

# **Young People's Perceptions of Smoking Behaviour and the Implications for Social and Health Workers**

*Linda Homan, Emma Regan*

**Linda Homan**<sup>1</sup> is a Senior Lecturer in Social Work, at Anglia Ruskin University, Cambridge, UK. This post involves teaching and assessing social work students. A particular research interest is to address the inequalities faced by those living in poorer socioeconomic areas.

**Emma Regan**<sup>2</sup> is Public Health Coordinator for Colchester Borough Council (Essex, UK). This post is designed to help embed Public Health within the borough council by implementing a series of projects and initiatives to work collaboratively on giving children and families a good start in life.

## **Abstract**

**OBJECTIVES:** Addiction to smoking has serious health implications, particularly as addiction may lead to a lifetime smoking. Social workers work with socially deprived clients and therefore can have a role in assisting in health behaviour choices.

**THEORETICAL BASE:** Social constructionism - what constitutes young people's need to smoke.

**METHODS: To understand why young people smoke** qualitative phase one interviews ( $n=40$ ) took place in six deprived areas of Essex, in England. A quantitative questionnaire was sent to 14 districts of Essex. Comparison was made between Higher deprivation (HD) and Lower Deprivation (LD) areas (Total  $n=1711$ ). Ethical approval was via Anglia Ruskin University Faculty Research Ethics Panel, and Essex, Thurrock and Southend local authorities.

---

<sup>1</sup> Contact: Linda Homan, Anglia Ruskin University, Guild House, Peterborough, PE2 9PW.  
linda.homan@anglia.ac.uk

<sup>2</sup> Contact: Emma Regan, Public Health Improvement Coordinator,  
Environment Services, Colchester Borough Council, 33 Sheepen Road, Colchester, Essex, CO3 3WG,  
emma.regan@colchester.gov.uk

**OUTCOMES: Phase One:** The phase one results demonstrate that young people who smoke are mainly stimulated by stress (14 of the 40 participants). **Phase Two:** Found that 70.1% of high deprived area (HD) and 62.6% of less deprived area (LD) Smokers identified 'stress' as the most significant reason for smoking.

**IMPLICATIONS FOR SOCIAL WORK:** Social workers can help people understand their feelings of needing to smoke cigarettes / smoking behaviour, and to help them manage stress without the need to smoke.

**Key Words:** Young people; smoking, stress; addiction; boredom, poverty.

## **INTRODUCTION.**

This article sets out some of the results of a research project which looked into smoking disparities amongst young people in Essex, England (UK). Smoking is a risk to the long-term health of children and young people throughout the world, and in in England, it is estimated that 463 out of 3.7 million children aged 11–15, begin to smoke daily (Hopkinson et al., 2014). Although smoking prevalence in the UK is just 15.5% (LTCP, 2016), and the smoking prevalence for Essex is 14% (LTCP, 2016), amongst those people who have routine or manual jobs in Essex, the rate of smoking is 23.8%.

UK legislation is briefly presented here. The Children and Young Persons (Sale of Tobacco etc.) Order 2007 increased the age of children purchasing tobacco products to 18 years (this was previously at age 16 in the Children and Young Persons (Protection from Tobacco) Act 1991. The Health Act 2006 brought about enforcement of smoke free public places such as restaurants and public houses, and smoke free workplaces. The Children and Families Act 2014 (HM Government, 2014) has been an important breakthrough in UK legislation, ruling that it is an offence for children to be subjected to passive smoking in cars, highlighting the passive effect on children from adults smoking. Tobacco packaging guidance was introduced in the UK in May 2016, meaning that all cigarette packaging by law, needs to be neutral and contain health warnings. The EU Commission of the European Communities Council made recommendations in 2002 which sought to tighten tobacco control measures with a particular emphasis on youth access to tobacco (EUCECC, 2002). This proposal included the removal of tobacco products from display, and for young people to prove their age prior to purchase. Despite the attempts of legislation to curb smoking uptake, 8% of 15 year old young people in England smoke (NHS, 2014), and because most smokers start in their youth (ASH, 2015)

this is a concern for youth, health and social care workers as the inherent risk is that young people will develop an addiction and will become lifelong smokers (US, 2014). To address high rates of smoking in deprived areas of Essex, the Smoke Free Essex Tobacco Control Alliance (SFECTA) invited members to join an Anglia Ruskin University (ARU) researcher to examine why young people take up *or refuse* smoking (particularly in areas of High Deprivation (HD)) Emma Regan, and one other member of SFETCA joined researcher Linda Homan (several other professionals wished to be informed of updates only).

Poverty and deprivation in England are measured using the English Indices of Multiple Deprivation 2010 (IMD) (IMD, 2010; McLennan et al., 2011). These Indices have been developed to encapsulate poverty on seven levels looking closely at local areas known as Local Super Output Area's (LSOA). These levels of domain indices are compared in order to reveal the vast range of deprivation experienced by people in England and applied at a local level. The seven levels are: income deprivation, employment deprivation, health deprivation and disability, education skills and training deprivation, barriers to housing and services, living environment deprivation, and crime (McLennan et al., 2011:7).

This fine-grained local level data has been useful in helping local authorities and health providers in England assess local needs and target interventions towards the most vulnerable and have been instrumental in identifying poorer parts of the geographical area of Essex for this research. In 2011 six LSOA areas of Essex which are high on the IMD were identified. The areas were not chosen by IMD score, they were identified by SFETCA colleagues as deprived areas with high smoking rates, however, they all feature highly on the IMD.

