely to want to smoke as an adult in 1999 and 2001, while having a smoking sister was not associated with future intention at any point during preadolescence. In the same way, there was no statistical association between living with a smoker and intending to smoke as an adult in the course of the study.

However, the smoking behaviour of friends emerged again from the analysis as a key influence on preadolescents' views on smoking. Each year, children who wanted to smoke as adults were more likely to have friends who smoked. Having a best friend who smoked was also associated with future intention to smoke in 2001.

As with current intention, many of the sociodemographic variables analysed were not statistically related to wanting to smoke as an adult. Gender was not statistically associated with future intention to smoke. Likewise, no association was found between wanting to smoke as an adult and ethnicity. Again as with current intention, wanting to smoke as an adult was not associated with any of the measures of socioeconomic status (occupational class, benefit status or deprivation). In the same way, future intention to smoke was not found to be statistically related to spending time in smoky places or to knowing someone with smoking-related disease.

In 2001, although the questionnaires asked children to explain their future intentions to smoke, none of the children who wanted to smoke when they were adults were able to list a reason. However, children who did not want to smoke as an adult gave many reasons that reflected the explanations that children gave when they described why they also did not currently want to try smoking. Again, these explanations focused on the risks smoking poses to health and also a concern for fitness. In addition to these, new justifications emerged from the data that were unique to children's understanding of the consequences of becoming a smoking adult, and were perhaps based on the experiences of adults they knew. Children were concerned about being a healthy adult role model and were also deterred by the expense of cigarettes:

> I want to have children and I don't want them to smoke and to be unhealthy (Shauna Mally, Q, 2001).
>
> If I have children I want to set a good example (Billie-Jo, Q, 2001).
>
> You have to spend lots of money (Maggy Haniford, Q, 2001).
>
> I don't want to waste my money on cigarettes (Bill Jeremy, Q, 2001).

Conclusions

Statistical analysis of these data on current and future intentions to smoke suggests that friends have a much greater influence on children's views about smoking than either

living with a smoker or the smoking behaviour of family members. These influences on intentions contrast with the associations revealed by the data on experimentation with cigarettes. Statistical analysis of these data suggests that living with a smoker and the smoking behaviour of parents and siblings are related to trying smoking, in combination with the influence of friends and best friends. The analyses also suggest that living in a low-income household and in a deprived area are related to smoking uptake. However, diagrams that displayed the relationship between individuals' susceptibility and subsequent first trials suggest that current intention is not a useful predictor of smoking during preadolescence. (A statistical analysis of the usefulness of current intention at age 9 to predict smoking behaviour at age 11 is presented in section 6.3.2.) Similarly, it is unlikely that future intention to smoke during preadolescence is a useful predictor of adult smoking behaviour because a greater proportion of the cohort are already smoking regularly than intend to smoke as adults. In addition, on the basis of current rates of adult smoking prevalence in the city, it is likely that in excess of 30% of the cohort will go on to smoke during adulthood.

Appendix L: Experiences of Passive Smoking

The vast majority of the adult population knows that passive smoke harms children's health. A recent survey carried out in the UK found that 90% of respondents knew that environmental tobacco smoke (ETS) puts children at risk of chest infections and 84% knew that children's chances of developing asthma were increased by exposure to passive smoke. However, current smokers were less likely than ex-smokers and adults who had never smoked to admit that ETS damages health. Adults from manual socioeconomic groups were also less likely to be aware of the threat ETS poses to health, and therefore less likely to modify their smoking behaviour in the presence of non-smokers (Lund *et al*, 1998; Lader and Meltzer, 2001).

Exposure to ETS was measured by asking the children if they spent time in smoky places. This self-reporting of exposure to passive smoke has been validated as a useful indicator of exposure to ETS by other researchers who have compared children's self-reports with data collected using biochemical indicators of nicotine exposure (Nelson *et al*, 1999). Three-quarters of the cohort (2000: 73%, n=187; 2001: 74%, n=175) reported that they spent time in smoky environments. They described a wide range of spaces where they were exposed to ETS. As the data in Figure L.1 show, children reported exposure to passive smoke in both private and public spaces. In both 2000 and 2001 the place where the children reported the greatest exposure to ETS was in their own homes. Just over half the children lived with at least one smoker (2000: 56%, n=143; 2001: 55%, n=130), and in 2000 the same proportion reported being exposed to ETS at home. However, in 2001 a greater proportion of children reported being in a smoky environment at home than reported living with a smoker. Presumably this is because they also experienced passive smoking at home as relatives and their parents' friends were permitted to smoke when they came to visit. The other two places where the most children reported exposure to ETS were the homes of grandparents and other relatives. It is striking that now legislation exists to protect children from inhaling secondhand smoke in public places, the areas where children are most likely to be exposed to ETS are their own homes and

