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The Application of Health Psychology in Public Health; Developing and Delivering Health Promotion and Behavioural Interventions

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For the qualification of Professional Doctorate in Health Psychology

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May 2011

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SECTION A

PREFACE

PREFACE

This thesis is designed to illustrate the links between the theoretical knowledge and the applied areas of practice that a health psychologist in training experiences and reflects upon in order to attain a Doctorate (D.Psych.) in Health Psychology.

In this thesis these links of theory and practice are illustrated through the core competencies of a research study and a systematic review, as well as case studies detailing a consultancy project, delivering teaching and training and two competencies of implementing behaviour change interventions and clinical supervision of others. These competencies are reported as separate pieces of work yet are interlinked and to some extent overlap despite different knowledge and skills required to fulfil each competence. Additional knowledge that is learned and added to the field of health psychology is also identified.

The majority of the training illustrated in this thesis has been completed within the structure of a smoking cessation service; the one exception is a section of delivering teaching in an academic environment on the contribution of health psychology to the management of diabetes. However, as is seen in this case study, when discussing a chronic disease such as diabetes, there is also an opportunity to introduce the commonality and impact of smoking. This serves to illustrate that disease and behaviours do not occur in a vacuum and what many see as an isolated behaviour, smoking, has an impact on the management of chronic diseases. This is further highlighted in other sections of the thesis with other chronic diseases such as chronic obstructive pulmonary disease.

This training was conducted in the context of increasing the uptake of preventative behaviours to reduce the burden of smoking in the United Kingdom (U.K.); attention focused on smoking in the U. K. with the launch of the Smoking Kills White Paper (Department of Health, 1998). This document recommended a number of strategies of tobacco control to

achieve a reduction in the prevalence of smoking from 28% to 21% of the general adult population by 2010. These recommendations followed a World Bank six strand strategy for comprising; 1) reducing exposure to secondhand smoke; 2) communication and education; 3) reducing the availability and supply of cheap tobacco; 4) support for smoking cessation; 5) reducing tobacco promotion and 6) tobacco regulation. As a result of a combination of these strategies in 2007 the U.K. was ranked a being the leader in tobacco control in Europe (Joossens & Raw, 2007).

Despite achieving the target prevalence rate of 21% by 2010, the subsequent tobacco control strategy, A Smokefree Future (Department of Health, 2010), reported that there are segments of the population, especially those from lower socio-economic groups, including routine and manual workers, where the smoking prevalence is higher (Department of Health, 2009; National Institute for Health and Clinical Excellence, 2008) and where additional focused work is required.

Improving the health of these populations was at the centre of most aspects of this thesis. Working in a London borough ranked the 19th most deprived in England (Office of the Deputy Prime Minister, 2004) smoking rates have been reported as higher than the national average as well as the London average (Camden Primary Care Trust, 2007a); it was estimated that between 30-35% of the adult population are smokers (Camden Primary Care Trust, 2007a).

The driver for the research project undertaken was a finding in the Camden Health Equity Audit (HEA) (Camden Primary Care Trust, 2007b) that despite a higher prevalence of smoking amongst men their access of smokefree support services was lower than would have been expected. This, coupled with the findings of the Office for National Statistics (2009) that those from lower socio-economic groups are more likely to be smokers, focused the research on men from predominantly routine and manual or socially disadvantaged groups

who do not want to stop smoking. In addition, with a reported higher smoking prevalence in gay men, another minority group, ranging between 27%-71% higher than the general population (Greenwood et al., 2005; Gruskin, Greenwood, Matevia, Pollock & Bye, 2007; Tang et al., 2004) this group was also investigated as a comparison to the general population. The conclusions provide a number of useful findings on variables to be considered when discussing smoking with to men, when promoting a 'smokefree' life and smoking cessation as well as for the design of interventions to improve the perception of these services and to encourage the uptake of these support services.

It has been estimated that in 2008 approximately 80,000 people died from smoking related diseases, including respiratory diseases such as chronic obstructive pulmonary disease (NHS Information Centre for Health and Social Care, 2009). Of those with smoking related diseases, 50% die prematurely; approximately 20% of deaths in middle age are due to smoking (Doll, Peto, Boreham, & Sutherland, 2004). Although mortality was reduced from 106,000 per annum between 1998 and 2002 (Twigg, Moon, & Walker, 2004) this still results in many others continuing to live with a reduced quality of life due to smoking. In order to provide effective interventions to increase the numbers of people with COPD who stop smoking a systematic review found that psychosocial and pharmacological support for patients diagnosed with COPD are effective. However, it is unclear what the effect of a number of the key variables have on these outcomes, e.g. nicotine addiction levels, motivation levels and disease severity and it remains challenging to achieve successful outcomes with this group.

Reducing the health related aspects of smoking was also attempted with the consultancy case study and one element of the teaching and training case study; the promotion of smokefree environments aimed at protecting children aged under 5 years from the effects of exposure to tobacco smoke. Both of these projects were carried out with a local

authority agency, Sure Start, and involved training family workers in rolling out the Smokefree Homes initiative and enrolling families on to this initiative. Training included increasing their knowledge of the effect of secondhand smoke as well as a functional element aimed at increasing their skills and confidence to approach families about this issue.

Two areas of this thesis also revolve around clinical work; supporting smokers who want to stop smoking and supporting, or supervising, healthcare professionals who offer behaviour change support.

Although hundreds of thousands of smokers try to quit each year, new smokers replace any recent ex-smokers; it is estimated that in 2010 up to 250,000 people will initiate smoking (West, 2009). For this reason the need for behaviour change support, offered in groups and in individual support, is seen as necessary and effective due to the complex constituent aspects that have made smoking such a popular behaviour; it is addictive, becomes automatic and habitual and is pleasurable (Lawrence & Haslam, 2007). This is especially the case for those from lower socioeconomic backgrounds, with co morbidities and from specific ethnic backgrounds, all of which influenced the location of such interventions and was reflected in the composition of clinics.

Coupled with this direct smoking cessation intervention, the role also comprised offering clinical support, supervision and professional development of health trainers following the tenets of health psychology theory including behaviour change models and effective communication techniques. Drawn from the local community and following the recommendations laid out by the Department of Health (2004) these health trainers worked in the boroughs' most deprived wards. As well as offering interventions to facilitate more healthy behaviour, including stopping smoking, increasing physical activity and eating more healthily, their role also incorporated signposting to other local authority services and health services.

This thesis illustrates the observance of the legal, ethical and professional standards stipulated by the British Psychological Society (BPS) Code of Ethics and Conduct (2006) whether undertaking a research project, conducting consultancy on a health related area for a non-NHS organisation, training employees not based in a healthcare environment, teaching health psychology post-graduates and supervising non-psychologically trained healthcare employees or delivering direct clinical interventions. These different situations and competences also provide an opportunity to demonstrate the interconnectedness of the application of theory and practice not only within a smoking cessation area but to other health related areas, raising the awareness of the utility and value of health psychology (Newson & Forshaw, 2009). Within a rapidly changing health service this pragmatism to illustrate the benefits that health psychology can afford in terms of financial value to that public and the impact for society (Prutton, 2010) is accentuated.

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SECTION B

RESEARCH

Men and Smoking: Factors Affecting the Maintenance of Smoking and Smoking Cessation for Gay and Straight Men

ABSTRACT

The objectives of the study were to focus on factors affecting smoking and health and to recognise and explore diversity among different groups of men. The overall aim was to gain a better understanding of men in their decision to continue or to stop smoking and the impact this may have on service provision.

Seventeen semi-structured interviews with men were conducted; ten with straight men and seven with gay men. The qualitative data was analysed using grounded theory.

The theme that emerged from the data was 'Reducing the potential for cognitive dissonance, caused by the action of smoking, by rationalising, normalising and minimising intrinsic and extrinsic factors and negotiating the sense of self'. These intrinsic factors included rationalising maintenance behaviour through understanding the mechanism of smoking, the availability of the product, the life-stage of the smoker, psychosocial factors and sexuality and rationalising future stopping through life changes, perceived likelihood of success and support services. The extrinsic factors included product choice, meaning of smoking on self, interpretation of health advice, health protective behaviour, their relationship with their body and the impact of legislation. These are negotiated by the image of smoking, the image of the product and masculinity.

A definitive difference between the two groups to explain their desire to continue to smoke or to stop smoking was not found. The main factors that emerged and implications for service provision are discussed. The challenge for the men is to transfer an awareness of the potential dangers of smoking to themselves to make them more health conscious in the present and to accept any level of smoking behaviour as problematic.

CHAPTER 1

INTRODUCTION

1.1 Men and Health

1.1.1 Background

A continuing and striking health difference between males and females is the disparity in their life expectancies with males being more likely to die at a younger age than females when compared at all age ranges across the lifespan (Galdas, Cheater, & Marshall, 2005; Office for National Statistics (ONS), 2008). Despite recent improvements in life expectancies in the United Kingdom (U.K.) there is still a stark gender-gap inequality; in the U.K. mortality rates in 1980–82 showed that 26% of newborn males would die before age 65 compared to 16 % for newborn females, by 2006-08 this disparity had reduced by 11% for newborn males to 15% compared to a reduction of 6% for newborn females to 10% (ONS, 2008). As well as a reduction these figures also show that the gap in life expectancy between males and females is narrowing.

Similar variations are also seen between other countries as well as within countries. This can be illustrated in the following international and national data.

Internationally, female life expectancy in the Russian Federation is more than 13 years greater than male life expectancy; in the Netherlands the difference is only a little over four years (Gjonca, Tomassini, Toson, & Smallwood, 2005). Similarly, within countries, differences between different groups of men can be seen. In the U.K., in Scotland the life expectancy at birth for males is 75.0 years compared to 79.9 years at birth for females. This contrasts with England where the comparable figures at birth are 77.7 years for males and 81.9 years for females (ONS, 2008).

However, these figures can also vary within small geographical areas; for example, Wilkins (2009) has reported that in London for each station east from central London on the

underground system, male life expectancy falls by nearly a year where a male born in the affluent borough of Westminster (Central London) can expect to almost reach the age of 79 whereas a male born a few miles away in Canning Town in East London will be expected to live to 73 years. Wilkins (2009) has noted that such variations in mortality rates are also seen within cities and between regions throughout the world.