These six areas are listed here with information regarding their IMD status:

1. Basildon – which has 12 areas that are in the most deprived 10% on IMD.
2. Colchester which has Four LSOA's in the top 10% of most deprived in the country.
3. Harlow does not have any areas in the top 10% of most deprived on the IMD, however overall deprivation is significant with Harlow being amongst the most deprived 10-20% of local authorities in England, this is compared to Tendring which is in the most deprived 20-30% and Basildon which is in the most deprived 40-50%.
4. Southend has 18 LSOA's in the top 20% of the most deprived on the IMD, with four of those areas having parts of the district in the top 10% of most deprived.
5. Tendring has 89 neighbourhoods, and 14 of these areas feature among the 10% most deprived in the country. The suburb of Jaywick (in Tendring) has the overall lowest score of all the 32,844 districts of England.
6. Thurrock has five LSOA's which are in the 10% most deprived areas of England and 12

are in the 20% most deprived areas.

Qualitative Interviews began Phase One of what turned out to be a two-phase sequential design project (Cresswell and Clark, 2007). Results from this phase revealed a high number of young people with a self-perceived 'need to smoke', and the reason for smoking mainly given as stress relief. This was of interest particularly as socioeconomic disadvantage is associated with higher rates of both self-perceived stress (Fidler and West, 2009), and smoking initiation and escalation of smoking (O'Loughlin et al., 2009).

### **Theoretical Base**

The theoretical underpinning of the research project in Essex, was that of social constructivism. The social constructivist view acknowledges that the reality of those studied manifest in personal constructs, in this case, that of the reasons for smoking behaviours. These constructs are therefore central to understanding the meaning attributed to actions and world views. Social constructionism is concerned with analysing the processes that people use to make sense of and describe the world (including themselves) in which they live (Gergen, 2003:15). The focus of this approach therefore concerns the construction of the reality as perceived by a group and how they create meaning and knowledge, and representing these as accurately as possible in research. Khun addresses this as a group process:

'Knowledge is intrinsically the common property of a group or else nothing at all. To understand it we shall need to know the special characteristics of the groups that create and use it.' (Khun, 1970:210).

Understanding how meaning and knowledge are made in this constructivist way also involves acknowledging the influence of the different layers of social political, family, community and friendship structures. These layers of influence affect the world view of the people living in an area, and therefore affect their interpretation of reality. The ecological perspective of the many layers of impact from direct social relations to public and community forces is one proposed by Bronfenbrenner (1979). According to Bronfenbrenner a fundamental integration between public policy and the basic social science of understanding the impacts on populations is necessary to fully understand what is happening in both the societal setting and in individual construct of the situation (Bronfenbrenner, 1979: 8).

This perspective can shift the balance from introspection of social problems to the macro view of what the socio-cultural and economic impacts are. Critical social work requires that practitioners re-define service user's (SU) problems in terms of challenging the accepted oppressive discourse, and to empower them to look at new ways to tackle problems (Rosco,

2009). Health issues such as smoking can then be viewed holistically in terms of the functionality smoking offers to those coming from higher deprivation groups (Amos et al., 2006). This would involve the social worker in exploring new ways for SU to function and cope without the need to smoke.

The conceptualisation of poverty as a social construct has gained much attention. Social status and wealth need to be examined from a structural perspective. Those who do not have the means to improve their social position are limited in choice and in personal development. They are often subjected to longer working hours and less favourable working conditions. This in turn impacts on stress and health. This type of unequal pressure does not happen to individuals only, but communities and groups can suffer from the effects of poorer working conditions and poorer housing provision. This type of housing and employment poverty ultimately stems from policy and is reproduced because of the lack of opportunities causing a poverty trap (Lawson, 2012). From Durkheim (2013:158) we learn that if a situation is replicated, then we can confirm that this is a *social fact*. On youth he noted that:

“... in order to ascertain the direction in which a social phenomenon is evolving, one will compare what it is during the 'youth' of every species with what the phenomenon becomes in the 'youth' of the succeeding species.”

Research on smoking confirms the *social fact* that there is still a youth problem with smoking, and also that there are higher rates of smoking in poorer areas of society (Fergusson et al., 2007; Moore et al., 2012; Hiscock et al., 2012 a; Hiscock et al., 2012b). It is also acknowledged that smoking is seen as a coping mechanism to help with stress (Tsourtos, Ward and Muller, 2008; Fidler and West, 2009; Sperlich, Maina and Noeres, 2013). Poverty linked with health damaging behaviours are repeated throughout cities in the UK and across the world (Dahlgren and Whitehead, 1993; 2007; Wilkinson and Marmot, 2003; Wilkinson and Pickett, 2010).

In an exploration on smoking and socioeconomic status in England, Hiscock et al. (2012a) found that between 2001-2008 there were four times as many smokers in poorer areas, and that incidence of smoking carried on longer in this group with fewer quitters. Whatever the reason for smoking, the life limiting illnesses associated with smoking mean that this ‘habit’ is serious and any help to stop smoking and cope with stress are welcome. People who start to smoke soon become dependent on smoking, making the quitting process more difficult. Although the term ‘addiction’ should be used carefully, there is no set number of cigarettes within which one is classed as addicted to smoking, rather, the need for nicotine coupled with the intensive need to smoke throughout the day is measured, usually by an assessment of the

desire to smoke (Stop-tobacco.ch). In America, the Fargerström Test for Nicotine Dependence (Fargerström et al., 2012) is used, however, as Benowitz notes (2008:4) the terms dependency and addiction are applied to those who have little or no control over the (smoking) behaviour. Below, in the findings from qualitative interviews, there are signs of loss of control in the need to smoke, however, this is understood here to be associated with heightened emotional circumstances. (This is discussed fuller below).