those of other relatives. Although some parents make their homes smoke-free in order to protect their children's health, it is noticeable that some children are regularly exposed to passive smoke at home by visitors even though their parents are non-smokers.

Some children also reported being exposed to secondhand smoke in pubs and hotels. Perhaps this is because smoking is an intrinsic part of relaxation and leisure time for adults, and children are then exposed to ETS either if their parents smoke or if they spend their leisure time with friends or relatives who smoke. Some children were also in a smoky environment outside. As the data presented in section 6.2 demonstrated, many children smoke outside, and perhaps the children who reported exposure to secondhand smoke outdoors spent time outside with friends who smoked. Similarly, one child reported spending time in a hangout or den where his friends gathered to smoke and drink, thus exposing him to passive smoke.

A few children spent time in a smoky environment while they were travelling. Although smoking is not permitted on buses in Liverpool, this restriction is not enforced and instead is openly flouted by drivers and passengers alike. Therefore, some children described travel on the bus as smoky. More contentious still is travel by car. A few children described the car as a smoky place, and expressed concern that when they were travelling in the cars of smokers they were unable to move away from the smoke but instead had little alternative but to inhale.

As Figure L.1 shows, some children also associated health care settings such as the hospital and the GPs' surgery with passive smoking. Perhaps this is because they spent time standing outside with their parents who may have smoked to manage the stress of a consultation or of visiting a hospital patient who was seriously ill. In addition, one child reported being taken into a 'smoking room', possibly also in a hospital.

Figure L.1: Places where the children reported exposure to ETS
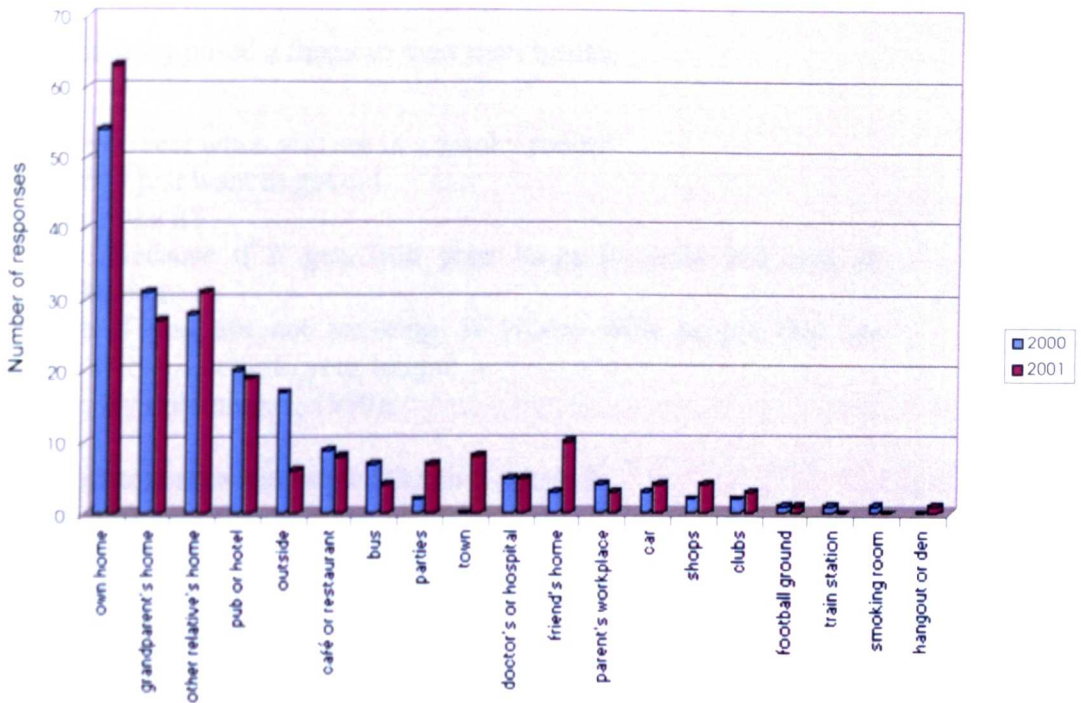
In the interviews and focus groups, the children reported being exposed to ETS in a wide range of public and private settings:

> *Betty Willson:* I see [people smoking] when I go out, in shops and that. When I go to parties and in my communion they were smoking.
> *Int:* They were smoking at your communion?
> *Betty:* Not in the church. In the party (I, 1999).

> When I was going to the park with my friends [in their car] the Dad was smoking but he didn't have the window open, so I pretended that I was hot and he opened the window (Kyla Conway, I, 1999).

> Sometimes when you are in the hospital and you are in the smoke room or the television room you see a lot of people smoking there (Girl, I, 1999).

> When I used to go and visit my Nan in hospital, my Grandma used to take me up and she had to go in the smoke room and I had to go in the smoke room with them (Louise Wright, FG, 1999).

> In my house when you're on the couch watching telly and you're sitting by my Mum, my Dad throws a ciggy over to her and she lights it and she

blows it out right in your face. And it always goes up my nose and in my mouth and it gives me a sore throat (Girl, FG, 1999).

The vast majority of these children disliked inhaling other people's smoke because many knew that passive smoking posed a threat to their own health.

Int: How do you feel when you are in a smoky room?
George Smith: I just want to get out.
Int: You don't like it?
George: No. Because if it gets into your lungs it could kill you, or something like that.
Int: So even if you are not smoking, if you're with people that are smoking could it still get into your lungs?
George: Yes. By breathing (I, 1999).

Int: Are you ever somewhere where the air's smoky?
Clare Smith: Yes.
Int: Where are you when it's smoky?
Clare: Sometimes in my Mum's room if I'm helping her do something. And in my Mum's best friend's.
Int: And how do you feel when it's smoky?
Clare: I don't like it because I know that the smoke will go into me and them my lungs might gradually go black like theirs (I, 2001).

Melinda: My Mum doesn't smoke loads when I'm around.
Int: So when she's smoking, does she smoke near you or...?
Melinda: Not really. She usually goes out into the kitchen so none of the smoke goes through the house. And she opens the back door.
Int: So why wouldn't she want the smoke to come near you?
Melinda: Passive smoking.
Int: And what's the problem with passive smoking?
Melinda: You can get tar in your lungs.
Int: And what would happen then?
Melinda: You would probably get heart disease and die or something (I, 2001).

These children expressed unhappiness at the way inhaling secondhand smoke affected their sense of well-being and at how they were sometimes forced to leave a room or a place because they could no longer tolerate the smoke:

I do not like people smoking because you breathe in other people's smoke (Kerry Williams, Q, 1999).

I hate smoking because people who smoke give me asthma and babies get asthma and grown ups (Steve Austin, Q, 1999).

I think that smoking is horrible. When my Dad smokes in the house it makes me cough. I will never smoke (Betty Ann, Q, 1999).

In a room with a smoker it's hard to breathe (Maggy Haniford, Q, 1999).

Int: How do you feel if you are somewhere that is a bit smoky or people are smoking near you?
Jeffery Tin: I don't like it because I have got asthma and it brings out my asthma (I, 1999).

Lucy Morgan: When I'm in a room full of people smoking, I just can't help breathing it in because everybody's smoking and I don't know where to go to. I can't help being there really.
Int: And how do you feel about that?
Lucy: I can feel it tightening in my body and it hurts (FG, 1999).

In addition, one child mentioned that he did not like spending time near his father when he was smoking, because he had been burnt:

Mick Smith: My Mum wants my Dad to stop smoking because he's burnt me four times.
Int: He's burnt you?
Mick: Yes. I'm always by the ashtray and my Dad doesn't look and he did that [shows cigarette burn on his arm]
Int: So your Dad just stubbed it out and your arm was there?
Mick: Yes (FG, 1999).