But is it possible to explain this gendered difference by a perceived biological advantage alone? Gjonca et al. (2005) note that due to such national and international variances in life expectancies, inherent biological differences between men and women can be only partly responsible for such discrepancies in morbidity and mortality rates. As such, being unable to account for these differences purely in terms of an explicit female biological advantage results in having to find an alternative explanation. Keleher (2004) has stated that in determining the effect on health, the term gender refers to the inter-related dimensions of biological and psychological differences as well as social experiences. Keleher (2004) commented that when discussing gender (referring to women) it was important to not only refer to biological and psychological differences but also to recognise "... stereotypes, societal expectations, discriminations, power relationships and social and sexual norms that shape so much of women's experience, and the social, cultural and economic environment that shapes women's opportunities" (2004, pp 277-278).

Within this framework the effect of gender on health can be summarised as a tripartite relationship between biological, psychological and social differences. Keleher (2004) has reported that the biological advantages that women experience when compared to men, for example better infant survival rates as well as longer life expectancies noted earlier, are counteracted by other disadvantages. Such disadvantages are manifested in areas such as social, economic, cultural and political inequalities and are largely socially determined (Krieger, 2000). Other commentators refer to the politicisation of women, from the struggle

to get the vote, to equality in the workplace among other things which have made them band together in an on going struggle to improve their social position (Connell, 2005). This, it has been claimed, has helped to increase their awareness of their needs and the setting up of lobby groups etc to achieve these aims. In relative terms, men, having always historically being the power holders and brokers, have not had such struggles to contend with and has lead to the situation where the status quo of earlier mortality, increased morbidity and general health inequality when compared to women has become the norm; men are expected to be less healthy.

Due to the complexity of these variables Keleher (2004) has cautioned against 'crude universalism' (p278) based on gender alone as there are differences between and among men and women, leading to inter-relationships between social gradient, work, violence, disability and rights. In addition, it has been noted that men's social experiences, including health, have been allied to factors such as sexuality and ethnicity as well as disability and social class (Robertson, 2007).

In this context, a definition to encompass what constitutes a male health issue or health concern could be;

"... one that arises from physiological, psychological, social, cultural or environmental factors that have a specific impact on boys or men and/or necessitates male-specific actions to achieve improvements in health or well-being at either individual or population level" (Wilkins & Baker, 2003).

Research has found that males use health services less often, attend surgeries less frequently and delay seeking help when ill (Holroyd, 1997). On the other hand, with women using health services more often, attending surgeries more frequently and not delaying seeking help when ill result in differences in illness behaviour and health reporting that are usually used to explain higher female morbidity (Verbrugge, 1989). This situation is further

enhanced by the added effect of the female social role where women are portrayed as the custodians of health not just for themselves but also for their partners and families (Miles, 1991) which in turn increase their exposure to health services.

In this context, as well as understanding the biological effect on differences in health outcomes, there is a requirement to also understand the influence of gender-specific earlier learned health behaviours and social circumstances within which these are enacted in order to explain more fully the observed gendered health inequality. Investigating these behavioural and socio-cultural influences will make it possible to understand more clearly the socio-culturally constructed 'male script' (Lee & Owens, 2002) of appropriate behaviour which has traditionally led to biomedical choices and a health care utilisation and engagement with 'high-risk' behaviours that have been disadvantageous to male morbidity and mortality (O'Brien, Hunt, & Hart, 2009).

1.1.2 The male in society

The male role in society has an impact on health;

"Much ill-health among men is a consequence of their lifestyle ... There is a need to help men recognise that stereotypical gender role behaviour ... can pose a risk to health and should be changed." (Fareed, 1994, p26).

Traditionally, such roles include extrinsic influences such as employment choices and/or employment availability as well as intrinsic factors such as taking part in risky behaviours such as smoking, drinking and violence that add to this perspective (Lloyd, 1996). In comparison, females have traditionally not been widely exposed to dangerous working conditions, such as heavy industry, that due to their higher risk to health have been assumed to lead to men dying younger. Women have also tended to engage in fewer behaviors that negatively affect health as well as better profiting from advances in health care provision.

As well as these employment choices, an increase in unemployment and the

subsequent loss of self-esteem and removal of their traditional role as 'breadwinner' has also been shown to put men at a higher risk from all causes of death (Firn, 1995; Lewis, 1998). Studies have shown the effect of unemployment on men's health; Morris, Cook, and Shaper (1994) found that the mortality rate for men who had been continuously employed for at least five years doubled in the five years after redundancy for those aged 40-59 and that adjustment for socioeconomic variables, previous health related behaviours and other health indicators had almost no effect on this increase. This increased risk of mortality after redundancy also tends to be greater in men than in women (Mathers & Schofield, 1998) because men are generally affected more from a prevailing belief that when things go wrong no one will be there to help (Kraemer, 2007).

Men's health has historically tended to be under emphasised in the public's consciousness. An intuitive reason for this could be a perceived lack of 'need' for medical help over the lifespan when compared to females. However, this could be too simplistic a rationale. An additional variable is the possibility that there may also be reluctance by men to follow health-protective behaviour as well as a higher degree of risk-taking behaviour. In the context of this study, reduced take-up of health-protective behaviour could be due to a combination of reduced access to support services that are mediated by socially-constructed barriers.

It was not until the early 1990's that men's health became a policy concern (Department of Health, 1992);

"Gender differences in mortality and morbidity undoubtedly exist: but what are they caused by and what can be done about them? There is increasing evidence that many of the patterns observed stem from differences in health-related behaviour, which may be influenced by the knowledge, attitudes and beliefs of men." (Department of Health, 1993, p105).

This was particularly the case over conditions associated with men such as lung

cancer and heart disease.

Added to this recognition, in more recent years family structures have also changed from the 'nuclear family' to more diverse structures where roles are not as clearly delineated (Cameron & Bernardes, 1998). Despite these structural changes, Cameron and Bernardes (1998) found that across an age range of 20-92 years health is still seen as the female domain and responsibility; men are not seen as being proactive about their health, most know little about health, they tend to keep quiet about their health problems (some not even discussing issues with their partners), and they 'suffer in silence'. In comparison, those men who did discuss health problems with their family and friends were aware that they were going against what is normally accepted as the male role. With the socially constructed view that health and health promotion is 'female', being a man is therefore seen as denying oneself a self-monitoring role; such an approach is therefore connected to the construction of masculinity.

These stereotypes therefore set the context for health promotion and for men's health in particular and affect what may be done to change the status quo and any reinforcement of this construct as the male identity is likely to make further change difficult.

1.1.3 The male and the healthcare system

It is recognised that females have more contact than males with routine health provision eg, in their role as primary care givers and as such are 'gatekeepers' of family health (Camiletti & Marchuk, 1998; Mackereth & Milner, 2009). This role as 'gatekeeper' is facilitated and reinforced from an early stage by the female having maternity leave and consequently more flexibility for attending healthcare appointments. This situation has been found to be more pronounced in families on low incomes (Mackereth & Milner, 2009) where men tend to be absent from any interactions with healthcare professionals, either leaving the home or going into another room. Mackereth and Milner (2009) explain this as being a coping strategy to deal with their discomfort generated through the interaction with

predominantly female healthcare professionals; ideas of masculinity confirm this tendency, especially in working class men, to conform to the traditional male role.

Seen as the traditional female role, and until recently also viewed by some as reducing their power in society when compared to men, this position has possibly improved awareness of health and made them more empowered to discuss health issues, while O'Dowd and Jewell (1998) have referred to the 'absent man' in a variety of clinical settings such as child health clinics, family planning centres and antenatal classes. Added to this is the advance in routine medical programmes such as cervical smears and high profile self-screening programmes such as breast cancer. Consequently, uptake of health-seeking services and an emphasis on self-help 'normalises' health concerns for women in a social setting (Seymour-Smith, Wetherell, & Phoenix, 2002). In addition, these processes establish health protective patterns from an early age, e.g. the recent introduction of cervical cancer vaccinations in early teenage years.

In comparison, where health is not widely discussed by males the question of health-maintaining behaviours becomes more hidden making it harder to a) discuss the main areas of concern and b) acknowledge the psychosocial meanings of such issues for the male.

Seymour-Smith, Wetherell, and Phoenix (2002) have reported on how men are traditionally poor at seeking medical advice. In a literature review of men's health-related help seeking behaviour Galdas et al. (2005) have reported how reluctance to seek medical advice can impact on a range of problems as diverse as depression, substance abuse, physical disabilities and stressful life events; Möller-Leimkuhler (2002) found that although minor emotional symptoms may increase their seeking advice from a general practitioner it was the presence of physical symptoms which were the determining factor for their help-seeking behaviour; in regards to self awareness of their bodily changes men often have an air of

unwarranted optimism such as thinking things will get better on their own or even denial of symptoms and the potential outcome.

1.1.4 The male and the healthcare professional

Such psychosocial effects do not just exist within the male but within a broader sociological context, including the medical consultation. When discussing health, Smith and Robertson (2008) have noted that many health professionals continue to approach men from a traditional biomedical approach, with a focus on issues of their physical health and lifestyle advice to the exclusion of the effect of the wider social context on their health. Such an approach has been found to impact negatively upon men's health practices in everyday life (Williams & Robertson, 2006). This reinforces findings of Watson (2000) where in a study of 'well-men' clinics healthcare professionals concentrated on the physiological body which compared with the man's own concern with their functioning body, referred to as the pragmatic embodiment, in everyday life. In contrast, Smith and Robertson (2008) also comment that where health professionals approach men from a more sociological perspective this can result in a homogenised perspective of masculinity with an exploration of the complex relationship between men, masculinity and health.