Theories concerning the addictiveness of smoking behaviour suggest that nicotine addiction causes the compulsion to smoke, and that the withdrawal of nicotine triggers this compulsion (Abreu-Villaca and Seidler, 2003; Scragg et al. 2008; Racicot, McGrath and O'Loughlin, 2011). Research concerning compulsion to smoke not only highlights the pharmacological effect of nicotine dependency (of which the physical withdrawal symptoms are just one part); but also highlights the effects which have a dominant psychological and behavioural effect (Abreu-Villaca and Seidler, 2003; Scragg et al. 2008; Racicot, McGrath and O'Loughlin, 2011). The experiences of clinical withdrawal, and the behavioural and psychological aspects, appear to be two very different (although related and overlapping) components of continuing smoking.

Nicotine addiction is not simply a chemical response (Benowitz, 2008; 2010; O'Loughlin et al., 2009) and there are many complex factors for each individual which determine their susceptibility to nicotine. Benowitz (2010) notes that addiction to nicotine combines learned factors as part of conditioning from social and environmental factors, and that this interplays with the pharmacological effects. These views on addiction to smoking tend to share a focus both on the medical aspects of smoking addiction (pharmacological, genetic), and the social influences (learned behaviour and environmental factors) that lead to smoking uptake (Okoli et al., 2009).

Light smokers or experimenters (light smoking is usually based on  $\leq 5$  cigarettes per day) have been found to show symptoms typically associated with nicotine addiction such as impulsivity and 'feeling the need to smoke' (Benowitz, 2010). The criteria of 'needing a cigarette' has been shown to affect smoking uptake with those claiming to have smoked just 3 to 4 cigarettes in their lifetime having a diminished autonomy with regard to smoking of between 20 to 35% (Scragg et al., 2008). Self-perceived addiction has been shown to be a key predictor of smoking initiation and (to a lesser degree) daily smoking (Okoli et al., 2009), also self-perceived mental and physical addiction has been shown to predict those who would go on to sustained smoking habits (O'Loughlin et al., 2009).

A study by Panday et al. (2007) found that weekly and monthly teenage smokers, who

smoked as few as one cigarette per week, reported high levels of dependency. Despite only smoking monthly 28.5% reported withdrawal symptoms of craving to smoke, 22.8% reported feeling irritable, and 18.9% reported that they were unable to concentrate (Panday et al., 2007). Whilst this study was not undertaken in the UK, similar findings in a UK study by Wilkinson and Abraham (2004), found that behavioural intension was a significant indicator in future smoking. It has been suggested that it is the associated thoughts and feelings, as well as the psychological effects which trigger the desire to smoke the next cigarette (Wilkinson and Abraham, 2004; Panday et al., 2007; West, 2009). This means that it is important to understand how cravings affect people, and at what point light smokers perceive themselves as addicted. The 'needing to smoke' category moves on to 'cravings' to smoke, and this can ultimately trigger continued smoking, and as detailed above, this has been shown to be experienced by those who smoke very few cigarettes or even irregularly (West, 2006). An important question to ask therefore is whether this is actual addiction to nicotine, or perceived addiction when 'craving' a cigarette is asserted by a young person.

West (2009) suggests that assessment of nicotine addiction should always consider how much the behaviour controls the individual's repertoire, and also his self-image (West and Brown, 2012). The type of language used to describe the need for a cigarette can reveal a lot about the severity of feelings being experienced. In a study by Fidler and West (2009), addiction to cigarettes and continued smoking was directly related to both the description of the enjoyment of smoking and the strength of any urges to smoke. Also, that the emotional gratification found from low level nicotine consumption has been found to have the same behavioural components as confirmed nicotine dependence.

There is no doubt that experiencing physiological or psychological effects, especially those associated with withdrawal, make giving up smoking a difficult task (Scragg et al., 2008; Doubeni, Reed and Difranza, 2010; Wileyto, 2009; Hughes, 2009). West describes the urges to smoke as a 'nicotine hunger' (2006) which is satisfied by continuing to smoke. This 'hunger' to smoke can be non-nicotine related and this assertion is born out in a study utilising nicotine free cigarettes (Perkins et al., 2010) which identified that smoking was found to alleviate the negative effects of stress despite nicotine content of the cigarettes. Therefore, there is a case to suggest that regular smoking can take place when young people *feel* the need to smoke because of a psychological desire for nicotine, however, they may not necessarily have reached a *clinical* or physiological nicotine addiction. It is important that young people do not adopt the label of addiction to nicotine and define themselves as smokers (Haines, Poland and Johnson, 2009; Vangeli and West, 2012), but are helped to cope

with stress and other associated behaviours. Essex stop smoking services were particularly keen to find out what young people (local to them) were saying and experiencing in relation to smoking uptake and refusal. To date, apart from the Schools Health Education Unit (SHEU) survey, which does not look closely into aspects of smoking, detailed information pertinent to smoking was not available, and so this study was carried out.

## **Objectives**

The Smoke Free Essex Tobacco Control Alliance (SFETCA) and Anglia Ruskin University (ARU) undertook a professional collaborative/participatory research project with an exploratory two-phase design. The working group consisted of two representatives from SFETCA (including Emma Regan), and the social work researcher Linda Homan. SFETCA were instrumental in highlighting the areas of concern within Essex, co-reviewing the qualitative findings with ARU, and co-suggesting a further stage. The first phase involved qualitative interviews with individuals, friendship pairs, and small groups ( $n=40$ ) in the six most deprived areas of Essex according to the Indices of Multiple Deprivation.