However, a significant minority surprisingly reported that they did not mind spending time in a smoky atmosphere. A few of the children said that they felt 'OK' while spending time in the company of smokers (2000: 8%, n=20; 2001: 12%, n=27). Children who shared a household with a smoker were perhaps accustomed to spending a lot of time in a smoky environment, and were more likely to feel either positive or ambivalent about passive smoking (2001: X^2=4.649; p=0.031). Children were asked where they spent time in a smoky place, and how they felt:

At home – Alright (Max D, Q, 2001).

In my home – Nothing (Lee Pu, Q, 2001).

My house – It's OK but sometimes I go upstairs and watch television or stay there because I am OK with it (Hannah Clare, Q, 2001).

In my house – I feel normal (Bob Quinn, Q, 2001).

In my living room – Normal (Karl Gerrard, Q, 2001).

My house – I'm not bothered (Lily, Q, 2001).

In my kitchen – I get used to it and it is alright (Melinda, Q, 2001).

Even more surprisingly, in 2001 two children even said that they actively enjoyed inhaling second-hand smoke. Children who had already tried smoking were more likely to feel positive about spending time in a smoky place (2001: X^2=9.345; p=0.002). These children who were already smoking regularly said that it made them feel 'relaxed' but also that it made them want a cigarette themselves. In this way, passive smoking may reinforce the development of children's early smoking careers:

Pub – Relaxed as the smoke gets to me (Jamie Smith, Q, 2001).

House, park – That I want a cigarette (Girl, Q, 2001).

Research shows that two-thirds of smokers say they do not smoke at all when they are in a room with a child, and a further quarter say that they smoke fewer cigarettes in the presence of a child. Smokers also report that they are more *likely to* modify their smoking behaviour in the presence of children than in the company of non-smoking adults (Lader and Meltzer, 2001). Data from the children reflected these findings and some of the children of smokers described the measures that their parents took to protect them from secondhand smoke. Some parents made every effort to protect their children from tobacco smoke and some children reported that their homes were kept smoke-free:

My Mum's mate always comes round and she smokes but my Mum tells her to go in the back yard to smoke so that it doesn't smell or anything (Ellie Campbell, FG, 1999).

However, the protective measures that the children described were perhaps more symbolic of the desire not to harm the children's health and less effective in actually

protecting the children from passive smoke, for example moving a few feet away or using an air freshener:

> *Int:* How do you feel if your Nan is sitting next to you and she is smoking?
> *Matt B:* She doesn't sit next to me when she is smoking. She always tells me to go on the other side of the room (I, 1999).

> *Clare Smith:* [Mum] smokes in the living room when we're not eating or if we've got the air freshener on.
> *Int:* What's the air freshener?
> *Clare:* It's the one for cigarettes. It's like you know the things where they've got gel inside them and you press them as well? (I, 2001).

In 2001, 34 of the children who lived with a smoker surprisingly said that they never spent time in a smoky place. Perhaps mindful that smoking is socially undesirable, some children were keen to stress that their parents did not smoke in front of them:

> *Int:* Are you ever in a smoky place?
> *Kyla Conway:* Not really.
> *Int:* When your Mum smokes, does she smoke in the house or does she...?
> *Kyla:* If we are in the car she doesn't smoke. She only really smokes if we have all gone up to bed and she closes the door.
> *Int:* So are you ever in a smoky place?
> *Kyla:* No (I, 1999).

> *Int:* Are you ever in a smoky place?
> *Becky Sullivan:* No.
> *Int:* If your Mum and Dad smoke at home, why is it not smoky there?
> *Becky:* Because they always smoke in another room.
> *Int:* Why do they smoke in another room?
> *Becky:* Because I breathe the air – I take in 70 per cent of what they blow out (I, 2001).

> *Int:* Are you ever somewhere where it's smoky?
> *Andrew Woods:* No.
> *Int:* Why isn't it smoky at home when your Mum and Dad smoke?
> *Andrew:* Because we've got two back rooms. We've got a living room and a dining room, so they always go in the dining room because of the baby (I, 2001).

Conclusions

The children who participated in the LLSS were exposed to secondhand smoke in both private and public spaces. They were most likely to be exposed to passive smoke in their own homes, and in the homes of grandparents and other relatives. The majority of children disliked inhaling ETS because they knew that it posed a threat to their own health. However, some children – especially those who lived with a smoker - were accustomed to inhaling passive smoke said that they felt no different in a smoky place. Furthermore, two children who were regular smokers enjoyed spending time in smoky environments, and the data suggest that exposure to passive smoke may reinforce early smoking careers. The implications of these findings for policy are discussed in Chapter 8.