Seymour-Smith et al. (2002) investigated the effect of the attitude and style of the healthcare professional (GP's and nurses) on the male patient behaviour in terms of the meanings, conflict and mediation between their masculine identity and their identity as 'the patient'. The main finding was that the male has a number of 'subject positions' (Davies and Harre, 1990) leading to;

"...a series of ideological dilemmas for men and health professionals between the maintenance of hegemonic (dominant masculine culture and values) masculine identities and negotiating adequate health care" (Seymour-Smith et al., 2002, p253)

It was found that any alternate enactments of masculinity away from the hegemonic, or

accepted, role were ignored. There is the potential to be stigmatised with ideas of effeminacy and vanity that can compromise any effort to convince men to 'perform' masculinity differently, even for the sake of their health (Seymour-Smith et al., 2002).

Health professionals may also rely on familiar clichés and anecdotes to form an "interpretative repertoire" (Wetherell, 1998, p387) for the patient. This is similar to an accepted truth or version of the world but which varies depending on the demands of the immediate context. This may become blurred when discourses of care by the health professional meet discourses around masculinity and set up subject positions for the patients making identity fluid and flexible, contextual and affected by the power relations present; "...one speaker can position others by adopting a story line which incorporates a particular interpretation of cultural stereotypes to which they are 'invited' to conform" (Davies & Harre, 1990, p54).

Such repertoires imply that health professionals treat males and females as dichotomous binary categories using available, taken for granted cultural resources. As such, men are not health conscious but irresponsible, evidenced by them having to be brought by their partner, "...kicking and screaming" (Seymour-Smith et al., 2002, p257) to the surgery. Males also either think that their presenting problem is not serious or conversely, if it is serious, they have a problem admitting it and/or presenting at all. Supporting the findings of Marshall and Funch (1986), compared to women men are also portrayed as not talking to friends about health issues. It is suggested that this supports the idea of a gendered body, with males seeing their body as a machine, dealing with the mechanics of inputs, outputs and effects rather than emotions and feelings (White, Young, & McTeer, 1995).

Cameron and Bernardes (1998) found that the positioning of men and women is thus paradoxical; women are health conscious (good) but worry too much (bad); men do not take responsibility for their own health (bad) but are usually the 'properly' ill patients (good).

Dichotomous categories continue, with women presenting with symptoms that a man would consider trivial and therefore ignore, eg. aches, which a man interprets as something you live with and adapt to while not defining themselves as unwell (Cameron & Bernardes, 1998). While these 'bad' categories of masculinity are considered humourous, women's weaknesses are not and indicate that traditional hegemonic masculinity is overvalued in relation to femininity (Phoenix & Frosh, 2001). This results in a traditional masculinity enactment which is rewarded by negative reinforcement; what men do which is negative to themselves, eg attitudes to health, is positively constructed. Such negative reinforcing behaviour, through behaving like a 'typical man', is portrayed as better than behaving like a woman with behaviour which does not reinforce the hegemonic position being problematic and is interpreted as 'deviant' (Seymour-Smith et al., 2002).

Across a range of illnesses it is the GP who is usually the first point of contact for the patient within the healthcare system and this study contributes to the discussion over not only the social acceptability for men to report illness but also how those men negotiate health and illness. From childhood men learn what it is to be a 'male patient'. As such the health environment, both physical and discursive, sets the norm for which role men perform and how they reinforce this identity. It is claimed that this results in a hegemonic form of masculinity (Cameron & Bernardes, 1998) which impacts negatively on illness and men's experiences and behaviours surrounding that illness.

In a study of practitioners Tudiver and Talbot (1999) identified three factors which impact on men's health help-seeking behaviour and corroborate other studies; a) most support offered to the male about health concerns is given by female partners rather than from male friends, b) when seeking help issues of perceived vulnerability, fear and denial are important influences, with men seeking help for specific problems rather than more general concerns and c) barriers which can be related to their view of self within the traditional social

role and impede health-seeking behaviour are characterised by feelings of immunity and immortality, a need to be in control, a perception that seeking help is not acceptable and a belief that men are not interested in illness prevention. Such aspects have been found to delay help seeking and affect outcomes (Galdas et al., 2005).

1.2 Masculinity

A factor mentioned earlier that has an impact on health related behaviour is the concept of masculinity. To understand and explain health-seeking behaviour it is possible to attribute differences between men and women to their socialisation as children that manifest themselves in later adult role expectations and obligations, for example, the 'housewife' role (Hibbard & Pope, 1986). They claim such socialisation allows greater flexibility for women to pay attention to symptoms and take action that is enhanced by their later mother/primary caregiver role. This affords women greater access and familiarity with health care services. In comparison, males tend to be socialised to be strong, stoic and self-reliant. Consequently, these differences have allowed females to become more dependent on others with the result that it is perceived to be more acceptable for them to seek help. As a result it is thought that men cope less well with illness due to a fear of both losing control and increasing uncertainty over their role; an acceptance of illness and displaying passivity associated with illness would be perceived to be aligned more with the traditional female gender role (Bury 1991).

Such aspects of male behaviour may be influenced by an idea of masculinity and the extent to which this perception impacts on decisions to act in a health-compromising way (Courtenay, 1998). For example, one of the only areas of health-protective behaviour where males outnumber females is in the area of physical activity (Dubbert & Martin, 1998). This may be due to sporting activity being identified with masculine-type behaviour. In comparison, a concern at a younger age for longer term health concerns has been constructed by some men as mimicking feminine or homosexual concern with appearance (Petersen,

1998).

One explanation for this male behaviour has been the social construct of maintaining a 'hegemonic' masculinity (Connell & Messerschmidt, 2005). This traditional model for masculinity is defined as a role where men "...must conform to a particular stereotype: to be strong, unemotional, aggressive, competitive and unconcerned with family life" (Lee & Owens, 2002, p9). Communicating this sense of masculinity, or manhood, is most effectively done through actions, hence aggression, not expressing emotion, not seeking healthcare as well as engaging in risky behaviour (Connell, 1992; Courtenay, 2000; Griffiths, 2004; Halikitis & Palamar, 2003).

This construct has been both critiqued for its detrimental consequences on health as well as resulting in a position that is indulged and protected by various sources, resulting in a paradox which makes behaviour change difficult for men to follow. Just as Cameron and Bernardes (1998) reported on healthcare professionals view of males and females as either 'good' or 'bad' healthcare users in the previous section, the social construct of masculinity has also been investigated by Noone and Stephens (2008) from the patient's perspective. They found two different and conflicting subject positions of the male either being a 'virtuous regular health care user' or the 'masculine infrequent user of health care services'. However, in order to maintain a position as virtuous users of health care services and maintain a masculine identity, the men taking part in this study compensated by positioning women as frequent and trivial users of health care services. Noone and Stephens (2008) concluded that these positions highlight the construction and maintenance of a number of masculine identities by men in order to make sense of their reality.

However, just as there have been limited findings which show when this construct of hegemonic masculinity has a positive effect on health protective behaviour (physical activity, Dubbert and Martin, 1998) hegemonic masculinity has been found to have a positive effect

when related to either restoring or preserving an element of self which is closely associated with this masculine type such as when working as a fire fighter or maintaining sexual performance or function (O'Brien, Hunt and Hart, 2005). Similar to Noone and Stephens (2008) illustrating how men try to rationalise their cognitive beliefs regarding preserving a sense of their masculinity O'Brien, Hunt and Hart (2005) also illustrate a strategy to explain and negotiate any deviation from this hegemonic perception. Such negotiation has also been found by Hodgetts and Chamberlain (2002) where health information given through a television documentary to a group of lower socioeconomic status (SES) men was not rejected or accepted passively by them but was negotiated, resisted and interpreted into their own lives. For example, by introducing factors such as their limited resources and social inequalities the responsibility for illness is moved away from the individual to 'contextual constraints' (p281) such as societal expectations and financial restraints.

In terms of masculinity Seymour-Smith et al. (2002) draw attention to the way in which this may be portrayed by referring to the discourse used in newspaper articles. Such media discourse impacts social learning. By deconstructing media representations of men's health appearing in a national broadsheet newspaper, Coyle and Morgan-Sykes (1998) revealed broad narratives around masculinity, health and illness. Examples they cite include a 6-week guide to men's health which constructed men as 'new victims' caused by the cultural expectations of masculinity that veered between 'traditional masculinity' and 'new man'. The overall result is the sense that men's health as 'in crisis'. Similarly, rather than resulting in more choice or emancipation for the male, the dichotomy of cultural expectations of masculinity veering from this 'traditional masculinity' to 'new man' paradoxically led to an increase in anxiety and fear caused by the worry of being construed as potential indicators of effeminacy and vanity. This is similar to the findings noted earlier by Petersen (1998) whereby an early interest in longer term health concerns are interpreted as mimicking a

feminine or homosexual concern with appearance.

This view of a dichotomy in the media was also supported by Lyons and Willott (1999) in the form of a 'Woman's Guide to Men's Health'. This discourse illustrates and links the role of the male being a 'risk taking superhero' while the woman's role is that of protecting men as if they were children, with the dominant discourse reinforcing unequal social relations and the traditional female nurturing role. In comparison to Coyle and Morgan-Sykes (1998) they identified the assumption that men are not capable of taking care of themselves so reinforcing social relationships and putting the onus onto the female to look after them in a traditional maternal role. This constructs women as health conscious and responsible while men are not; men don't talk about emotional issues and men are 'serious' users of the health service, i.e. only going to the doctor when there is something demonstrably wrong with them. Finally, and similar to other studies (Coyle & Morgan-Sykes, 1998; Petersen, 1998) the discourse used left no room for those who did not fit the traditional hegemonic role of 'masculine', implying deviance, while gay men were rendered 'invisible' in the general health services.

Since these papers, a number of international initiatives have been taken to increase men's awareness of their health; for example in 2004 a Department of Health promotional leaflet in partnership with Cancer Research UK entitled 'Testicular Cancer: Spot the Symptoms Early' was launched. However, being positioned within the hegemonic masculine role by the use of football imagery, this could be perceived as excluding some sections of the male population. A similar campaign in 2005 used a female celebrity to raise awareness of testicular cancer (Everyman, 2005). Robertson and Williamson (2005) and Smith (2007) have commented that such an approach can be counter productive in terms of public health by reinforcing health-damaging male stereotypes and adding to inequitable gender relations by legitimising the objectification of women. These examples suggest that there may be a need

for a more focused approach to health promotion aimed at men to ensure accurate targeting of the sub-populations who may not be taking up services.