In Phase One, the main researcher met with young people in schools, youth clubs and at youth drop in meeting places ( $n=40$ ) to ask them about their encounters with the habit of smoking. Youth leaders and teachers helped advertise the sessions in some of the most socioeconomically deprived places in Essex and were on hand for support. The young people chose either one to one interviews or friendship pair interviews; also there were two group meetings. The results were transcribed and analysed using 'FrameWork' software (now incorporated into NVivo), and Colaizzi's procedural analysis (1978) to discover the significant themes from the dialogue. The themes arising included whole family entrenched smoking, buying single cigarettes at school, and smoking to help cope with stress.

The smoking rates in the six areas are listed below showing the overall area rate, and the smoking rate for routine and manual workers.

1. Basildon: 18.5% smoking rate and 24.2% for routine and manual workers.
2. Colchester: 21% smoking rate and 36.3% for routine and manual workers.
3. Harlow: 23.8% smoking rate and 36.4% for routine and manual workers.
4. Southend: 22.5% smoking rate and 36.4% for routine and manual workers.
5. Tendring: 22.5% and smoking rate and 30.9% for routine and manual workers.
6. Thurrock: 21.3% smoking rate and 25.8% for routine and manual workers.

In Phase Two, a questionnaire was used to see whether some of the phase one

themes/findings applied to a wider cohort, and also to compare various smoking behaviours and views between HD and LD areas. The sample included two schools in each of Essex's 14 districts ( $n=28$ ) (Basildon, Braintree, Brentwood, Castle Point, Chelmsford, Colchester, Epping Forest, Harlow, Maldon, Rochford, Southend, Tendring, Thurrock and Uttlesford). In each area two schools were chosen. One nearest the highest and one from nearest the lowest super output areas (LSOAs) on the Indices of Multiple Deprivation (IMD). In each school four tutor groups of year 10 pupils (ages from 14-15) were chosen randomly by the head of Personal, Social and Health Education (sample  $n=120$ ), and each class was invited to complete the questionnaire. The responses (sample  $n=1711$ ) were analysed using SPSS. Chi-square and Likelihood ratio tests were used to produce inferential statistics, and some statistics are presented as % of the cohort to make a comparison between HD and LD areas straightforward.

The 17 questions concerned reasons for, and attitudes towards smoking. Amongst the questions, young people who took part were asked: Do you/did you smoke? And What makes you/made you smoke most? The questionnaire contained a list of reasons developed from phase one, as well as a space to write any 'other' comments. The list included: Boredom; To fit in with friends; To socialize; Hooked on nicotine; To look older; To look good; Stress; and Other (please state). The findings from both phases were integrated and analysed on a topic by topic basis. Non and ex-smokers were included in the research along with smokers as the researcher wanted to find out what made people refuse smoking or give up smoking. This was one of the findings in Phase One.

## **Outcomes**

This section presents the results of the Phase One qualitative study, and the Phase Two quantitative questionnaire, as they apply to the topic of the 'need' to smoke and stress in young people from Essex. The qualitative phase one findings will examine the discourse around stress and smoking, and one chart from the phase two findings will be linked to this.

## **Phase One Qualitative Results**

The qualitative phase one findings show that the 'need' to smoke was most often directly related to stress. 12 of the 40 participant's mention wanting or needing to smoke, and 14 of the 40 participants mention stress as a reason for smoking. Young people reported a *need* to smoke, and a *need* to carry on smoking.

*'I didn't really see why everyone wanted to smoke but 'er, as I got older it's kind of like I just*

... it was there at the back of my mind. I need a fag.' (15 year old female smoker, from a smoking home).

Similarly, another young person reported continuing after first trying a cigarette as a 'need': *'I threw up after my first cigarette but after your first one you feel you need another one and it goes on from there...'* (17 year old male smoker, from a smoking home).

Smoking can become a habit, and it can also become a perceived relief from stress. Smoking as a coping strategy has been noted by West (2009) who acknowledges that smokers form beliefs about the benefits of smoking (evaluations), such as the belief that smoking will help relieve stress, and that these beliefs contribute to their smoking choices. This is particularly pertinent when emotions are extreme, as they can be in adolescence. One young person reported extreme emotions when needing a cigarette:

*'Other people get really stressed out and need a cigarette. Like me yesterday, I was so upset, I was just really in a mood and I looked in my bag and someone had taken my cigarettes, and I just thought 'Oh my God', like I actually walked off and I just cried, I was so wound up.'* (15 year old female smoker, from a smoking home. Smokes up to 20 cigarettes a day).

Another young person reported:

*'I have been using it (smoking) as a stress relief because as soon as I have a fag then I am fine. Smoking helps with my stress.'* (17 year old female smoker, from a smoking home. Smokes 5-10 cigarettes a day).

Similarly two other young people reported smoking 'helps' if you are stressed, and that smoking 'relieves stress'. Another young person said:

*'...when I am stressed the first thing that comes into my mind is a fag.'* (15 year old female smoker, from a smoking home. Non-daily smoker).

Some young people reported that they smoked without 'needing' to smoke:

*'Four years I have been smoking now. I smoke 10 a day. I am cutting down. I don't NEED a cigarette, I just do it.'* (13 year old female smoker, from a smoking home).

Despite reporting that she has a smoking habit of 10 cigarettes per day, and that she has been smoking for four years, this young person went on to say:

*'In the holidays I didn't have a fag for a week until we came back (to school) and it was alright.'*

Similarly another young person stated:

*'I think smoking does relieve stress but it's psychological...[.] ... I gave up last year for 12 weeks and every time I got stressed I had a chewing gum instead that was really good.'* (17 year old female smoker, from a smoking home. Smokes 25 cigarettes a day).

