Manchester
Metropolitan
University

'Smoking makes me happy and I'd rather die early being happy.' A qualitative study exploring the smoking behaviours of young females

Alice Trew

Supervised by: Carly Jim   April 2014

'Smoking makes me happy and I'd rather die early being happy.' A qualitative study exploring the smoking behaviours of young females

ABSTRACT

The research focused on the smoking behaviour of young females who identify as 'smokers' and were in the 'pre-contemplation' stage of change (Prochaska & DiClemente, 1983), thus not currently looking to quit smoking. The research aimed to understand the reasons for smoking as a background for proposing interventions for this group of smokers.

Semi-structured qualitative interviews were undertaken with six volunteers, discussing their smoking behaviour. The interviews were analysed using thematic analysis, extracting six key themes; starting smoking: social influence, smoking within a social context, smoking and identity, benefits outweigh long-term health issues, cognitive dissonance and stopping smoking: a problem for the 'future'.

The findings suggest interventions should focus on smoker's perceptions of benefits and their susceptibility to experience health problems, as a result of their smoking behaviour. Moreover, alternatives for perceived benefits should be sought to fulfil the role smoking currently plays in these smoker's lives.

KEY WORDS:	SMOKING	SMOKING BEHAVIOUR	SMOKING CESSATION	THEMATIC ANALYSIS	QUALITATIVE

Introduction

The health issues that can arise from smoking are well catalogued (British Medical Association, 2004; US Department of Health and Human Services, 2004; NHS, 2012). By smoking, you increase the risk of more than fifty serious health conditions, with smoking being one of the leading causes of death and illness in the UK (NHS, 2012). 'Smoking injures almost all bodily organs, and tragically this often leads to incurable disease and death' (U.S. Department of Health and Human Services, 2004). Therefore, it is somewhat shocking that twenty per cent of the adult population in the UK continue to smoke (HSCIC, 2012). 'Most [people] know that smoking can cause lung cancer, heart disease and premature death' (QUIT, 2013) but in addition, there are many other lesser-known health problems that can arise from smoking. These include: skin ageing and yellowing of the teeth (DoH, 2010, cited in Grogan et al., 2011), premature aging (QUIT, 2013), an increase in reproductive health problems (BMA, 2004), early menopause (BMA, 2004) and osteoporosis (BMA, 2006, cited in QUIT, 2013).

It is now accepted that cigarette smoking is maintained primarily by dependence on nicotine; the ease in which a smoker is able to stop smoking, in addition to the severity of the withdrawal symptoms they may experience, will be related to a smoker's degree of dependence on nicotine (Fagerström et al., 1990). However, whilst the link between nicotine addiction and smoking is a key element that drives smoking behaviour, it does not exclude other influences. Social, economic, personal and political influences all contribute to smoking prevalence and cessation. So whilst, the underlying nicotine addiction drives the behaviour, wider social influences are imperative in predicting who starts smoking, who is able to give up and who continues to smoke (Jarvis, 2004).

With this understanding we can look at the other influences of smoking behaviour, with a focus on the psychological contributors, as well as the nicotine addiction, which will now be outlined.

Peer Influence

Peer influence is highlighted as a key factor in smoking behaviour, particularly in young people and adolescents (Kobus, 2003; Stewart-Knox, 2005; Fry et al., 2008), with most initial smoking experiences taking place in the presence of peers (Flay et al., 1994). These social influences impact the instigation of smoking, maintaining smoking behaviour and smoking cessation. For many smokers, smoking constitutes a considerable part of their social and cultural worlds (Allbutt et al., 1995). Kobus (2003) highlights how understanding the processes that influence smoking in young people is pivotal in developing prevention and intervention programs which address smoking.

There are numerous social factors associated with smoking, cigarettes play a 'complex social role' in the lives of young people, influencing whether smoking is initially instigated and increasing difficulties when considering termination of smoking (Fry et al. 2008:763). Young people highlighted how they needed to provide 'an excuse to peers' to resist smoking, in addition to the difficulty in stopping smoking

because of the social settings and pressures that cannot be easily avoided (Fry et al., 2008:770). Stewart-Knox et al. (2005) go on to further look at peer related social factors that motivate young people to smoke. The findings show that smoking provides a means to define social groups, which serves to highlight the similarity within groups and difference between groups.

<u>Social Identity Theory</u>

When looking at the social influences that can affect smoking behaviour we can perhaps apply social identity theory. Originally coined by Tajfel & Turner (1986) this theory states that an individual holds a conceptualisation of themselves at an individual level and a group level.

Social identity refers to the aspects of a person that relate to group membership and are characterised by the groups they belong to. Expanding this, our identity is based on how people see themselves as members of a specific group (known as the 'in-group') compared to other groups (which are the 'out-groups') (Abrams & Hogg, 1988).
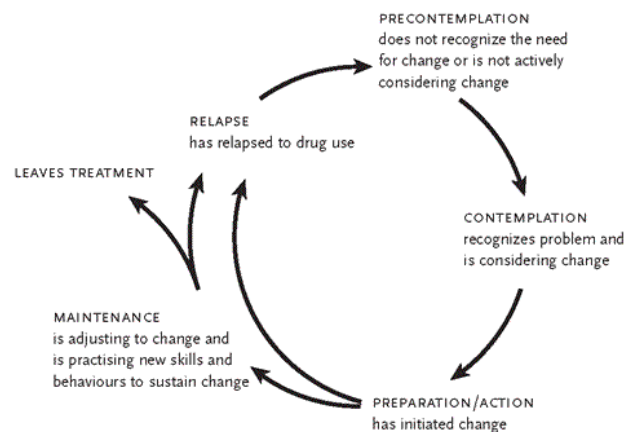
Kobus (2003) discusses how this theory can be applied specifically to smoking behaviour. If social identity is salient to the individual, and takes precedence over personal identity, individuals are more likely to conform to the norms and behaviours central to the group. In groups where 'smoker' or 'non-smoker' status is central to the identity of the group, the members are likely to have similar smoking habits. Thus, smoking may be more likely to initially occur and be sustained. Additionally, smoking is 'seldom the purpose of social interaction, but rather an outcome of the social identity process' (Stewart-Knox et al., 2005:398). It is not driven by the need to adhere to social pressures but actually by the desire to conform to the group norms.