In the past these populations may have been ignored but this could now be changing with the emergence of multiple masculinities (Connell & Messerschmidt, 2005) and the uptake and use of representations and terms such as 'metrosexual' (Simpson, 2002) and 'new man' (Edwards, 2003) which have allowed for a convergence of traditional male-female gendered roles (despite the paradox mentioned earlier in relation to the conflict between the 'traditional' and 'new' men construct).

Despite the passage of time and social changes which have been witnessed in the UK over the roles of men and women in society, De Visser, Smith, and McDonnell (2009) have recently commented that the concept of hegemonic masculinity does not take into account the changes and variation seen in masculine discourses and the representation of these in various masculinities. As such, they claim that such a position of hegemonic masculinity exists not just as the polar opposite of femininity but also as an opposite when compared to other representations of masculinity. As a consequence, anyone who does not conform to this 'ideal' of masculine is deemed either non-masculine or feminine.

Hodgetts and Chamberlain (2002) have pointed out that there is no one coherent sense of what it means to be a man as men tend to be positioned differently in society according to factors such as sexuality, race and social class. The impact of these factors upon men's health concerns would require taking account of the 'individual in context', and examining the role of social structures, social expectations and social constructions in their pattern of behaviour (Striegel-Moore, 1994). The impact of these factors upon men's health concerns requires moving the issue of health in general away from the individual and towards wider social structures such as access to appropriate health care, support and financial constraints such as the cost of giving up work if ill which on its own may affect a persons

perspective of health preventative behaviour;

"It is clear that the current debate around men's health and perhaps men's place in society is crippled by the lack of attention paid to personal accounts and perceptions of maleness" (Watson, 2000, p4).

As has been noted, a sense of masculinity is formed by social interaction and is influenced by beliefs and behaviour, with terms such as 'strong', 'tough' and 'self-sufficiency' being commonly applied as positive masculine characteristics. Although such stereotypes can alter socio-culturally over the course of the lifespan most ideas of masculinity equate to potency, both physically and socially, for all age groups (Good & Sherrod, 2001) and a lack of conformity to performances of this interwoven sexuality and masculinity may constitute a focus of significant threat.

Another aspect is fear or fearlessness regarding the effect of risky behaviour and possible health problems related to this behaviour. Hodgetts and Chamberlain (2002) propose that concerns over health matters for males is located in the future; health problems are constructed as not happening in earlier life and so they do not see themselves as vulnerable which is compounded by the view of a man being self-reliant and able to fight disease. Another factor is whether the emotional energy to engage in ceasing a potentially health damaging behaviour is justified. There is thus a dichotomy between the expectation of self-reliance and stoicism against acknowledging the need for help. Therefore to understand the uptake of knowledge regarding the risks and the effect of information-giving it is essential to consider other constraints to locate the person and therefore to contextualise their concerns and appreciate the boundaries of their lived experience.

One question which arises but which is difficult to answer is whether this situation is changing with mens' changing role in society, which traditionally has valued men for their economic productivity rather than their ability to sustain positive relationships (Lee &

Owens, 2002).

Robertson (1995) commented that to meet men's health needs services, which at that time were found to be operating within a medical orientation, it was necessary to also consider changing socioeconomic environments as well as a reduction in the strength of what had been predominantly patriarchal structures. As well as innovative health promotion initiatives, this was seen as a prerequisite to reduce what Robertson (1995) described as 'destructive male lifestyles'. In 2005, in a review of the intervening 10 years, Robertson and Williamson suggest that although there had been innovative changes in practice as suggested as well as a more holistic approach to the policy agenda, there has not been a great change in either health related practices or health outcomes for men.

1.3 Gay Men and Health

In the previous section reviewing the general area of men and health, and in particular the role of masculinity, the sexuality of the participants was not specified in the cited research articles. Analysing data on health risk behaviours and their associated health outcomes in relation to sexual orientation is difficult, as most behavioural studies have not distinguished between how individuals define and describe their sexuality and how they feel emotionally compared to how they behave. Thus even when sexual orientation has been asked this may not necessarily distinguish between men who self-identify as either gay or as men who engage in same-sex behaviour but who self-identify as either bisexual or heterosexual, described in some research findings as Men who have Sex with Men (MSM; Greenwood et al., 2005; Sell & Becker, 2001). This is especially the case in younger men when their sexual orientation is developing (Rhodes, McCoy, Wilkin, & Wolfson, 2009); this could result in under-reporting at this age when a different response may be given if the same men were asked to indicate their sexual orientation at a later age (Rhodes & Yee, 2006).

This difference in definition presents one of the problems in estimating the size of the

gay population. In a review of surveys into the size of the lesbian, gay and bisexual population in the UK, Aspinall (2009) found that the figure varied between approximately 1% and 14% of the adult population, dependent on the location of the survey and the question posed, for example whether it was sexual identity, sexuality, or sexual orientation.

This could be one factor to explain the lack of research into the general health of gay men in particular. As a consequence of this systematic omission the author has assumed that the majority of the participants in studies discussed earlier were heterosexual. It could be posited that this assumption is reinforced by the fact that in many of the findings any veering from the norm was reported as homosexual or feminine, and concepts of masculinity and sexuality have appeared to be conflated.

However, such concepts of masculinity do not develop in a vacuum. Within this perspective it will be interesting to observe the effect that the 'outing' of men who otherwise fit the image of a traditional man will have on future men's health campaigns, for example Gareth Thomas, a former captain of the Welsh rugby team (The Guardian, 2009).

Where sexuality has been reported, a literature search regarding gay mens' health found that the majority of studies indicate that gay men are disproportionately affected by a number of health outcomes when compared to the general population. These include communicable diseases including HIV and types of viral hepatitis (Atkins & Nolan, 2005) and non-communicable diseases such as anal carcinoma (Gee, 2006; Klencke & Palefsky, 2003), lung cancer as a result of increased smoking rates (Greenwood et al., 2005, Gruskin & Gordon, 2006, Ryan, Wortley, Easton, Pederson, & Greenwood, 2001, Tang et al., 2004) and AIDS-related malignancies (Palefsky, Holly, Ralston, & Jay, 1998).

This emphasis on the studies of the health effects of HIV/AIDS and gay men, rather than studies concerning gay men and other more general male health issues, would appear to be justified given that the figure for HIV in gay men, or MSM, in 2009 was 40% of the total

of people both diagnosed and undiagnosed with HIV in the U.K. (Health Protection Agency, 2010). This is disproportionate when considered in light of the relative small percentage of the population estimated to be gay and which was noted earlier.

1.4 Smoking in the United Kingdom

1.4.1 Smoking strategy

Attention focussed on smoking in the U. K. with the launch of the Smoking Kills White Paper (Department of Health, 1998). This document recommended a number of strategies to achieve a reduction in the prevalence of smoking from 28% to 21% of the general adult population by 2010. These recommendations followed a World Bank six strand strategy comprising the following; 1) reducing exposure to secondhand smoke; 2) communication and education; 3) reducing the availability and supply of cheap tobacco; 4) support for smoking cessation; 5) reducing tobacco promotion and 6) tobacco regulation. As a result of a combination of these strategies in 2007 the UK was ranked a being the leader in tobacco control in Europe (Joossens & Raw, 2007).

Despite achieving the target prevalence rate of 21% by 2010, the subsequent tobacco control strategy, A Smokefree Future (Department of Health, 2010) reported that there are segments of the population, especially those from lower socio-economic groups, including routine and manual workers, where the prevalence is higher (Department of Health, 2009b; National Institute for Health and Clinical Excellence (NICE), 2008) and where additional focussed work was required to improve cessation rates.

1.4.2 Health effects of smoking

It is acknowledged that the effect of smoking on health is immense. In England, in 2009 81,400 people died from smoking related diseases such as cardiovascular disease (e.g. ischemic heart disease and cerebrovascular disease), respiratory diseases (e.g. pneumonia and chronic respiratory disease) and cancers (e.g. lung and oesophagus) as well as a decline in

general lung function and increases in the risk of ischaemic stroke, subarachnoid haemorrhage, peripheral vascular atherosclerosis and erectile dysfunction (Department of Health, 2011a; US Department of Health and Social Services, 2004). This equates to 18% of all deaths of adults aged 35 and over (NHS Information Centre, 2010). This is a significant drop from 120,000 deaths in 1995 and 106,000 per annum between 1998 and 2002 (Twigg, Moon & Walker, 2004). However many others also continue to live with a reduced quality of life due to smoking.

Of those dying from smoking related diseases, 50% die prematurely; approximately 20% of deaths in middle age are due to smoking (Doll, Peto, Boreham, & Sutherland, 2004). Over 25% of all cancers are attributable to tobacco use with 90% of lung cancer being directly attributable to smoking (Department of Health, 2007). On average, depending upon the age of stopping, a lifelong smoker can gain between 10 years by stopping at age 30 compared to 9 years stopping at 40, 6 years stopping at age 50 and 3 years stopping at age 60 (Doll, Peto, Boreham & Sutherland, 2004).

1.4.3 Financial effects of smoking

Added to the health costs for the individual and the health service, smoking also has a financial cost for employers. Smokers take an average of 8 days additional sick leave in a year compared to a non-smoker (Lundborg, 2007) with a total cost of approximately £2.5 billion due to a combination of sick leave and lost productivity (McGuire, Raikou & Jofre-Bonet, 2009).

1.5 Men and Smoking Prevalence

As has been reported earlier, by 2010 there has been a reduction in the national smoking rate from 28% to 21% (Department of Health 2010). However, across the U.K. there is a disparity in smoking prevalence between the genders; in the General Household Survey (2006) Goddard reported that the prevalence is 23% for males and 21% for females; when

further analysed this gender difference is even greater in London where 24% of smokers are male while 19% are female. Similar figures have been reported by Wardle and Mindell (2008) with 24% of men and 21% of women reporting being smokers in 2007.