Appendix M: Respondent Validation

When the fieldwork was carried out in 2001, a summary of some of the analysis of data collected in 1999 and 2000 was presented to focus groups. The aims of this exercise were two-fold. Firstly, to have the key findings that had emerged from the analysis validated by respondents. Secondly, to consider how children's views had changed over time by seeing if there were areas of disagreement from those views expressed in previous years. In many ways, using respondent validation with children was an exploratory step to see if 11 year olds were able to comment on research findings that were presented in simple and appropriate language.

The exercise focussed on asking children to consider discourses around smoking uptake and around the social construction of smoking as an adult behaviour. After the main focus group discussion had finished, a brief summary of the analysis was presented to the children as follows:

Why do some children try smoking?

- Some children learn to smoke at home. Friends also influence some children to smoke.

- Some children want to smoke because they think smoking makes you more grown up. Some children who smoke think they are harder than other children.

- Some children worry that other people might force them to smoke.

Is smoking worse for grown ups or worse for children?

- Some children think that smoking is OK for adults because they are already 'old' and they have lived their lives.

- Smoking is OK for adults because their bodies are bigger so they can cope with the smoke. Smoking is OK for adults because they know how to make decisions.

- Smoking is dangerous for children but adults can handle the smoke.

This feedback was presented to the children with the introduction 'These are things that other children have said about smoking. I'd like you to tell me if you agree or disagree'. The researcher then discussed each statement with the children in turn, and they appeared open and frank in expressing their agreement or disagreement. Once each child had agreed or disagreed, the researcher then invited him/her to discuss his/her point of view further. So that the feedback of research findings to participants did not affect the data collected, the exercise was only used in focus groups after the questionnaires and draw and write exercise had been completed, and after the focus group discussion itself had ended. The respondent validation exercise was tape recorded, and although it was not transcribed, detailed notes were made from each recording. Generally the exercise worked well – it was fascinating to hear the children's insights into the researcher's analysis and the respondents usefully validated many of the findings, while simultaneously showing how the cohort's views had evolved since age 9. However, sometimes when the children disagreed it was with the phrasing of the finding rather than with the sentiment expressed.

Each of the points for discussion will now be considered in turn.

- **Some children learn to smoke at home. Friends also influence some children to smoke.**

The children were in unanimous agreement that some children learn to smoke by watching their parents:

> By watching their parents, they learn by watching them (Girl, FG, 2001).

> [They learn] From their parents if they smoke all the time. If their parents smoke, they think it's good (Boy, FG, 2001).

The children's comments also reflected the finding from the first wave of the study that parents are both promoters and preventers of the smoking habit (Porcellato, 1998). While

there was agreement that smoking parents could influence their children to take up the habit, it was noted that:

> Most parents tell you not to smoke (Boy, FG, 2001).

The children also agreed strongly that others are influenced to smoke by friends. Some of the children particularly emphasised that older friends were likely to persuade someone to smoke, and that this was a particular concern as they made the transition to secondary school. They reiterated that people don't want to be called names and they don't want to be excluded from the friendship group.

- **Some children want to smoke because they think smoking makes you more grown up. Some children who smoke think they are harder than other children.**

A few children found the wording 'grown up' problematic in the first statement, because they related it to physical growth rather than to adult status:

> [Smoking] doesn't make your body grow (Boy, FG, 2001).

Not withstanding these linguistic difficulties, the children agreed that some people think smoking makes them appear more mature:

> Yes, because grown ups do it (Girl, FG, 2001).

> Because it's mostly older people that smoke and they think they look good smoking (Girl, FG, 2001).

> Yes, because adults do it so they think it will make them the same as the adults (FG, 2001).

> Yes, older people do it: adults, parents, teenagers do it (Boy, FG, 2001).

The children also concurred that young smokers think that they are harder than other children, adding that this was because adults smoke and because some children smoked despite knowing that smoking harms health:

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Because they're doing adult things and adults smoke (Girl, FG, 2001).