<u>Self-identity</u>

When looking at smoking in young people, and especially females, it is clear to see that personal identity plays a large role in smoking behaviour (Michell & Amos, 1997; Denscombe, 2001). Smoking uptake for girls was shown to have powerful and enduring significance related to hierarchical peer group structure, style, image and social identity (Michell & Amos, 1997). Denscombe (2001:157) discloses how young peoples' 'uncertain identities' are a clear contributing factor to the smoking in young people. Smoking for young people ties into their own self-image of being 'grown up', 'looking cool' or 'looking hard' (Denscombe, 2001:167) and more personally, the self-empowerment that taking risks, such as smoking, gave them over their body.

Denscombe (2001) elaborates stating there was a self-affirmation aspect also reported, where young people believed by taking the risks of smoking they set themselves apart from others. Identifying as a 'smoker' formed their own sense of self, separate from the social identity of the groups they belonged to.

Stages of Change

PRECONTEMPLATION
does not recognize the need
for change or is not actively
considering change

RELAPSE
has relapsed to drug use

LEAVES TREATMENT

CONTEMPLATION
recognizes problem and
is considering change

MAINTENANCE
is adjusting to change and
is practising new skills and
behaviours to sustain change

PREPARATION/ACTION
has initiated change

Source: Prochaska, J., Norcross, J. & DiClemente, C. (1995). *Changing for Good: A Revolutionary Six-Stage Program for Overcoming Bad Habits and Moving Your Life Positively Forward*. New York: Avon Books.

Figure 1. Stages of change model (Prochaska et al., 1995)

The stages of change model (Figure 1) can be applied to health behaviour change in smoking (Prochaska & DiClemente, 1983). This 'integrative model of change' was applied to subjects who were changing their smoking habits independently. Five stages of change were identified: 'precontemplation, contemplation, action, maintenance, and relapse,' through which the subjects progress in order to achieve abnegation of smoking behaviour. (Prochaska & DiClemente, 1983:390).

There is great emphasis placed in the area of smoking cessation, and especially in recent years with increase in government funding and the introduction of national campaigns, such as, 'Stoptober', which was launched in 2012 and encourages people to stop smoking for an initial 28 days, in the hopes they will continue to abstain from smoking (NHS Smokefree, 2013).

There is not a great deal of research looking at smoking behaviour, and specifically why people smoke and continue to do so with the knowledge that it is bad for health. By looking at this wider area, we can hope to help people who smoke, but are not actively looking to quit. By applying, Prochaska & DiClemente's (1983) stages of change model we can see that this group of smokers are in the 'precontemplation' stage and thus have not realised the need for change or are not actively considering change. With more knowledge we can potentially understand how to encourage more people to reach the 'contemplation' stage.

Whilst most research focuses on the initial start of smoking, maintaining of smoking behaviour should also be considered and why people continue to smoke. Social influences have been emphasised as a key factor in this; smoking plays a 'complex social role' in the lives of young people (Fry et al., 2008) and is completely 'ingrained in their social world' (Stewart-Knox et al., 2005). Therefore it is no surprise that young people who find the activity 'so compelling' are 'resistant to smoking prevention initiatives' (Stewart-Know et al., 2005:412).

Objectives

This qualitative research looked at the smoking behaviour of young females who identify as 'smokers', and are currently not looking to quit smoking. Semi-structured interviews were conducted, discussing the interviewee's smoking behaviour. The main objectives of the research are as follows;

1) Identify key themes in the data to understand personal reasons for smoking, as a background for proposing intervention, for smokers in this group of individuals who are not motivated to quit.
2) To explore the reasons current smokers give for smoking with the knowledge of the potential health risks and their justification of this behaviour.
3) To suggest clinical improvements in the area of smoking cessation.

Method

Design

The predominant strategy of qualitative research is to capture the deep meaning of participant's experience, in their own words (Marshall and Rossman, 2011). The current research focuses particularly on the individuals' attitudes, behaviours, opinions and personal experiences; this is where qualitative research excels and is why this methodology was selected. The strength of qualitative research lies in its ability to understand the insiders' perspective and to capture the 'essence of a lived experience' (Onwuegbuzie & Mallette, 2011:303).

Semi-structured qualitative interviews were conducted, where each interviewee partook in an interview for roughly thirty minutes on their smoking behaviour. Qualitative interviews generate very rich and in-depth data (Baumann & Bason, 2011:405), and thus proved to be an auspicious method for this research.

Sample

Qualitative research usually involves a relatively small number of participants (Willig, 2008). The sample consisted of six female undergraduate students, between the ages of nineteen and twenty-two, who were current smokers and not actively looking to quit at the time of the interview. The interviewees were recruited using opportunity and snowball sampling. The researcher made contact with a small number of potential participants who could be recruited, then through these initial contacts recruited further participants, using snowball sampling (Langdridge & Hagger-Johnson, 2009).