Despite these reductions in the smoking prevalence for both males and females, there are however also differences in the type of smoker and their smoking behaviour. For example, Wardle and Mindell (2008) found that males smoke more cigarettes per day (males smoking 14 per day compared to 12.4 per day for females) while for both genders older smokers have a higher daily consumption. In comparison, prevalence across age groups were similar for both males and females, with the exception of the 25-34 year old group where the pattern is reversed with a 9% difference (34% and 25% respectively).

In comparison to these national and regional figures, when broken down further there are also local differences. Smoking rates in the London Borough of Camden have been reported as higher than the national average and the London average (Camden Primary Care Trust, 2007a). With a wide range of deprivation between its wards, this borough is ranked overall as the 19th most deprived borough in England in 2004 (Office of the Deputy Prime Minister, 2004). The consequence of these differences in deprivation is a higher smoking prevalence overall; in this inner London borough it is estimated that between 30-35% of the adult population are smokers (Camden Primary Care Trust, 2007a).

In 2007 the Camden Health Equity Audit (HEA) (Camden Primary Care Trust, 2007b) reported that of those accessing smokefree support services, given the breakdown of smoking by gender and based on national access rates, 54% of attendees to support services would have been expected to be male while 46% would have been female. However, the actual figures showed a disparity with just 48.5% attending being male (5.5% lower than expected) while females were 5.5% higher than expected at 51.5%.

Further analysis of these figures showed that despite a higher prevalence rate of

smoking in the 25-34yr age group, (38% compared to a national rate of 30%), access to services within this age group was also under-represented; within this age group, a larger number of men attended services provided in pharmacies than the Camden average. This highlights the need for not only availability of services to help smokers to stop this behaviour but also the need for appropriate services to be available. For example, this raises the question of why this service provider, the community pharmacy, is more popular for men than other providers, such as the general practice, and whether this could be another manifestation of the historical pattern of under-use of traditional health services by men?

Just as there are differences in prevalence rates both between and within gender there are also differences dependent on ethnicity. For example, 5% of Bangladeshi women smoke compared to 25% of Irish women and over 40% of Bangladeshi men (Robinson & Bugler, 2010).

When considered from a socioeconomic perspective, Koivula and Paunonen (1998) found in a Finnish study that men with a lower level of education and who are out of work smoke more than others. In the same study 85% of non-smokers reported better perceived health than smokers (30%); 25% of the participants regarded smoking as an integral part of their life but also felt that public opinion was hostile towards smoking.

1.6 The changing sociocultural environment and smoking prevalence

Smoking is perceived as a risky behaviour and Lee and Owens (2002) make the observation that such behaviours are allied to social, media and cultural stereotypes. Historically, the media advertising of tobacco has portrayed this in terms of the hegemonic male. Such advertising, and sponsorship, especially of sporting events, has been has been shown to affect adolescent uptake of smoking (Vaidya, Naik, & Vaidya, 1996) and transfers the identity of the brand to the product; sports events transfer excitement and masculinity (Smith, Offen, & Malone, 2005). Although advertising on television in the U.K. was banned

in 1965 and there were gradual wider controls in later years it was not until 2002 with the Tobacco Advertising and Promotion Act that all advertising was banned, including promotion of sporting events such as Formula 1 motor racing. It could be hypothesised that tobacco use uptake and maintenance is now due to internal rather than external factors. However it is possible that the effect of these strategies would still be mediated by the wider socio-cultural context in an increasingly globalised entertainment media world, including the internet, where some countries do not have such strict tobacco control legislation, e.g. Indonesia. Such imagery can give the impression that smoking is more common than it actually is (Cabinet Office Behavioural Insights Team, 2011).

Despite the lack of media advertising, uptake of smoking is not uniform across ages but is seen especially in younger age groups. It may be too early to see the effect that successive restrictions on tobacco advertising in specific countries will have on this given the globalised nature of media and sporting events in countries with varying restrictive levels on these advertising streams. Similarly, due to strong brand images, tobacco companies have expanded away from their core business of tobacco and into other products such as clothing, e.g. Marlboro. Consequently there is a need to understand why men may indulge in a behaviour that can affect their health, including possible stereotypes of forms of 'masculinity' in order to be able to challenge these constructs.

1.7 Masculinity and smoking behaviour

Of interest when studying smoking behaviour are hyper-masculine attitudes that encompass an exaggeration of male stereotypical behaviour, such as an emphasis on strength, aggression, body hair, odour and virility. When examined alongside smoking behaviour, such attitudes were found to be related to the use of maladaptive coping skills, lower overall use of coping skills, increased levels of stress and higher level of smoking, as well as holding more favourable perceptions of smokers (Mackey, 2005). When measured, 'masculinity' scores are

found to be not just limited to men; using the validated Bem Sex Role Inventory (Hunt & Strobele, 1997) measuring 10 items each recognised as being culturally characteristic of males, e.g. assertive, and of females, e.g. affectionate, Emslie, Hunt, & Macintyre (2002) found that high masculinity scores in men and women in non-manual jobs are associated with risky behaviour such as smoking and heavy drinking. This suggests the need to also consider gender role orientation.

This has been found across cultures. In a study in India, Augustine and Mrinal (1996) found that when comparing men and women, smokers of both genders scored significantly higher than non-smokers on extraversion and masculinity sex-roles. They also had significantly more smoking peers and relatives, indicating support for the influence of social conformism across cultures.

Similarly, in Indonesia Ng, Weinehall and Ohman (2007) found that smoking is a culturally internalised habit and for young males is part of the process of becoming a man. With the presence of a cultural resistance against women smoking, this use of tobacco in the construction of masculinity underlines the importance of gender-specific interventions. The impact of this social conformism was also found in Portugal, where student smokers adopted the social stereotype of masculinity and higher daily tobacco consumption was found to be a proxy measure for the strength of social conformism (De Cassia Rondina, Moratelli, & Botelho, 2001).

1.8 Fatherhood and smoking

Added to the personal health issues faced by smokers of both genders, there is an increased risk of early pregnancy loss for non-smoking women whose husbands smoke more than 20 cigarettes per day (Venners et al., 2004). In addition, there is an association with low birth weight, Sudden Infant Death Syndrome and respiratory and middle ear diseases in infants and children of smokers (British Medical Association, 2004; Shiva, Nasiri, Sadeghi,

& Padyab, 2003). However, despite these negative consequences, it is not clear what maintains the smoking behaviour of either an expectant father or a new father although given the preceding findings on the male approach to health one factor could be the effect of perceived susceptibility.

One reason could be the concept of perceived susceptibility to not just the health effects but also the effect smoking has on their self-identity. Research by Botorff, Oliffe, Kalaw, Carey, and Mroz (2006) has found that the strength of the perception of masculinity extends to partners of pregnant women and new fathers. Men's smoking habits followed themes including 'relating smoking to expressing masculinity through smoking', 'ideas of losing the freedom to smoke' and 'resisting a smoke-less life'. A reliance and commitment to dominant ideals of masculinity precluded them from viewing their partner's pregnancy and their partner's cessation attempt as an opportunity for their own cessation (Bottorff et al., 2006).

Although Owen and Penn (1999) found that approximately 50% of partners of pregnant women made any change to their smoking habit since the beginning of pregnancy, Blackburn et al. (2005) and Everett et al. (2005) found that only a small reduction in the prevalence and level of the fathers' cigarette consumption occurred during the pregnancy which Blackburn et al. (2005) explained in part by the level of tobacco addiction and a low level of health knowledge.

1.9 Gay Men and Smoking

1.9.1 Smoking prevalence

The findings in the previous section, in the context of the general male population or when compared to women who smoke, lead to the question of whether there is also any influence of smoking prevalence by individual variables such as sexuality. There are no nationally or locally gathered statistics on sexuality. However, what has been found is that

the propensity to smoke among gay men is much higher than for straight men (Offen, Smith, & Malone, 2008b) and led them to comment that;

"Smoking prevalence in the lesbian and gay community exceeds that in nearly all other demographic groups" (p2).

In the UK Harding, Bensley, and Corrigan (2004) estimate this smoking prevalence at between 40-48%, while in a literature review Ryan et al (2001) found that in 8 studies between 1987 to 2000 rates of smoking in the Lesbian Gay Bisexual Transgender (LGBT) population was as high as 50%. Elsewhere, levels have been similar, between 27%-71% higher than the general population (Greenwood et al., 2005; Gruskin, Greenwood, Matevia, Pollock, & Bye, 2007; Tang et al., 2004). More recently these figures have been corroborated by the American Lung Association (2010) reporting that gay, bisexual and transgender men are between 2 and 2.5 times more likely to be smokers than heterosexual men.

In California, Tang et al. (2004) reported a prevalence of 33.2% in the gay population compared to 21.3% in the straight population while similar figures were found in the same state by Gruskin et al. (2007) with figures of 27.3% for the gay population and 19.7% in the straight population; being gay was associated with a threefold increase in the risk of being a smoker among male college-educated adults. This last finding would appear to negate the effect that having a higher level of education generally results in more health protective behaviour, and consequently a reduced smoking rate, although it is not clear whether these students maintain this behaviour once they have qualified. In a meta-analysis, Marshall et al. (2008) found similar large effect sizes in tobacco use (recent and life-time) in sexual minority groups in affluent countries outside the U.S.

In 2005, the national smoking prevalence rate in England was 24% (Taylor, Lader, Bryant, Keyse, & Joloza, 2006), with the male smoking rate being slightly higher than the female smoking rate (25% and 23% respectively). In the same period, Hickson, Weatherburn,

Reid, Jessup, and Hammond (2005) estimated that in Camden, 40% of gay men smoked, compared to 31% of the general Camden population (Smith et al. 2004).