It was acknowledged by some of the young respondents that parents and older siblings smoked to ease stress, thus adding to a picture of social learning (social construction). Four non-smokers acknowledge that stress had an effect on smokers. Those young people who lived in a smoking home, but did not themselves smoke (non-smokers) were of great interest to the researcher as they could offer some insight into resilience to smoking uptake (this will be the discussion of another article).

**Phase Two Quantitative Results:**

In phase two smokers were asked to tick a set of pre-fixed answers developed from phase one responses. There were 1711 returned questionnaires. The 17 question questionnaire contained questions about smoking habits etc., however, only part of the results relevant to this article are presented here (why young people smoked the most). Table 1. Contains the results comparing HD and LD schools for this question. The most significant reason young people gave was ‘stress’. 70.1% of HD and 62.6% of LD cited this as the reason they most want to smoke. The second highest response was ‘boredom’ with 42% of MD and 42.9% of LD school pupils indicating this as a reason for smoking. The third most popular response was to ‘socialise’ while the next most popular reasons young people indicated were being ‘hooked on nicotine’ and ‘to fit in with friends’.

**Table 1. Results from unpublished research in Essex amongst 14-15 year old young people. (Response to questionnaire *n*=1711).**

<b>What makes you/made you smoke most?</b>	<b>School HD</b>	<b>School LD</b>
Stress	70.1%	62.6%
Boredom	52.2%	42.9%
Socialize	35.8%	49.0%
To fit in with friends	30.6%	25.9%
Hooked on nicotine	26.9%	29.9%
To look good	17.9%	11.6%
To look older	11.9%	11.6%
Other	11.2%	12.9%

The results in the table above confirm the findings from Phase One of the study, that young people use smoking to cope with stress. They also confirm that smoking is still more prevalent in HD areas.

### **Implications for Social Work**

Social workers are not stop smoking advisors, and yet they work with people who are in the most deprived groups in society who are therefore most likely to be smokers. Social workers working with young people are well placed to give advice which can be health promoting, and this part of the article has presented the implications of what it means to rely on cigarettes as a relief for stress, boredom, or just to socialise for those young people living in poorer areas of Essex. It is hoped that an understanding of reasons young people smoke, will give social workers insights into how to help young people deal with stress, boredom, and socialising, without having to smoke.

In phase one, the *need* to smoke was expressed in various ways. A couple of young people mentioned the word addiction in relation to nicotine dependence and withdrawal, however many smokers offered descriptions of a *need* or *want* to smoke. This was almost always referred to in the context of stress relief. Some were specific in their explanation of the need to smoke because they depended on smoking to relieve cravings. One participant revealed very deep feelings concerning this stating ‘You see like when I get stressed, if I don’t have a fag I will end up like just sitting there and punching walls.’ This graphic depiction, whilst not common, helps to highlight an intensity of feelings expressed when smoking is needed.

The terminology or language used, can reveal intensity of feelings about the need to smoke or how much stress is impacting on them (Wilkinson and Abraham, 2004; Fidler and West, 2009; Ursprung and DiFranza, 2010), however, as adolescence is a stage of increased intense emotions (Yurgelun-Todd, 2007; Zimmermann and Iwanski, 2014), it is important to put this into context and listen carefully to young people about the nature and degree of their smoking habit, as well as any other negative behaviours when they are feeling stressed. The proposal here is not to take lightly or suggest that young people are not ‘addicted’ to nicotine and merely experiencing emotional extremes; but that if their emotions lead them to smoke (and smoke when emotions are intense) then they may well need the help of professionals such as stop smoking services earlier in their smoking habit. They may also benefit from help offered by youth and social workers to access strategies to help them cope with stress such as emotional intelligence and advice on positive ways to cope with stress. If such help to avoid smoking are in place for these early smokers, there could be alternatives on offer when the

'need' to smoke arises. Some purport that e-cigarettes can aid smoking cessation. E-cigarettes are a contentious issue however, in the UK, stop smoking services acknowledge the fact that e-cigarettes can help people quit (Hartmann-Boyce et al., 2016) and that professionals should take an e-cigarette friendly approach (PHE, 2017). Having healthy alternatives and strategies to occupy time in a healthy way is also important in avoiding smoking. Some young people in the Essex research reported that if they wanted to, that they would be able to give up easily when they decide to. This could be harnessed by using strategies to help young people gain a non-smoking identity (Vangeli and West, 2012). This seems to add to the proposal I am making here that suggests that a perceived mental and emotional dependence on smoking exists for some, rather than actual dependence on nicotine. This concept has not been fully explored in research, however some research does confirm aspects of this phenomenon. A study by Okoli et al. found that non-smokers and light smokers were susceptible to perceived mental, (and not perceived physical) addiction to smoking, and that this led to greater susceptibility to future smoking.

Young people have strong emotions affecting their motivations, and these have sometimes been associated with withdrawal symptoms (Hoffman et al., 2006; 2007; McGee et al., 2013). Amos et al. (2006) highlights the importance of understanding the attitudes and perceptions of young smokers, and how will power (being in control) plays an important role in smoking cessation. Trinidad et al. (2004) found that emotional intelligence was a strong protective factor in smoking choices. This seems to suggest that the perception of lack of control vs. having control, or at the very least a lack of access to understanding empowerment and emotional intelligence could be a key factor in understanding young people's perceptions in quit attempts. Perceived dependence vs. actual dependence on nicotine therefore needs further exploration. It is important when trying to help young people who are making health behaviour choices (such as alcohol, drugs, smoking, consensual sex, etc.) that health and social care professionals try to understand the way that the young people themselves perceive their own need to smoke, or undertake health behaviour choices, and also to gauge how any extreme emotions might be handled. Emotional literacy advice may empower young people so that they are better able to understand and interpret their feelings and emotions, especially if these emotions impact on negative health behaviours.