Data Collection

A flexible interview schedule (Appendix 1), consisting of topic areas, was written and planned prior to the interviews. This included open-ended questions and prompts prepared to be used if the interviewees struggled with any questions.

An emphasis was placed on the comfort and control of the interviewees. The interviews only ended when a natural closing was reached and the interviewee has been given the opportunity to talk about everything they wished to. This was further implemented by the qualitative interview design, as it allows the interviewer and

interviewee to 'engage in more of a conversation than a series of questions and answers' (Baumann & Bason, 2011:405). The interviewees were asked to talk about their smoking behaviour, and discuss this as freely as they wished to; giving them the utmost control over the information they wanted to share.

The researcher must strive to 'establish an atmosphere in which the subject feels safe enough to talk freely about… experiences and feelings' (Kvale, 1996:125). Therefore, a relaxed environment was created with an emphasis on the physical location. The interviews all took place in a quiet and comfortable setting to help the interviewees' feel at ease.

An audio recorder was used to record the interviews. As Willig (2008) indicates, simply taking notes during the interview is no substitute for a full recording, and can consequently lead to the loss of data.

Data Analysis

The interviews were audio-recorded and transcribed using verbatim transcription, which 'refers to the word-for-word reproduction of verbal data' (Poland, 1995, cited in Halcomb & Davidson, 2006:38). The written transcriptions are exact replications of the audio-recorded interview, which is required for most qualitative methods of analysis (Willig, 2008). The transcribing of data is imperative for analysis, and the act of transcribing itself is beneficial, as it brings the researchers closer to their data (Halcomb & Davidson, 2006). Transcribing the interview provided a great way for the researcher to completely immerse themselves in the data before analysis took place.

Once the transcribing of the interviews was complete, thematic analysis was used to analyse the interview data, following Braun & Clarke's (2006) guidelines. Thematic analysis is used to 'draw out overarching themes' in the interview (Langdridge & Hagger-Johnson, 2009:382). It offers an 'accessibly and theoretically-flexible approach to analysing qualitative data' and gives an element of flexibility to the analysis which allows for a wide range of potential outcomes from the data (Braun & Clarke, 2006:77).

Braun & Clarke's (2006) phases of thematic analysis consist of:
1. Familiarising yourself with your data- transcribing data, repeated reading and initial noting down of ideas
2. Generating initial codes- identifying features of the data that appear interesting to the analyst
3. Searching for themes- sorting the different codes into potential themes
4. Reviewing themes- refinement of themes, generating a thematic 'map' of the analysis
5. Defining and naming themes- refining the specifics of each theme
6. Producing the report- final analysis and writing-up of report

Ethical Considerations

The study follows the ethical guidelines set out by the BPS (2009). Application for Ethics Approval Form (AEAF) was completed and approved by a supervisor before interviewees were identified and interviews undertaken (Appendix 7).

The specific ethical issues that have been considered with the present research are as follows. Interviewees were asked to read an information sheet (Appendix 4) when they first arrived at the interview, outlining the purpose and structure of the interviews, which ensured there was no deception in the research. The interviewees were then asked to sign a consent form (Appendix 5), and informed of their right to withdraw at any point during or after the interview.

During the interviews, interviewees were given the option to stop the recording for breaks at any time if they felt uncomfortable. The protection of interviewees was paramount where no more stress should be induced in the volunteers than they would experience in their everyday life. Correspondingly, the interviews were conducted in a place where the interviewees felt comfortable and the researcher helped to make the interview as easy to access as possible.

After the interview the interviewees were given a debrief document (Appendix 6), which restated their right to withdraw. It also included information for Samaritan's and MMU Counselling Service in the event that any issues arise with the interviewees. Furthermore, if interviewees wished, NHS Quit Smoking information was provided if they wished to investigate stopping smoking.

Personal details, such as names, were changed after the interview to ensure participant anonymity. The interviewees selected pseudonyms which they were referred to throughout the interview transcript and written report. Interview recordings were deleted once they were transcribed, to avoid replication or data being accessed by additional people. In addition, once the transcription was complete, interviewees were given access to the transcribed interview for them to review and request the removal of any parts that they were not comfortable with. This was undergone before any analysis took place on the transcripts. The data collected cannot be confidential as it has been discussed with a supervisor; however interviewees were informed of this prior to the interview.

Analysis and Discussion

Starting Smoking: Social Influence

Initial smoking experiences often begin in the presence of peers (Flay et al., 1994), and this was consistent for all interviewees. Whilst smoking is highly influenced by the presence of other smokers all interviewees expressed their initial smoking behaviour was not exclusively due to social influence, but was more of a personal choice.

> *'I told [my friend] I wanted to try it to see what it tasted like and so did she, so… if it wasn't for [her] I wouldn't have tried one at that time…'* (Bailey, 76-78)

> *'…if none of my friends had smoked then I probably wouldn't have gone out looking to smoke… it meant that when I wanted to… I could.'* (Daisy, 180-182)

> *'…a group of people that I got on with used to smoke a lot so… I would go with them, then ended up smoking…'* (Kaylee, 99-101)

However, there is an emphasis on the fact that whilst having friends who smoked allowed access to cigarettes, personal choice was paramount and smoking always would have occurred.