1.9.2 Psychosocial explanations

Reasons for the higher smoking prevalence rate within the gay population are varied, but one explanation could be that it is used to manage daily stress of due to anxiety and stress caused by being members of a minority group (Meyer, 1995; Sheahan & Garrity, 1992; Skinner, 1994). This behaviour could then become self-perpetuating as the behaviour becomes the norm for this particular population (O'Riordan, 2002). Concurrently, this behaviour is also reinforced by the nicotine addiction which is also increased through repeated use. This situation could be further enhanced by the fact that this group may feel less constrained by rules, norms and values which are often set by a mainstream society from which they may feel excluded (O'Riordan, 2002). Just as socioeconomic disadvantage is recognised in the general population as increasing smoking prevalence (Fiore et al., 2008; Kreuger & Chang, 2008) the same situation is seen in the HIV-positive population; Niaura, Shadel, Morrow, Flanigan, and Abrams (1999) identified a higher prevalence of both HIV and smoking in lower SES groups.

Associations with other factors may also explain higher rates of smoking eg. heavy drinking, frequent gay bar attendance, greater AIDS-related losses, HIV seropositivity, lower health rating than members of a same-age cohort across the sample, lower educational attainment and lower income (Stall, Greenwood, Acree, Paul, & Coates,1999). Aspects such as heavier drinking, depressive symptoms and reduced access to health care have also been reported (McKirnan, Tolou-Shams, Turner, Dyslin, & Hope, 2006) in all ages ranging from 18 years – 64 years, but with a higher level in the younger population group. Bontempo and D'Augelli (2002) found that within the Lesbian Gay Bisexual (LGB) population an earlier initiation of smoking and other high risk behaviours was associated with increased levels of

victimisation experienced by LGB children; young people initiate smoking for a number of reasons including modelling from peer influence, social desirability, risk taking and rebellion against established social norms, low self-esteem and negative mood states (Easton, Jackson, Mowery, Comeau, & Sell, 2008; Ryan et al. 2001). Added to these factors seen in the general population, with the LGBT population at a time of identity formation such as an assumption of masculinity (Ryan et al. 2001), higher levels of depression and suicide (Remafedi, Farrow, & Deisher, 1991; Russell, & Joyner, 2001) issues of an awareness or questioning of sexuality and 'coming out' (Lombardi, Silvestre, Janosky, Fisher, & Rinaldo, 2008) and the implications this may have on support from family and friends, feelings of loneliness and physical and verbal homophobic victimisation can increase substance use, including tobacco (Easton, et al., 2008; Russell, Driscoll, & Truong, 2002; Savin-Williams, 1994). Offen et al. (2008b) relate this sense of 'coming out' as having to give '... greater weight to one's own feelings than to the demands of a heterosexual norm and peer pressure" (p10). In fact, Remafedi (2007) found that up to a third of young LGBT's did not know any other gay youth who did not smoke, so making smoking almost essential to gay identity. As such, this then becomes an habituated coping mechanism which is maintained into adulthood.

1.9.3 Sociocultural explanations

Before various legislative changes to prevent tobacco advertising the role of media may also have had an effect; smoking had often used images associated with 'hegemonic', or hypermasculine, masculinity, eg Marlboro man (Washington, 2002) although it could be argued that this image was also a stereotype look which some gay men perpetuated. While this is one expression of masculinity, Halikitis & Parsons (2003) have noted that gay men who do not meet rigid and stereotypical notions of masculinity described earlier have intensified outcomes in asserting their sense of manhood, asserting their masculinity by risky behaviour such as having multiple partners (Rhodes & Yee, 2006).

However, when an alternate gay marketing niche was identified advertising was further developed and placed in gay publications (Goebel, 1994; Smith & Malone, 2003). This coincided with support for LGBT organisations that had followed a previous boycott in 1990 of Philip Morris (one of the major tobacco industry companies) products, including Marlboro cigarettes and Miller beer. This situation arose after Philip Morris offered support to a political figure in the United States Senate who was a leading opponent of AIDS funding and LGBT rights (Offen, Smith, & Malone, 2003). This funding was particularly offered to sponsor community organisations and events, especially those for AIDS-related causes. Rather than seen as either a health threat or exploitation of this new market, after being ignored or denigrated for so long, this funding was welcomed and seen by many within the gay community as acknowledging that they were becoming not only more visible but also more acceptable to mainstream corporations and, by implication, society.

At this time homophobia, anti-gay assaults, same sex marriage, sexually transmitted diseases and drug addiction eg., methamphetamine, were of more concern for community organisations and smoking was not necessarily seen as a particular 'gay issue' or priority; it was a question of personal choice, although this perception ignores the addictiveness of nicotine which subverts that choice (Offen et al., 2008b). Although this financial support was welcomed by many in the gay community, it was not universal. For example, the health advocates responded by saying that "This is a community already ravaged by addiction: we don't need the Marlboro man to help pull the trigger" (Goebel, 1994, p65).

This was similar to past strategies used by the tobacco companies that Offen, Smith, and Malone (2008a) have commented was the approach taken with other minority communities such as the African American population. However, in comparison to the reaction of the gay community that saw this attention as a form of acceptance, the targeting of African Americans was seen as exploitation (Yerger, Daniel, & Malone, 2005). Explanations

of this refer to most African Americans being raised with family and community and being a visible population for decades whereas most LGBT individuals do not experience this 'community' until later in life and only recently being part of mainstream consciousness. In this example, it is this experience that makes the difference between a feeling of being accepted or exploited (Smith, Thomson, Offen, & Malone, 2008). Smith et al. (2008) also draw attention to the debate over social identities being created in the late 20th century through consumerism; this may in part be explained as the gay community being reported as having a higher disposable income than the average household (Smith & Malone, 2003; Washington, 2002) and which has been referred to in more recent times as the power of the 'pink pound' as well as a higher degree of social inclusion.

This concept of inclusion was highlighted by Yerger and Malone (2002) and other research by Portugal, Cruz, Espinoza, Romero & Baezconde-Garbanati (2004) and Stone and Siegel (2004) as a way for the tobacco industry to "...normalise tobacco use, gain support for industry positions and thwart community tobacco-control efforts," (Offen et al., 2008a, p144). In analysis of gay press media in the US, Offen, et al. (2008b) found that most imagery used of smoking contained positive or neutral messages with advertisements for products other than cigarettes glamourising smoking while many articles not related to smoking were illustrated with tobacco use images. This normalisation was further achieved by using sexually ambiguous imagery of smokers, with text such as "If you always follow the straight and narrow you'll never know what's around the corner" (Goebel, 1994) where, for example, a man and woman walk arm in arm in the foreground; however, the woman is looking over her shoulder at a female just behind them. This underlying message, Goebel (1994) claimed, would only be picked up by LGBT people (Stevens, Carlson, & Hinman, 2004).

A similar approach was taken to men, where in the straight magazine advertisement a

shirtless man was seen watching a woman in floating in a swimming pool in the distance; in the gay magazine version another shirtless man was placed between the man and woman of the initial advertisement so it was not possible to tell whether the focus of the first man was the woman in the distance or the second man (Stevens, Carlson, & Hinman, 2004). This approach allowed the industry to deny that they were specifically targeting the gay population, described as 'coded ads' by Goebel (1994). Such an approach, where the source of the message, however direct or indirect, is believable can influence the persuasiveness of the message (Petty & Cacioppo, 1981). In these examples, the images used were similar to the target audience, making them more effective in their persuasiveness.

The effect of such campaigns was also increased by being aimed at bar culture and areas associated with LGBT youth (Washington, 2002) with free cigarettes being distributed or buying free drinks. This may be illustrated by Project SCUM (Sub Culture Urban Marketing; Stevens, Carlson, & Hinman, 2004), developed by a major tobacco company and aimed at the gay and homeless communities, 'consumer sub-cultures', in San Francisco in the mid 1990's (Washington, 2002).

1.10 Current Service Provision

1.10.1 The need for a support service

Hundreds of thousands of smokers in the U.K. try to quit each year but these are replaced by new smokers; it is estimated that in 2010 up to 250,000 people will initiate smoking (West, 2009). However, despite being detrimental to health changing behaviour such as smoking is complex due to its constituent aspects which have made smoking such a popular behaviour; it is addictive, becomes automatic and habitual and is pleasurable (Lawrence & Haslam, 2007). For those who desire to quit the NHS offers the predominant provider of smoking cessation support in the U.K.

1.10.2 The model of support

A number of health psychology models described earlier have attempted to explain behaviour change. The stop smoking intervention follows the withdrawal-oriented (abstinence) model developed by the Maudsley Hospital Smokers Clinic (Hajek, 1989) and which has been the base for the development of services offered by the NHS and stipulated in the Service and Monitoring Guidance (Department of Health, 2009a). The primary objective of the abstinence model is to support smokers to quit all smoking on a specific day, and not to cut down to quit, by helping them to overcome their addiction to nicotine and the withdrawal discomfort this causes. By 'normalising' the motivational system and maintaining the stability of the addiction, the ideal conclusion is a change in self-identity to that of a non-smoker (West, 2006).

The model followed by NHS services is recommended by the Department of Health to comprise a minimum of 5 sessions: week 1 is preparation to quit, week 2 is the quit date and the following 3 weeks are support sessions following the quit date. Following a biopsychosocial approach this support addresses the biological (addictive) aspect of smoking by the provision of a range of pharmacotherapies such as nicotine replacement therapy, varenicline or bupropion, while also addressing the psychosocial elements of smoking through behavioural support. These behavioural support elements include social-cognitive variables that have been shown in the general population to affect a persons motivation to stop smoking (Hyland et al., 2006; West, McEwen, Bolling, & Owen, 2001). This support consists of advice, discussion and exercises with the aim of helping clients cope with urges to smoke, maximise the motivation to remain abstinent, boosting self-confidence, maximising self-control and optimising the use of pharmacotherapy through compliance and adherence (Department of Health 2009a). The aim is to bolster restraint to achieve a more lasting and pervasive shift in behaviour through replacing identified cues, motives and impulses, established through associative learning, with alternative coping mechanisms.

Best outcomes of behaviour change occur when the behaviour change is planned, initiated and maintained with the potential for relapse recognised and planned for (Sniehotta, Scholz, & Schwarzer, 2005). This is facilitated by action planning, increasing individuals' self-efficacy and action controlling to bridge the 'intention-behaviour gap' (Sniehotta et al., 2005) which is recognised as being a barrier to enacting successful behaviour change. Success rates in the intervention services offered by the NHS range from 32-74% for group support and for individual support range from 22-52% success rate (Department of Health 2009a). As such the NHS smoking cessation programmes have been identified as extremely cost effective interventions (West, McNeill, & Raw, 2000).