If help was provided to young people by giving them strategies to cope with their emotions alongside advice on alternatives to smoking, this may help prevent the young person turning to cigarettes as an emotional prop. Another young person in the qualitative phase of this study described heightened emotions when cigarettes are withheld and reports crying as a result of

the upset of this. Whatever the perceptions of the young people are regarding the need to smoke, the fact remains that they *perceive* themselves as dependent on cigarettes and should be taken seriously. Psychological and *perceived* dependence, without a clinical nicotine *addiction*, may be a stage that is, for some young smokers, a very real part of the progression to smoking addiction, and one that could be at risk of being overlooked by smoking cessation services.

A novel new theory proposed by Robert West (2006, 2009; West and Brown, 2013) 'PRIME theory', proposes five motivational layers: Plans, Responses, Impulses, Motives, and Evaluations. The first layer is in the mind, the plans which someone has in order to undertake the health behaviour. The impulses which trigger the intended plans, and motives to rationalise, and finally the evaluation of whether to smoke or not. Utilising this theory, West and Brown (2012) have proposed that smokers can adopt a non-smoking image. Closely aligning their identity and the 'self' image that they have, the person can construct a self which can exist without the negative health behaviours. Social workers can utilise PRIME theory to engage SU by empowering people and helping them utilise self-efficacy gained in quit attempts, thus helping the person develop coping skills. This has been shown to work with substance abusers (Biernacki, 1983; McIntosh and McKeganey, 2000).

Smoking cessation interventions are usually targeted at confirmed nicotine addicted smokers. What is needed is an acknowledgement of the strength and significance of young people's feelings, and support for young people to interpret and manage these feelings and stresses and have a repertoire of coping skills which do not rely on substances such as nicotine. Whilst a nicotine substitute may be an important part of any treatment of smoking addiction, this needs to be delivered alongside skills-based interventions to help young people understand and cope with stress in order to adequately address and promote smoking cessation.

In Essex the SFETCA have been utilising these results with young people in school educating them on how to cope with stress and how to become more emotionally literate. The stop smoking services have tools such as a stress ball so that the young people have something physical to use when tension is high. Often young people want to deal with their stress and not just react to it and by upskilling young people professionals can aid them in coping with stress throughout life. Social workers are well placed to help with emotional literacy, helping to build self-efficacy, helping people re-frame and challenge the negative identities which are so often associated with users of social care services, and those dependent on substances such as nicotine. Social workers should also consider empowering people from poorer areas to challenge government regarding unacceptable health outcomes in poorer areas, campaigning

for additional funding to support health outcomes and put in place coping skills at a grass roots level.

## REFERENCES

- ABREU-VILLACA, Y. SEIDLER F. J. 2003. Short-term adolescent nicotine exposure has immediate and persistent effects on cholinergic systems: critical periods, patterns of exposure, dose thresholds. *Neuropsychopharmacology*; 28 (11):1935-1949.
- AMOS, A., WILTSHIRE, S., HAW, S. et al. 2006. Ambivalence and uncertainty: experiences of and attitudes towards addiction and smoking cessation in the mid-to-late teens. *Health Education Research*. Apr; 21(2):181-191.
- ASH. 2015: 'Young people and smoking'. [online] *Action on Smoking Health*. [20/6/18]. Available from: [http://www.ash.org.uk/files/documents/ASH\\_108.pdf](http://www.ash.org.uk/files/documents/ASH_108.pdf)
- BIERNACKI, P. 1983. Getting off dope: Natural recovery from opiate addiction. In STALL and BIERNACKI, P. 1986. Spontaneous remission from the problematic use of substances: An inductive model from a comparative analysis of alcohol, opiate, tobacco, and food/obesity literatures. *International Journal of Addiction*, 21(1), 1-23.
- BENOWITZ, N. L. 2008. Neurobiology of nicotine addiction: implications for smoking cessation treatment. *The American Journal of Medicine*, 121 (4), pp.S3-S10.
- BENOWITZ, N. L. 2010. Nicotine addiction. *New England Journal Medicine*. 62(24):2295-2303.
- BRONFENBRENNER, U. 1979. *The Ecology of Human Development: Experiments by Nature and Design*. Cambridge, MA: Harvard.
- COLAIZZI, P. F. 1978. 'Psychological Research as the Phenomenologist Views it'. In VAILS, R. and KING, M. (Ed.). 1978. *Existential Phenomenological Alternative for Psychology*. New York. Oxford University Press.
- CRESWELL, J.W. and CLARK, V.L.P. 2007. *Designing and conducting mixed methods research*. London. Sage Publications Ltd.
- DAHLGREN, G. and WHITEHEAD, M. eds. 1993. Tackling inequalities in health: What can we learn from what has been tried? Working paper prepared for the king's fund international seminar on tackling inequalities in health. [online] *Oxfordshire, Kings Fund*. [24/06/18]. Available from: <https://www.kingsfund.org.uk/projects/time-think-differently/trends-broader-determinants-health>
- DAHLGREN, G. and WHITEHEAD, M. 2007. European Strategies for tackling social inequalities in health: Levelling up part 2. [online]. *WHO*. [12/06/18]. Available from:

<http://apps.who.int/iris/handle/10665/107791>

DOUBENI, C.A., Reed, G. and Difranza, J.R., 2010. Early course of nicotine dependence in adolescent smokers. *Pediatrics*, 125 (6), pp.1127-1133.

FIDLER, J. A. and WEST, R. 2009. Self-perceived smoking motives and their correlates in a general population sample. *Nicotine Tobacco Research*. 11(10):1182-1188.