> *'…I still think I would have tried it sooner or later, because I've never hesitated at the thought of smoking and I was always curious.'* (Bailey, 79-81)

Whilst previous research has suggested that non-smokers begin to smoke due to 'coercion, bullying and rejection from a desired group', this has been refuted by suggestions that the process is more complex with elements of 'self-determined behaviour' (Michell & West, 1996:39). Individuals may have already decided to try smoking and thus pursue peers who smoke and social situations where smoking takes place.

The notion of 'peer pressure' as the driving force behind smoking initiation has been repudiated with very little evidence to suggest that direct peer pressure affects smoking uptake (Fry et al., 2008; Michell & West, 1996; Lucas & Lloyd, 1999). This was highlighted throughout the interviews;

> *'…I don't think there was anyone there telling me to smoke… I think people think there's this whole peer pressure thing when it comes to smoking, like someone is practically forcing you to take it and it wasn't like that at all.'* (Daisy, 174-176).

> *'I don't know if it was like pressure or anything like that, but more just influence, just like, oh let's… just try this.'* (Alecia, 66-67)

There is a balance between the influence of peers and personal choice to smoke. Non-smokers who spend time with smokers have a greater likelihood to transition to tobacco use than youth without smoking friends (Urberg et al., 1997).

Smoking within a Social Context

Whilst social influence plays a large part in the initial uptake of smoking, social influence further contributes to sustaining smoking behaviour and increasing the difficulty of smoking abstention. Smoking for the most part takes place in the context of peer groups (Pearson & West, 2003), which is consistent with the present research, where all interviewees stated how smoking plays a large part in their social lives.

> *'Now I only know two people that don't smoke who are… my age… so like there's always people around me smoking'* (Bailey, 53-55)

> *'…I'm constantly surrounded by smokers… And I think that makes me smoke more.'* (Alecia, 171-174)

Research has shown how close friends are pivotal in influencing the smoking behaviours of young people. This influence is present in smoking initiation (Urberg et al., 1997) as well as sustaining this behaviour where close friends often mirror each other's substance use behaviour, such as smoking (Kirke, 2004). Throughout the interviews, it became apparent that smoking behaviour is sustained by the presence of friends and peers who smoke. Interviewees highlighted how they smoke more in the presence of other smokers and smoke less when they were around people who do not smoke.

> *'Like if someone starts smoking… I'm going to start smoking as well. That's just kind of the way it is with smokers.'* (Bailey, 31-32)

> *'…people who smoke more than me will go out for a cigarette and I won't necessarily want one but I'll go out with them and end up smoking.'* (Kaylee, 141-143)

> *'…I am the worst when I'm around other smokers… I'll just end up lighting up every time someone smokes and I swear I don't even realise I'm doing it…'* (Emily, 84-86)

In their study of women who quit smoking during pregnancy, Nguyen et al. (2012) outline the numerous difficulties women have in refraining from smoking. These women faced challenges such as being tempted to smoke by members of their social network and noted changes in these relationships due to their non-smoking status. These findings can be applied to the interviewees in the present research; difficulties faced when trying to deviate from behaviour of the group are present for all smokers when smoking plays such prominent role in their social lives.

Smoking and Identity

> *'…I definitely class myself as a smoker, like it's an identity thing. It's part of me, like I've smoked for like… six years now… it's a big part of me.'* (Daisy, 313-314)

> *'I identify as a smoker completely.'* (Alecia, 178-179)

> *'I consider myself a smoker now because I suppose as I've got older smoking has become a bigger part of my life.'* (Bailey, 156-157)

Personal identity plays a large role in smoking behaviour, and this is especially prevalent in females (Denscombe, 2001; Michell & Amos, 1997). There were varying degrees of a smoking identity expressed by interviewees; the majority expounding how smoking was salient to their self-identity. Conversely, one interviewee, was far more reluctant to adopt this 'smoker' identity and whilst she expressed that she was a smoker, she did not want to be defined as so;

'…I don't think smoking defines who I am, therefore… I don't really like saying that label… I'm a smoker so I'm in that category, but… I don't want that to be a defining feature of me…' (Jen, 252-254)

Identifying as a smoker allows individuals to formulate their own sense of self (Denscombe, 2001). Whilst self-identity influences smoking behaviour and a defining feature of themselves, elements of Social Identity Theory (Tajfel & Turner, 1986) were also referred to by interviewees. The initiation of smoking is often the outcome of the social identity process, where smoking is driven by the desire to conform to group norms (Stewart-Knox et al., 2005), which can additionally continue on from original initiation to sustain smoking behaviour.

'I don't know, it was just like everyone else was doing it and I thought, well let's just have a bash.' (Alecia, 38-39)

'…I made friends with the smoking group at the halls where I lived and then I was friends with the smokers on my course…' (Daisy, 201-203)

Friendships are often characterised by smoking behaviour, where smokers migrate towards one another, with smokers befriending other smokers and non-smokers befriending other non-smokers (Ennett, 1994; Kobus, 2003). This was apparent throughout the interviews where interviewees talked about how the majority of their friends were smokers and how even with the move to university they often became friends with other smokers.

For smokers there is often a balance of smoking being a part of their self-identity in addition to their social identity within a group, perhaps best summed up with this quote;

'…when I'm at uni all my friends are smokers and I'm part of the smoking group, and then if I'm with my friends who don't smoke then I'm like the one smoker of the group, so like it's always a thing which is there. Like I'm always like the smoker or one of the smokers.' (Daisy, 320-323)

Benefits Outweigh Long-term Health Issues

Numerous benefits of smoking were featured during the interviews and were seen as a driving force behind their smoking behaviour.