It is recognised that this combined approach of behavioural support and pharmacotherapy can increase a smoker's chance of stopping by up to four times than trying alone with no pharmacotherapy (West, McNeill, & Raw, 2000). However, it is difficult to identify which aspects of the overall behavioural intervention, whether it is the form of delivery, its intensity or the duration, lead to success. What is known is that these factors are inextricably linked with features of the psychological interventions resulting in a synergistic effect (Lawrence & Haslam, 2007; Michie & Abraham, 2004).

1.10.3 Focussed service provision

Research by Greenwood et al (2005) in the US concluded that a complex set of socio-demographic, tobacco-related and other factors are associated with cessation, highlighting the need to target tobacco control efforts at MSM who may have different perceived subjective behavioural norms which have been impacted by unique stressors and shared different values than the general population (Schwappach, 2009). This may be evidenced in the successful outcome of a study in London by Harding et al (2004). Following the NHS-approved programme of withdrawal-oriented therapy outlined earlier (Hajek, 1989) this model created an environment where the gay men participating could also address areas such as socialising

and gay social locations, recreational drug use, sexuality and HIV with discussion about how these aspects may have impacted their motivation and ability to stop smoking. Although not a randomised controlled trial, in this community based intervention for closed groups of gay men a higher quit rate was achieved when compared to the national quit rate (76% against 53%). This led Harding et al, (2004) to suggest research to establish the utility, acceptability and preferences for the content of specific sessions over and above that recommended in the U.K.'s usual-care withdrawal-oriented model.

However, Schwappach (2009) has also pointed out that culturally specific cessation services may be perceived as counterintuitive for men who may be striving for normalcy in order to deal with their feelings of stigma associated with their sexuality.

In a review of the effectiveness of the use of preventative health services (including male gender-specific services such as prostate cancer screening and testicular self-examination as well as sex non-specific services such as smoking cessation and skin cancer services) Robertson, Douglas, Ludbrook, Reid and van Teijlingen (2008) concluded that it is not clear whether targeting men produces better outcomes than delivering a general service to all, raising the question of whether it is access to the service itself , the delivery and content of that service which should be altered or indeed something in the population or culture that is being targeted that leads to low uptake of services.

1.11 This Study

1.11.1 Context

To facilitate clarification of the issues surrounding male health, Watson (2000) recommends that a qualitative, constructivist and contextualist approach should be taken, especially when considering the perspective of men who live a more 'gendered' life in respect of the dichotomy between the 'traditional' hegemonic masculinity and the 'new' roles men lead. There has not been a large amount of research making direct comparisons based on

sexuality and this research could also identify differences in sub-groups within these different populations. Furthermore, Chamberlain and Murray (1999) have advocated such an approach where personal and social aspects interact to impact on behaviour. This will allow a greater participatory role for men when interventions are designed based on research findings.

Establishing whether men see themselves as conforming to this traditional model or to a more contemporary conceptualisation of masculinity, or 'new man', may give more insight into whether they see themselves as having a choice in their behaviour; one section of society may value health protective behaviour more positively than other sections or they may feel constrained by the social pressures to which they are exposed. This will also help to identify how important such socio-cultural expectations are to their choices and lifestyles.

Within this context, Galdas et al. (2005) have commented that overcoming men's reluctance to access health services is a primary health related issue for UK men and investigating such behaviour has great potential to improve lives as well as reducing health service costs by the development of more effective interventions. In a review of literature they found that comparisons between men and women alone were inadequate and that more intra-gender specific studies are required. They highlight that such studies have already found that there is a trend for men to delay health-seeking advice once ill. For example among white middle class men, traditional masculine behaviour is given as one reason to explain this delay. It is these findings which require more investigation especially between men from different backgrounds, particularly in relation to the more common reasons cited to explain health inequalities such as socioeconomic status and ethnicity.

1.11.2 Attitudes

In order to develop an understanding of the issues that may affect such 'male' attitudes towards health behaviour we should initially ask what is an attitude and 'where do they come from?'

An attitude is a learned orientation or disposition towards an object or situation which "...is expressed by evaluating a particular entity with some degree of favour or disfavour", (Eagly and Chaiken, 1998, p269).

An 'attitude object' can be anything a person discriminates for or against, whether concrete, abstract, inanimate, an individual or a group, and is commonly referred to as a prejudice, a values or a belief. Evaluation of these prejudices, values or beliefs is based on experience that is informed by three components: cognition, affect and behaviour (Hewstone & Stroebe, 2001) resulting in a three-component model of attitude.

Applying these factors to this particular research, the 'attitude objects' may be identified as smoking behaviour and the health effects of this behaviour; the cognitive component consists of beliefs about both of these objects; the affective component encompasses emotions and feelings elicited by these objects; and finally the behavioural component comprising intentions and action towards this behaviour.

Bandura (1986) has explained attitude formation through social learning by observing others where attitudes are formed by instrumental conditioning. The mechanism involves a person being actively rewarded or discouraged for holding certain attitudes or through social comparison where a person adopts the attitudes of a group through conformity, irrespective of whether these attitudes are seen by the individual as positive or negative. This results in a social world which is made sense of through language and culture leading to taken for granted assumptions as well as values and ways of life that give meaning, sense and identity to individuals and social groups, (Stokes & Reading, 1999). These factors, derived from social learning, observation and experience, when combined with knowledge may result in a specific personal behaviour or process which may or may not lead to the best outcome available for an individual.

When discussing the meaning of an attitude object to a person it is difficult to untangle the effect of all of these factors on an individuals view. This difficulty of using these variables to predict and change behaviour can be illustrated conceptually by the attempts to formulate a number of models such as the Protection Motivation Theory (PMT; Rogers, 1983), the Transtheoretical Model of Change (TTM; Prochaska & DiClemente, 1983), the Health Belief Model (HBM; Becker & Rosenstock, 1987), the Theory of Planned Behaviour TPB; Ajzen, 1991) and the Health Action Process Approach (HAPA; Schwarzer, 1992).

Sutton (1998) has noted that such models can explain just 19-38% of variance in behaviour, whatever the seriousness of the outcome of the behaviour identified, although more recently Burkhalter, Warren, Shuk, Primavera, & Ostroff (2009) have found that attitudes, subjective norms and perceived behavioural control account for a range in variance in tobacco use intentions of 26%-54%, depending on the study population.

Other aspects that have to be considered include the salience of the attitude to the individuals' circumstances, an experience of attitude relevant situations, eg. previous attempts to stop smoking, the strength of the attitude formation and the determination and willingness of the individual to perform a given behaviour (Ogden, 2004). Thus, an attitude can be changeable rather than constant. The meaning of this attitude can be further complicated by individual differences including gender, sexual and ethnic identity as well as the wider socioeconomic and cultural context. Overall, it must be recognised that individuals are not blank slates ready to absorb uncritically but that they use a form of selective perception (Kitzinger, 2002) all of which impact intentional and actual behaviour.

1.11.3 Aims of this study

Given the findings of Doll, et al. (2004) which highlighted the benefit in life years gained if a person stops smoking by the age of 40, there are a number of areas under

investigation in this study; past and current behaviour, beliefs and attitudes of men towards smoking, psychosocial effects on their health-seeking behavioural intentions and their knowledge and perception of services available to support potential smoking cessation attempts.

Following the recommendations of Lee and Owens (2002), the aim of this study is threefold; 1) to focus on factors affecting smoking and health, 2) to investigate the constraints of material, social and cultural contexts on smoking and health, and 3) to recognise and explore diversity among different groups of men, as well as individuals, regarding smoking and health.

This research is based within the construct of Ajzen's theory of planned behaviour (1991; 2008). The theory of planned behaviour (TPB) holds that human action is guided by three kinds of considerations:

- Beliefs about the likely outcomes of the behaviour and the evaluations of these outcomes (behavioural beliefs)
- Beliefs about the normative expectations of others and motivation to comply with these expectations (normative beliefs)
- Beliefs about the presence of factors that may facilitate or impede performance of the behaviour and the perceived power of these factors (control beliefs).

Taking these individually, behavioural beliefs produce a favourable or unfavourable attitude toward the behaviour; normative beliefs result in perceived social pressure or subjective norm; and control beliefs give rise to perceived behavioural control.

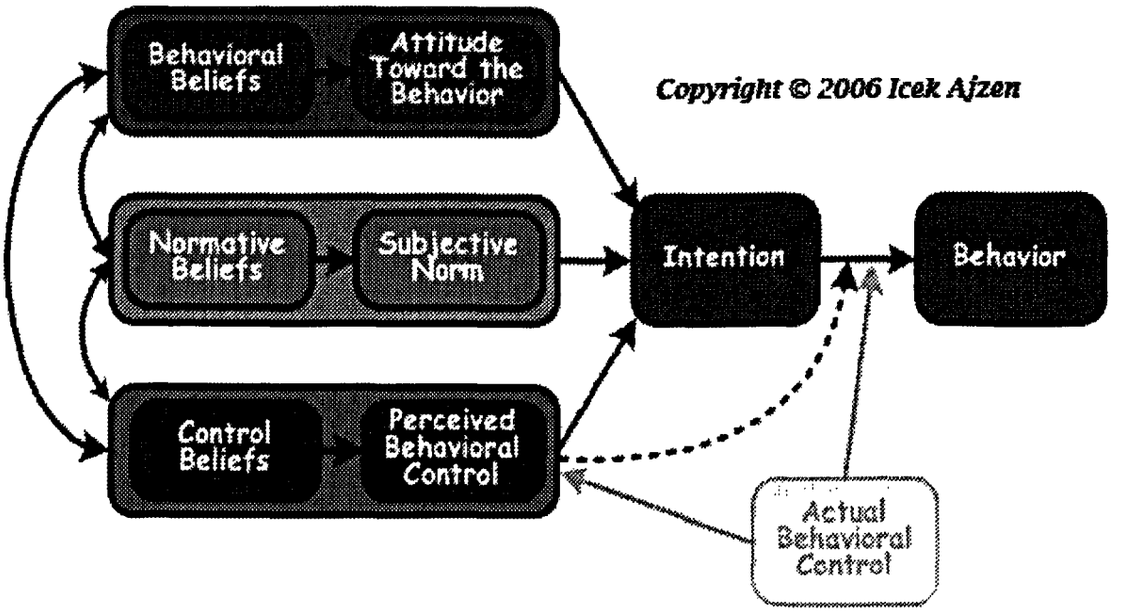
In combination, attitude toward the behaviour, subjective norm, and perception of behavioural control lead to the formation of a behavioural intention. As a general rule, the more favorable the attitude and subjective norm, and the greater the perceived control, the

stronger should be the person's intention to perform the behaviour in question. Finally, given a sufficient degree of actual control over the behaviour, people are expected to carry out their intentions when the opportunity arises.