DURKHEIM, E. 2013. *Durkheim: The rules of sociological method: And selected texts on sociology and its method*. London. Palgrave Macmillan.

EUCECC, 2002. Commission of the European Communities Council Recommendation on the prevention of smoking and on initiatives to improve tobacco control. [online] WHO. [20/06/18]. Available from:

[eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2002:0303:FIN:EN:PDF](http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2002:0303:FIN:EN:PDF)

FAGERSTROM, K., RUSS, C., YU, C. et al. 2012. The Fagerström Test for Nicotine Dependence as a predictor of smoking abstinence: a pooled analysis of varenicline clinical trial data. *Nicotine & Tobacco Research*, 14 (12), pp.1467-1473.

FERGUSON, D.M., HORWOOD, L.J., BODEN, J.M. et al. 2007. Childhood social disadvantage and smoking in adulthood: results of a 25-year longitudinal study. [online] *Addiction* [12/06/18]. 102 (3), pp.475-482. Available from:

<https://www.ncbi.nlm.nih.gov/pubmed/17298656>

FIDLER, J.A. and WEST, R. 2009. Self-perceived smoking motives and their correlates in a general population sample. *Nicotine & Tobacco Research*, 11 (10), pp.1182-1188.

GERGEN, K.J., 1985. The social constructionist movement in modern psychology. *American Psychologist*, 40 (3), pp.266-275.

HAINES, R.J., POLAND, B.D. and JOHNSON, J. L. 2009. Becoming a 'real' smoker: cultural capital in young women's accounts of smoking and other substance use. *Sociology of Health & Illness*, 31 (1), pp.66-80.

HARTMAN-BOYCE, J., MCROBBIE, H., BULLEN, C. et al. 2016. Can electronic cigarettes help people stop smoking, and are they safe to use for this purpose? [online] *Cochrane*. [12/06/18]. [http://www.cochrane.org/CD010216/TOBACCO\\_can-electronic-cigarettes-help-people-stop-smoking-and-are-they-safe-use-purpose](http://www.cochrane.org/CD010216/TOBACCO_can-electronic-cigarettes-help-people-stop-smoking-and-are-they-safe-use-purpose)

HISCOCK, R., BAULD, L., AMOS, A. et al. 2012a. Socioeconomic status and smoking: a review. *Annals of the New York Academy of Sciences*. [online] 1248 (1), pp.107-123. [18/06/18]. Available from: <https://nyaspubs.onlinelibrary.wiley.com/doi/full/10.1111/j.1749-6632.2011.06202.x>

HISCOCK, R., BAULD, L., AMOS, A. et al. 2012b. Smoking and socioeconomic status in

England: the rise of the never smoker and the disadvantaged smoker. *Journal of Public Health*, 34 (3), pp.390-396.

HOFFMAN, B.R., MONGE, P.R., CHOU, C. et al. 2007. Perceived peer influence and peer selection on adolescent smoking. *Addictive Behaviors*, 32 (8), pp.1546-1554.

HOFFMAN, B.R., SUSSMAN, S., UNGER, J.B. et al. 2006. Peer influences on adolescent cigarette smoking: A theoretical review of the literature. *Substance Use & Misuse*. [online] 41 (1), pp.103-155. [14/06/18]. Available from:

<https://www.sciencedirect.com/science/article/abs/pii/S0306460306003492>

HOPKINSON, N.S., LESTER-GEORGE, A., ORMISTON-SMITH, N. et al. 2014. Child uptake of smoking by area across the UK. *Thorax*, 69 (9), pp.873-875.

HUGHES, J. R. Smokers' beliefs about the inability to stop smoking. *Addictive Behaviors*, 2009; 34(12):1005-1009.

KUHN, T.S. 1970. *The Structure of Scientific Revolutions*. The University of Chicago Press, LTD., London.

LAWSON, V. 2012. Decentring poverty studies: Middle class alliances and the social construction of poverty. *Middle Class Poverty Politics Research Group. Singapore Journal of Tropical Geography*, 33 (1), pp.1-19.

LTCP: Local Tobacco Control Profiles (*Public Health England*). [online] [18/06/18].

Available from: <https://fingertips.phe.org.uk/profile/tobacco-control>

MCINTOSH, J. and MCKEGANEY, N. 2000. Addicts' narratives of recovery from drug use: constructing a non-addict identity. *Social Science & Medicine*, 50 (10), pp.1501-1510.

MCGEE, R., WILLIAMS, S., NADA-RAJA, S. et al. 2013. Tobacco smoking in adolescence predicts maladaptive coping styles in adulthood. *Nicotine & Tobacco Research : Official Journal of the Society for Research on Nicotine and Tobacco*. [online] 15 (12), pp.1971-1977. [18/06/18]. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3888179/>

MCLENNAN, D., BARNES, H., NOBLE, M. et al., 2011. The English indices of deprivation 2010. [online]. *London: Department for Communities and Local Government*. [12/06/18].

Available from:

[https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwi guNj5kOLbAhXSa8AKHfPXDNUQFggpMAA&url=https%3A%2F%2Fassets.publishing.service.gov.uk%2Fgovernment%2Fuploads%2Fsystem%2Fuploads%2Fattachment\\_data%2Ffile%2F6320%2F1870718.pdf&usq=A0vVaw3FBZlEqmgUYoUbsp1cRk5S](https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwi guNj5kOLbAhXSa8AKHfPXDNUQFggpMAA&url=https%3A%2F%2Fassets.publishing.service.gov.uk%2Fgovernment%2Fuploads%2Fsystem%2Fuploads%2Fattachment_data%2Ffile%2F6320%2F1870718.pdf&usq=A0vVaw3FBZlEqmgUYoUbsp1cRk5S)

MOORE, G.F., CURRIE, D., GIL, G., HOLLIDAY, J.C. et al. 2012. Socioeconomic inequalities in childhood exposure to secondhand smoke before and after smoke-free

legislation in three UK countries. *Journal of Public Health*. Oxford, England. 34 (4), pp.599-608.