'I think it's relaxing… and fag breaks are handy and give you something to look forward to…it's nice to be able to just relax, have a fag and it gives you a break from whatever you're doing…' (Bailey, 18-20)

'I've made a lot of friends smoking… you can go ask someone for a lighter… then you will get chatting… I'm quite shy so I wouldn't actually go and talk to them otherwise…' (Jen, 19-22)

> *'…it gets you chatting… even with people you know, like in my uni house, it means that we'll take breaks from work in the day to go and smoke together…'* (Daisy, 96-97)

For many interviewees these benefits seemed to outweigh the potential health issues that they may face without termination of their smoking behaviour.

> *'…I have a good time smoking and I enjoy it, like it's something I like doing so in a lot of ways the benefits kind of outweigh the costs... I'll deal with the consequences later.'* (Daisy, 285-288)

> *'…I've met a lot of people through smoking and… a good laugh with the people smoking… positive things really, so I've never thought that much about the health risks.'* (Jen, 183-186)

> *'…basically smoking makes me happy and I'd rather die early being happy than live longer and not smoke.'* (Bailey, 194-195)

Furthermore, for Kaylee who expressed how smoking helps her to combat feelings of anxiety and prevent panic attacks the benefits were accentuated to an even higher degree;

> *'…if it helps me now and it makes me feel happier, makes me feel less awful, I don't really mind what it does in the future...'* (Kaylee, 241-243)

Halpern-Felsher et al. (2004) noted that adolescent smokers see many benefits of smoking, such as looking cool, popular or grown-up, in addition to physical benefits such as feeling more relaxed. This research proposes that for smokers who continue to smoke after leaving adolescence benefits still remain prominent. Interviewees expressed how whilst they were aware of the potential health risks they may face in the future, the current benefits were more important than potential future health issues.

Cognitive Dissonance: 'I might be the lucky one.'

A key theme which became apparent from the interviews was that of cognitive dissonance. Interviewees were aware of health risks that could emerge because of their smoking behaviour; however even with this knowledge believed that they themselves were unlikely to experience this ill health. This falls in line with the Cognitive Dissonance theory, originally coined by Festinger (1957) which states that when two cognitions, or beliefs, are dissonant[1] it will cause psychological discomfort in an individual. If dissonance is existent in an individual they will be motivated to reduce it, actively avoiding situations and information which may increase dissonance, which is apparent throughout the interviews.

---

[1] Dissonance denote two elements 'out of agreement, accordance or harmony' (OED, 2014)

All interviewees were aware that smoking poses health risks to individuals; however various levels of knowledge with regards potential health issues were expressed. The health risks described by interviewees were often not very specific and denoted the idea that you can get 'cancer and stuff' (Bailey, line 36). However, interviewees additionally expressed how it was an area they often had not given a lot of thought to and expressed how it was something they did not particularly want to think about;

> '…I kind of just think with…cancer and stuff… that I won't get it… it's happened to all these people but it won't happen to me… I think it's probably that I don't think about it more than anything… I don't want to think about the fact that I could potentially die from something that I do like ten times a day.' (Daisy, 259-264)

> '…everyone tells you that you're going to get lung cancer and die, but you never think that it'll happen to you.' (Bailey, 173-174)

> '…like I don't really think about the health issues in any kind of depth, just like push them to the back of my mind, like yeah it may happen to other people but not me…' (Jen, 200-202)

Avoidance of thinking about potential health risks falls in line with the cognitive dissonance theory, where smokers may 'avoid new information that might increase the existing dissonance' in order to maintain harmony within their cognitions (Festinger, 1957:22). Additionally, interviewee's drew from their own personal experiences to express how they felt they were unlikely to experience negative health issues themselves;

> 'I've known people that have smoked loads for years and they're fine, so like all the numbers that are thrown about like this many people die a year from smoking and stuff, they're just statistics to me, like they're not real people.' (Daisy, 268-271)

> '[She] smoked since she was twelve and [she] never touched a fag her whole life. Guess which one died of lung cancer? The one who had never touched a fag.' (Bailey, 196-199)

> 'My nan smoked her whole life and she died when she was like ninety-five, so I think I'm going to be okay…' (Emily, 205-207)

By drawing on their own personal experiences surrounding smoking and the severity of smoking related health issues, interviewees are able to justify their smoking behaviour by downplaying potential health risks. When interviewees had knowledge of other long-term smokers who experienced no ill health, interviewees were able to justify their smoking behaviour, while statistics, which express how dangerous smoking is, had very little effect on how interviewees felt with regards the stopping of their smoking behaviour. Festinger (1957:6) highlights how a smoker will change their 'knowledge' about the effects of smoking and influences such as personal experience will reduce their cognitions of perceived risk.

The present researches findings support the idea of cognitive dissonance, which conforms to previous literature applying cognitive dissonance theory to smoking behaviour. McMaster & Lee (1991) found whilst smokers estimated their risk of contracting lung cancer as higher than non-smokers or ex-smokers, they still believed their own personal risk of contracting it as less than that of the average smoker. In line with this research it is clear that smokers, whilst aware of the health risks, do not believe that they will personally experience them, or the chances are lower than other smokers.

Stopping Smoking: A Problem for the 'future'

Whilst some of the interviewee's started they had previously attempted to quit in the past, for most these were not serious quit attempts;

> '…I've kind of tried to quit in the past. But… I don't think I ever really had a serious attempt at quitting...' (Bailey, 108-109)

> '…it lasted the entirety of a lecture… and that's pretty much it.' (Alecia, 185-186.)