Because they see older people who smoke look really hard and they think if they smoke, they'll be hard because they know it's bad (Boy, FG, 2001).

Respondents also suggested that smoking could signify mental competence. This was because smoking made people take on adult qualities, and that children who smoked seemed more grown up because 'adults can do what they want to do', that is to say they can make their own choices.

- **Some children worry that other people might force them to smoke.**

Respondent validation can raise issues with respondents who are unable to find their individual concerns reflected in the overview of findings supplied by the researcher (Miles and Huberman, 1994; Mays and Pope, 2000). There was a mixed response to this statement, perhaps because children were unable to empathise that maybe other children might feel concerned about bullying even if it was not a source of concern for them at the time of the focus group. Children who agreed expressed anxiety about name-calling particularly at secondary school. One group of boys said that 'forced' meant that people might bully them or threaten to 'batter' someone. There was concern that older teenagers could actually make a smaller child smoke on the basis of their bigger size and strength. Others commented on the issue of being 'forced' to smoke on the basis of their own experience:

Yes, older kids, they call you chicken and all that (Girl, FG, 2001).

[At secondary school] It's the bullies at the school (Boy, FG, 2001).

Yes, because I've been forced, so I know what it's like (Girl, FG, 2001).

I got forced and I just didn't like it (Girl, FG, 2001).

Children at the most affluent primary school seemed less concerned about being bullied in the focus groups. They suggested that people might get 'forced' to smoke, but not at

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their school, although they expressed some uncertainty about what would happen at their next school:

> *Boy 1:* I don't think it would happen anywhere too near here...
> *Boy 2:* But it might happen at secondary school (FG, 2001).

- **Some children think that smoking is OK for adults because they are already 'old' and they have lived their lives.**

While most of the children could identify with the discourses already discussed about smoking uptake, many appeared egocentric and had difficulty empathising that other children might express sentiments around the social construction of smoking as an adult behaviour if these differed from their own particular point-of-view at that time. Although this concept was widely expressed at age 9, by age 11 children's views had changed. Although a few children still agreed:

> With grown ups they've had a good life – young children, they might get more ill than grown ups (Boy, FG, 2001).

As the proportion of the cohort who knew someone with a smoking-related disease increased, others were beginning to recognise that smoking cuts adults' lives short too:

> It's just as bad for both (Boy, FG, 2001).

- **Smoking is OK for adults because their bodies are bigger so they can cope with the smoke. Smoking is OK for adults because they know how to make decisions.**

The same views were expressed with regard to whether adults' bodies could cope with cigarette smoke. Some children still agreed that adults were better able to cope with the smoke than children:

> Grown ups are stronger than children (Boy, FG, 2001).

> It's worse for children because their bodies are smaller (Boy, FG, 2001).

Although others recognised that adults' bodies were fallible too:

> If they smoke a lot, they're going to get diseases and stuff anyway (Boy, FG, 2001).

> *Boy 1:* They can't take the smoke.
> *Boy 2:* The smoke, it's just the same to anybody – they can't cope. It's just the same (FG, 2001).

The children's opinions at age 11 were also divided on whether adults were entitled to smoke because they knew how to make decisions. Some children conveyed that adults were usually the decision-makers, as opposed to children who have their decisions made for them. Other children were coming to realise that adults' decisions could be just as fallible as their bodies:

> They're older so they can make their own decisions (Boy, FG, 2001).

> Adults are old enough to make their own decisions – whether they want to smoke or not (Boy, FG, 2001).

> No, because adults can still make the wrong decisions (Girl, FG, 2001).

- **Smoking is dangerous for children but adults can handle the smoke.**

Many of the respondents agreed that smoking was dangerous for children, and that adults were better able to cope with the smoke:

> Little children could easily die because their organs aren't very strong (Girl, FG, 2001).

> An adult can handle it because some adults have been smoking for years so they're used to it (Girl, FG, 2001).

> If a child starts at a young age it might be bad for them because they might not know how to do it properly. How to handle it (Boy, FG, 2001).

However, in common with the other points, some also argued that of course adults cannot really handle the smoke:

I think adults can handle it for a while, but like they can still get diseases
(Boy, FG, 2001).

Adults can't handle the smoke because my Nan died and she was 62
(Boy, FG, 2001).