NHS, 2014. Smoking, Drinking and Drug Use Among Young People in England 2014.

[online]. [18/06/18]. Available from:

<http://webarchive.nationalarchives.gov.uk/20180328135950/http://digital.nhs.uk/catalogue/PUB17879>

OKOLI, C.T., RICHARDSON, C.G., RATNER, P.A. et al. 2009. Non-smoking youths' "perceived" addiction to tobacco is associated with their susceptibility to future smoking.

*Addictive Behaviors*, 34 (12), pp.1010-1016.

O'LOUGHLIN, J, KARP, I, KOULIS, T. et al. Determinants of first puff and daily cigarette smoking in adolescents. *American Journal of Epidemiology* 2009; 170(5):585. PANDAY, S,

REDDY, S. P., RUITER, R. A. C. et al. Nicotine dependence and withdrawal symptoms among occasional smokers. *Journal of Adolescent Health*. 2007; 40(2):144-150.

PERKINS, K. A., KARELITZ, J. L., CONKLIN, C. A. et al. 2010. Acute negative affect relief from smoking depends on the affect situation and measure but not on nicotine.

*Biological Psychiatry*, 67(8):707-714.

PHE, 2017. Models of Delivery for stop smoking services options and evidence. [online] *Public Health England*. [18/06/18]. Available from:

<https://www.gov.uk/government/publications/stop-smoking-services-models-of-delivery>

RACICOT, S., MCGRATH, J. J., OLOUGHLIN, J. 2011. An investigation of social and pharmacological exposure to second hand tobacco smoke as possible predictors of perceived nicotine dependence, smoking susceptibility, and smoking expectancies among never-smoking youth. *Nicotine Tobacco Research*, Oct; 13 (10):926-933.

ROSCOE, K.D. 2009. Critical social work practice a narrative approach. *The International Journal of Narrative Practice*. Spring 2009. Volume 1(1).

SCRAGG, R., WELLMAN, R. J., LAUGENSEN, M. et al. 2008. Diminished autonomy over tobacco can appear with the first cigarettes. *Addictive Behaviour*, 33(5):689-698.

SPERLICH, S., MAINA, M.N. and NOERES, D. 2013. The effect of psychosocial stress on single mothers' smoking. *BMC public health*, 13 (1), pp.1.

TRINIDAD, D.R., UNGER, J.B., CHOU, C. et al. 2004. The protective association of emotional intelligence with psychosocial smoking risk factors for adolescents. *Personality and Individual Differences*, 36 (4), pp.945-954.

TSOURTOS, G., WARD, P.R. and MULLER, R. 2008. Smoking and Stress. *Australasian Medical Journal*, 1 (1).

URSPRUNG, W.W.S.A; DIFRANZA, J.R. 2010. The loss of autonomy over smoking in relation to lifetime cigarette consumption. *Addictive Behaviours*, 35 (2010) 14-18.

US DEPARTMENT OF HEALTH AND HUMAN SCIENCES, 2014. The health consequences of smoking—50 years of progress: a report of the Surgeon General. *Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health*, 17.

VANGELI, E. and WEST, R. 2012. Transition towards a ‘non-smoker’ identity following smoking cessation: An interpretative phenomenological analysis. *British Journal of Health Psychology*, 17 (1), pp.171-184.

WEST, R. 2009. The multiple facets of cigarette addiction and what they mean for encouraging and helping smokers to stop. *COPD: Journal of Chronic Obstructive Pulmonary Disease*, 6(4):277-283.

WEST, R. 2006. Defining and assessing nicotine dependence in humans. *Understanding Nicotine and Tobacco Addiction*. 36-63.

WEST, R. and BROWN, J., 2013. *Theory of addiction*. London. John Wiley & Sons.

WILEYTO, P., OLOUGHLIN, J., LARGERLUND, M. et al. Distinguishing risk factors for the onset of cravings, withdrawal symptoms and tolerance in novice adolescent smokers. *Tobacco Control*, 2009. Oct; 18 (5):387-392.

WILKINSON, D. and ABRAHAM, C. 2004. Constructing an integrated model of the antecedents of adolescent smoking. *British Journal of Health Psychology*, 9 (3), pp.315-333.

WILKINSON, R.G. and MARMOT, M.G. 2003. Social determinants of health: the solid facts. [online] *World Health Organization*. [12/06/18]. Available from: <https://books.google.co.uk/books?hl=en&lr=&id=QDFzqNZZHLMC&oi=fnd&pg=PA5&dq=Social+determinants+of+health:+the+solid+facts.+&ots=xVpNiCRLkv&sig=7BtIf5SwKKUcOGXwex7zyBbb37U#v=onepage&q=Social%20determinants%20of%20health%3A%20he%20solid%20facts.&f=false>

WILKINSON, R. and PICKETT, K. 2010. *The spirit level: why equality is better for everyone*. London. Penguin. UK.

YURGELUN-TODD, D. 2007. Emotional and cognitive changes during adolescence. *Current Opinion in Neurobiology*, 17 (2), pp.251-257.

ZIMMERMANN, P. and IWANSKI, A. 2014. Emotion regulation from early adolescence to emerging adulthood and middle adulthood: Age differences, gender differences, and emotion-

specific developmental variations. *International Journal of Behavioral Development*, 38 (2), pp.182-194.