All interviewees expressed that they would like to stop smoking for good in the future, however, for all interviewees this was underpinned by the fact that there was no clearly defined plan for when this would take place;

> '…it tends not to affect people until they're in… their fifties or sixties… it's a problem to deal with in the future.' (Kaylee, 232-234)

> 'I do need to stop, but ah I'll do it later. The thirty year old Jen can give up. That's a problem for her!' (Jen, 245-246)

> 'So yeah, I'll give up at some point in the future… and chances are I won't get anything.' (Daisy, 276-277)

It is clear from almost all the interviews, that the interviewees believe they still have time to change their smoking behaviour and are likely to experience no ill health as long as they quit whilst still fairly young. This theme builds on the previous theme, with regards interviewees' perception of risk. Intention to quit smoking has been primarily predicted by 'perceived behavioural control and perceived susceptibility' (Norman et al., 1999:89). Most interviewees in the present research believed their susceptibility to smoking related health issues were relatively low and thus do not see their smoking behaviour as something which needs to be changed in the near future. The more smokers believe they will not experience adverse consequences of their behaviour, the less motivation to change subsists, and thus behaviour change is unlikely to happen.

Additionally it was indicated by one interviewee that if smoking was stopped by the age of thirty the impact on future health was significantly reduced. Numerous recent articles have highlighted these findings, stating that women who give up smoking by

the age of thirty will almost completely avoid the risks of dying early from tobacco-related diseases, giving these ex-smokers a life expectancy identical to that of people who have never smoked (Weeks, 2013; Gallagher, 2012). These widely broadcast news articles, whilst trying to emphasise that quitting smoking is a worthwhile endeavour, almost seem to give current smokers permission to continue with their smoking behaviour whilst they are still young and deal with the difficulties of quitting at a later date.

The foregoing themes conclude the complex relationship that young females have with smoking and the role that it play in their everyday lives. It is clear that smoking is not considered purely a biological addiction, but is influenced by social affiliation, routine and identity. These areas are all underpinned by cognitive dissonance and constitutions that they will stop smoking at some point in the future, with very little motivation. These findings build a representation of the views and beliefs of this smoking group and can potentially lead to intervention techniques which may increase motivation for change and lead to smoking abstention.

Limitations and Implications for Intervention

Limitations of Research

There are limitations which should be taken into account for this research. Whilst the qualitative approach of the research allowed for an in depth exploration of the experiences of female smokers, the opinions and experiences of the interviewees are subjective and cannot be generalised. Opportunity and snowball sampling methods were used and thus interviewees were mainly known by the researcher and in some cases other interviewees, thus the experiences of these interviewees may have been similar due to this and thus cannot be generalised to all smokers.

Implications for Intervention

A key objective of the research was to identify personal reasons for smoking behaviour, and from this, derive suggestions for clinical improvements in the area of smoking cessation and as a background for proposing interventions for this group of smokers.

Smokers need to be made aware that smoking is not purely addiction driven; with routine, social situations, boredom and stress all relating to their smoking behaviour. These other powerful drivers of smoking affect when and why people smoke, and how easy or difficult it may be to abstain. At the point where smoking behaviour becomes ingrained in the everyday life of the person, it becomes significantly harder to stop as it constitutes many parts of their lives. Moreover, at the point where smoking becomes salient to the identity of the individual, cessation becomes harder. Intervention methods need to be addressed to more effectively reach unmotivated smokers. Interviewees highlighted how they had not thought about their smoking behaviour in such detail prior to the interviews, and it made them aware of how prominent a role smoking plays in their lives. By encouraging smokers to think

reflexively about their personal smoking behaviour, change may be provoked, where smokers may realise the need for change and seek out help and support to attempt to quit.

Smoking within social situations was highlighted as a large part of interviewees' lives, affecting how much they smoked and facilitating conversation by providing a common ground to start a conversation. Alternative methods can be adopted to replace the social 'benefits' of smoking, breaking the connotation that smoking is the defining feature of a friendship group. Additionally, smokers often state when around other smokers they find themselves lighting up cigarettes subconsciously, where the presence of other smokers provokes smoking behaviour. For intervention, smokers should be asked to reflexively engage with their smoking behaviour, whereby if they have just smoked a cigarette and see someone else start smoking, they don't need to smoke again. This should increase the active role that smokers play in their smoking behaviour. If this reflexive attitude is adopted, smoking may be reduced.

All interviewees highlighted benefits of smoking, and these perceived benefits play a large role in why they smoke. Interventions need to take this into account and explore alternatives to fill the position previously met by cigarette smoking. The benefits of smoking are visible presently; however potential health risks are rarely experienced until later life. Thus smokers can easily justify their smoking behaviour because they will likely not see adverse consequence until they are older. Therefore, interventions need to focus on both the short and long-term risks. By primarily focusing on long-term consequences, such as cancer, very little change is likely to occur and thus emphasis should be placed on the here and now consequences, which the smoker is more likely to have experienced, such as feeling out of breath or being unable to engage in exercise.

Interviewees expressed elements of cognitive dissonance regarding their smoking behaviour. The ill effects of smoking are well publicised, however this only increases cognitive dissonance. Interventions need to identify smoker's perceived susceptibility of ill health and target these rationalisations for smoking, if smokers truly become aware that they are likely to experience ill health, this should increase motivation to quit. Additionally, with publicised information stating that quitting smoking before thirty means that no health problems are likely to be faced, smokers are almost given the green light to continue smoking. Intervention should focus on rationalising these thoughts, where smokers should be made aware that they may experience ill health before this cut off point. Findings such as these should be used to emphasise how quitting is a worthwhile endeavour and prior health can be regained.

Reflexive Analysis

'Reflexivity is important in qualitative research because it encourages us to foreground, and reflect upon, the ways in which the person of the researcher is implicated in the research and its findings'. This awareness of the researcher's personal 'biases' allows an insight to the researcher's relation to the research area and the effects this may have (Willig, 2013:25).

I am a third year Psychology undergraduate student with a well-established interest in my research topic. I found that there was limited literature in the area of smoking behaviour, with much of the focus falling on smoking cessation, and a finite amount looking at smokers in this 'pre-contemplation' stage. I believed by exploring the personal beliefs of current smokers and their smoking behaviour I could perhaps begin to understand why people smoke in light of the well-documented health risks in the hopes of being able to suggest improvements for intervention and encourage motivation to change health behaviour in this presently unmotivated group.

As a smoker myself I was interested to see what I would uncover through interviews and analysis. The findings were enlightening and uncovered many areas which I had not foreseen when I originally initiated the research. Furthermore, by completing this research I found myself embarking on somewhat of a personal journey, whereby I asked myself many of the same questions which were posed to the interviewees and throughout the process reflected on my personal smoking behaviour.

As I was personally acquainted with the majority of the interviewees prior to the interviews, the majority were aware that I was a smoker. For those who I did not know prior to interviews I decided to disclose that I was a smoker to allow them to feel comfortable openly discussing their smoking behaviour. Whilst this may have in some ways hindered the research as my own personal biases may have come into play at times, I believe that I have uncovered some interesting findings and the general experience was highly positive for both myself and the interviewees.

References

Abrams, D., & Hogg, M. A. (1988). 'Comments on the motivational status of self-esteem in social identity and intergroup discrimination.' *European Journal of Social Psychology*, 18(4) pp. 317–334.

Allbutt, H., Amos, A. & Cunningham-Burley, S. (1995) 'The social image of smoking among young people in Scotland' *Health Education Research,* 10(4) pp. 443-454.

Baumann, J. F. & Bason, J. J. (2011) 'Survey Research' *In* Duke, N. K. & Mallette, M. H. (eds.) *Literacy Research Methodologies.* 2nd ed., New York: The Guilford Press, pp. 404-426.

Braun, V. & Clarke, V. (2006) 'Using thematic analysis in psychology.' *Qualitative Research in Psychology,* 3(2) pp.77-101.

British Medical Association. (2004) *Smoking and the reproductive life.* Unknown place of publication: British Medical Association. [Online] [Accessed on 11th November 2013] Available from: http://www.rauchfrei-info.de/fileadmin/main/data/Dokumente/Smoking_ReproductiveLife.pdf

Denscombe, M. (2001) 'Uncertain identities and health-risking behaviour: the case of young people and smoking in late modernity' *The British Journal of Sociology,* 52(1) pp. 157-177.

Ennett, S. T. (1994) 'Variability in cigarette smoking within and between adolescent friendship cliques.' *Addictive Behaviours,* 19(3) pp.295-305.

Fagerström, K. O., Heatherton, T. F. & Kozlowski, L. T. (1990) 'Nicotine Addiction and Its Assessment' *Ear, Nose and Throat Journal,* 69(11) pp. 763-765.

Festinger. L. (1957) *A Theory of Cognitive Dissonance.* California: Stanford University Press.

Flay, B. R., Hu, F. B., Siddiqui, O., Day, L. E., Hedeker, D., Petraitis, J., Richardson, J. & Sussman, S. (1994) 'Differential influence of parental smoking and friends' smoking on adolescent initiation and escalation of smoking' *Journal of Health and Social Behaviour,* 35(3) pp. 248-265.

Fry, G., Grogan, S., Gough, B. & Conner, M. (2008) 'Smoking in the lived world: How young people make sense of the social role cigarettes play in their lives' *British Journal of Social Psychology,* 47(4) pp. 763-780.

Gallagher, J. (2012) 'Women smokers who quit by the 30 'evade earlier death risks'.' *BBC News.* [Online] 27th October [Accessed 21st March 2014] http://www.bbc.co.uk/news/health-19946427

Grogan, S., Flett, K., Clark-Carter, D., Gough, B., Davey, R., Richardson, D. and Rajaratnam, G. (2011) 'Women smokers' experiences of an age-appearance anti-smoking intervention: A qualitative study' *British Journal of Health Psychology,* 16(4) pp. 675-689.

Halcomb, E. J. & Davidson, P. M. (2006) 'Is verbatim transcription of interview data always necessary?' *Applied Nursing Research,* 19(1) pp. 38-42.

Halpern-Felsher, B., Biehl, M., Kropp, R. Y. & Rubinstein, M. L. (2004) 'Perceived risks and benefits of smoking: differences among adolescents with different smoking experiences and intentions.' *Preventive Medicine,* 39(3) pp. 559-567.

Health and Social Care Information Centre (HSCIC), Lifestyles Statistics. (2012) *Statistics on Smoking: England, 2012.* [Online] [Accessed on 27th May 2013] Available from: https://catalogue.ic.nhs.uk/publications/public-health/smoking/smok-eng-2012/smok-eng-2012-rep.pdf

Jarvis, J. (2004) 'ABC of smoking cessation: Why people smoke' *British Medical Journal,* 328(7434) pp. 277-279.

Kirke, D. M. (2004) 'Chain reactions in adolescents' cigarette, alcohol and drug use: similarity through peer influence or patterning of ties in peer networks?' *Social Networks,* 26(1) pp. 3-28.

Kobus, K. (2003) 'Peer and adolescent smoking' *Addiction,* 98(Supplement 1) pp. 37-55.

Kvale, S. (1996) InterViews: An Introduction to Qualitative Research Interviewing. Thousand Oaks, CA: SAGE Publications, Inc.

Langdridge, D. & Hagger-Johnson, G. (2009) *Introduction to research methods and data analysis in psychology.* 2nd ed., Harlow: Pearson Prentice Hall.

Marshall, C. & Rossman, G. B. (2011) *Designing Qualitative Research.* 5th ed., USA:SAGE Publications, Inc.

McMaster, C. & Lee, C. (1991) 'Cognitive dissonance in tobacco smokers.' *Addictive Behaviour,* 16(5) pp. 349-353.

Michell, L. & Amos, A. (1997) 'Girls, pecking order and smoking' *Social Science & Medicine,* 44(12) pp. 1861-1869.

Michell, L. & West, P. (1996) 'Peer pressure to smoke: The meaning depends on the method.' *Health Education Research,* 11(1) pp. 39-49.

Lucas, K. & Lloyd, B. (1999) 'Starting smoking: girls' explanations of the influence of peers.' *Journal of Adolescence,* 22(5) pp.647-655.

Nguyen, S. N., Von Kohorn, I., Schulman-Green, D. & Colson, E. R. (2012) 'The Importance of Social Networks on Smoking: Perspectives of Women Who Quit Smoking During Pregnancy.' *Maternal and Child Health Journal,* 16(6) pp. 1312-1318.

Norman, P., Conner, M. & Bell, R. (1999) 'The theory of planned behaviour and smoking cessation.' *Health Psychology,* 18(1) pp. 89-94.

NHS. (2012) *What are the health risks of smoking?* [Online] [Accessed on 6th November] http://www.nhs.uk/chq/Pages/2344.aspx?CategoryID=53

NHS Smokefree. (2013) *Stoptober Brand Guidelines.* Unknown place of publication: NHS Smokefree. [Online] [Accessed on 7th November 2013] Available from: http://smokefree.nhs.uk/resources/wp-content/uploads/2013/08/Stoptober-brand-guidelines-20131.pdf

Onwuegbuzie, A. J. & Mallette, M. H. (2011) 'Mixed Research Techniques in Literary Research' *In* Duke, N. K. & Mallette, M. H. (eds.) *Literacy Research Methodologies.* 2nd ed., New York: The Guilford Press, pp. 301-330.

Oxford English Dictionary. (2014) *Dissonant.* [Online] [Accessed on 19th March 2014] http://www.oed.com/view/Entry/55542?redirectedFrom=dissonant#eid

Pearson, M. & West, P. (2003) 'Drifting Smoke Rings: Social Network Analysis and Markov Process in a Longitudinal Study of Friendship Groups and Risk-taking.' *Connections,* 25(2) pp. 59-76.

Prochaska, J. O. & DiClemente, C. C. (1983) 'Stages and processes of self-change of smoking: Towards an integrative model of change' *Journal of Consulting and Clinical Psychology,* 51(3) pp. 390-395.

Prochaska, J. O., Norcross, J. C. & DiClemente, C. C. (1995) *Changing for Good: A Revolutionary Six-Stage Program for Overcoming Bad Habits and Move Your Life Positively Forward.* New York: Avon Books.

QUIT. (2013) *The Quit Guide: Women and Smoking.* Unknown place of publication: QUIT. [Online] [Accessed on 11th November 2013] Available from: http://www.quit.org.uk/guides/women/women_and_smoking.pdf

Stewart-Knox, B. J., Sittlington, J., Rugkåsa, J., Harrison, S., Treacy, M. & Abaunza, P. S. (2005) 'Smoking and peer groups: Results from a longitudinal qualitative study of young people in Northern Island' *British Journal of Social Psychology,* 44(3) pp. 397-414.

Tajfel, H. & Turner, J. C. (1986) 'The social identity theory of intergroup behaviour.' *In* Worchel, S. & Austin, W. G. (eds.) *Psychology of intergroup relations.* Chicago: Nelson Hall, pp. 7-24.

The British Psychological Society (BPS). (2009) *Code of Ethics and Conduct: Guidance published by the Ethics Committee of the British Psychological Society.* Leicester: The British Psychological Society. [Online] [Accessed on 29th October 2013] Available from: http://www.bps.org.uk/sites/default/files/documents/code_of_ethics_and_conduct.pdf

Urberg, K. A., Değirmencioğlu, S. M. & Pilgrim, C. (1997) 'Close friend and group influence on adolescent cigarette smoking and alcohol use.' *Developmental Psychology*, 33(5) pp. 834-844.

U.S. Department of Health and Human Services (2004) *The Health Consequences of Smoking: A Report of the Surgeon General.* Atlanta, GA: U.S. Department of Health and Human Services. [Online] [Accessed on 6th November 2013] Available from: http://www.ncbi.nlm.nih.gov/books/NBK44695/pdf/TOC.pdf

Weeks, C. (2013) 'How much damage can you undo- if you stopped smoking right now?' *The Globe and Mail.* [Online] 23rd January [Accessed 21st March 2014] http://www.theglobeandmail.com/life/health-and-fitness/health/how-much-damage-can-you-undo-if-you-stopped-smoking-right-now/article7687003/

Willig, C. (2008) *Introducing Qualitative Research in Psychology.* 2nd ed., New York: Open University Press.

Willig, C. (2013) *Introducing Qualitative Research in Psychology.* 3rd ed., Berkshire: Open University Press.