Intention is thus assumed to be the immediate antecedent of behaviour. However, because much behaviour pose difficulties of execution that may limit volitional control, perceived behavioural control is thought to have an additional direct effect on behaviour.

These can be seen in the following diagram.

Diagram 1.11.3 The Theory of Planned Behaviour model (Ajzen, 2008).



This study will therefore consider those areas of the TPB that affect the decision to make a behaviour change and attempt to identify new areas. To do this, two sections of the male smoking population will be investigated, with sexuality as the comparative variable. Having a comparison study it is hoped to identify factors which may need to be considered when targeting and supporting these two sections of the population. This will help to inform appropriate service design to ensure provision of support is service user led instead of being service provider led.

It is hoped that this approach will highlight those factors that are important to gay and straight men when deciding whether or not to stop smoking and the meaning this holds for them. The implications for service provision will then be discussed. It is hoped to discover more accurately what the barriers are to health discussions as such barriers prevent communication in both dyadic and social relationships. This will have a dual effect: 1) These concepts will add knowledge to factors affecting the level of explained variance in health psychology models used to predict behaviour, and 2) Converting this from the theoretical to a practical application, with smoking rates higher in certain sections of the male population, e.g. gay males, our understanding will be increased of men's perception of particular health issues, health promotion education and advertising programmes and interventions.

These programmes and interventions can then, if necessary, be tailored to meet the specific demands of these populations in terms of their behaviour initiation and maintenance as well as matching their demands for behaviour change support and interventions more closely with the aim to further reduce the morbidity and mortality caused by smoking.

CHAPTER 2

METHODOLOGY

2.1 Research Design

2.1.1 Rationale This research follows a qualitative methodology. A qualitative approach to research allows a depth, openness and detail in the analysis and is concerned with the quality and texture of the experience (Willig, 2001). This will identify psychological processes predicating behaviours that impact on health and illness (Payne, 2004). In comparison to a quantitative design that aggregates data, the qualitative approach allows the investigation of any areas of relevance for the participant and may possibly unearth previously unthought-of issues for the researcher. Such research does not presuppose assumptions of the perceptions of the participants. As such, rather than a predefined variable, we are interested in the meanings attributed to the events by the participant in order to construct their reality.

Qualitative data is generally based on a constructivist epistemology, derived from the quality of subjective experiences and opinions, illustrating how an individual creates, modifies and interprets the world -

"The emphasis... tends to be placed upon the explanation and understanding of what is unique and particular to the individual rather than of what is general and universal", (Burrel and Morgan, 1979, p7).

Data are normally collected from a smaller number of people and are presented mainly in written format giving direct quotes as opposed to reliance on statistical information. This enables the gathering of more detailed individual information, as well as possibly unearthing more sensitive, personal material which may not be discovered easily in any other way, but by their nature these techniques are more time consuming and could be perceived as resulting in less generalisable results when compared to quantitative data.

With this in mind it could be argued that, as we are interested in the internal dynamics

of an individual account, generalisability is not an issue per se. However, as Willig, (2001) has noted, if it is assumed that experiences are partially socially constructed, each individual reality is a representation of the social world and is consequently potentially generalisable. It should be noted however that this approach could be open to a degree of subjective interpretation by the researcher who is governed by their own personal experiences, values and philosophical views which must be taken into account when interpreting findings and which requires a degree of reflexivity.

2.1.2 Ethical Issues

As a non-clinical population was being recruited it was not necessary to obtain ethical approval by the Central Office for Research Ethics Committees (COREC) (National Research Ethics Service (NRES)) or the PCT Research and Development department. However, ethical approval was obtained from City University.

A participant information sheet describing the study was given to the participant and informed consent requested prior to taking part in the study. However, the participant had the opportunity to withdraw at any stage should they wish.

As much attention has focused on smoking in recent years, the researcher was aware that it was necessary to take a non-judgemental approach in order that the participants did not feel pressurised into stopping. The discussion may have resulted in participants thinking about stopping but this was not the goal of this research. As such no major ethical problems were envisaged. Although this study was not being undertaken within a clinical population the researcher was also aware that the participants may have experienced the health effects of smoking either directly or indirectly. Due to this if, after debriefing, additional support was required contacts for additional support were available for the participants.

2.2 Sampling and Participants

Based on the findings outlined in the previous sections of the local prevalence rates

and access to services, especially amongst routine and manual workers (Camden Primary Care Trust, 2007b) and of the optimal life-years gained by stopping smoking before the age of 40 years (Doll et al., 2004) participants aged between 18 and 40 years were recruited using a number of methods including street marketing, posters in local businesses and snowballing.

Street marketing techniques were used to generate leads for smokers within the local population who expressed a wish to access support to stop smoking. If during this conversation men indicated they were not interested in stopping smoking they were then offered the opportunity of taking part in this research.

Posters were displayed in a number of locations that included large local employers of routine and manual workers such as the Royal Mail as well as gay venues such as a local pub and a bookshop specialising in gay authors and literature aimed at this population.

Finally leads given by colleagues of the researcher of people who may be interested in taking part were also followed up.

With the exception of those participants who were recruited by the researcher from face to face meetings at health promotion events, all contacts were followed up by the researcher by telephone. The potential participant was given an outline of the research question and the process involved. Once they had indicated a continued interest in taking part a suitable quiet location for the interview to take place was then identified. Normally this was the office of the researcher; however, on occasion, the researcher sensed reticence on the part of the participant to do this and so a more convenient location (either their workplace or home) was agreed upon. This helped to ensure optimal participation in the research process as a number of barriers to recruitment were encountered, including an inability to contact potential participants, disinterest in taking part or non-arrival for the semi-structured interviews once arranged. The demographics of the participants in each group can be seen in the following tables.

Table 2.2.1 Straight Participants Demographic Data

Identifier	Age	Ethnicity	Employment Status	Housing Tenure	Qualifications	Number smoked per day	Interview Location
SP1	25	White British	Unemployed (Gardener)	Renting	NVQ	20-30	Office
SP2	21	White Irish	Routine Manual (Tattooist)	Other (squat)	None	5-10	Office
SP3	22	Mixed White/Black African	Routine Manual (Bar Work)	Other (with parents)	Degree	6	Office
SP4	21	White British	Routine Manual (Market stall)	Other (with parents)	GCSE's	5-10	Office
SP5	40	White British	Routine Manual (Postal worker)	Owner	A levels	6	Workplace
SP6	24	White British	Unemployed (Designer)	Renting	Degree	5-8	Participant s home
SP7	22	Asian/Asian Brit - Indian	Student	Renting	A levels	6-10	Office
SP8	38	White British	Actor	Owner	Degree	40-50	Workplace
SP9	38	White British	Unemployed (Post Graduate Student)	Owner	Degree	10	Office
SP10	36	White Other	Routine Manual (Market Stall)	Other (Squat)	Degree	20	Office

The straight group comprised 10 participants. All were recruited from street marketing and from workplaces. The average age was 29 years (range 21-40). Of these 6 identified as White British, 1 as White Irish, 1 as White Other, 1 as Asian/Asian British (Indian) and 1 as Mixed

White/Black (African). The majority (7) were educated to 'A' level standard or higher; 4 of these were included in the 7 participants who also identified as holding a routine manual job or being unemployed. Another proxy of socioeconomic status, housing tenure, identified 3 participants as being owner occupiers, 3 as renting and the remainder as 'other' including 2 in squats and 2 living with parents.

7 of these participants were interviewed at the researchers office, with 2 being completed in the participant's workplace and 1 at the participants home.

Table 2.2.2 Gay Participant Demographic Data

Identifier	Age	Ethnicity	Employment Status	Housing Tenure	Qualifications	Number smoked per day	Interview Location
GP1	20	White British	Student	Renting	A levels	5-10	Office
GP2	27	Asian/Asian Brit – Indian	Routine Manual (Gigs)	Renting	Degree	10-15	Office
GP3	35	White British	Routine Manual (Building porter)	Renting	GCSE's	20-40	Participants home
GP4	32	White Other	Intermediate (support worker)	Renting	NVQ	40	Office
GP5	27	Black/BlackBrit – Caribbean	Student (voluntary work)	Renting	HND	5-10	Office
GP6	27	White British	Routine Manual (Chef)	Owner	A levels	20-30	Office
GP7	24	White Other	Routine Manual (Kitchen Porter)	Renting	GCSE's	5	Office

The gay group comprised 7 participants. Similar to the straight participants, all were recruited from street marketing or snowballing. None were recruited from the gay-specific locations listed earlier. The average age was 27 years (range 20-35). Of these 3 identified as White British, 2 as White Other, 1 as Asian/Asian British (Indian) and 1 as Black/Black British (Caribbean). The majority (4; 57.1%) were educated to 'A' level standard or higher; 2

of these were included in the 4 participants who also identified as holding a routine manual job. Another proxy of socioeconomic status, housing tenure, identified 1 participant as being owner occupiers with the remainder renting accommodation. Six of these participants were interviewed at the researchers office with one being completed at the participants' home.

Procedure

Demographic and socio-economic status using a short questionnaire was gathered prior to the interview, and included variables such as age, sexuality, ethnicity, employment status and housing tenure. Written consent was also obtained from all participants.

One set of interviews comprised men who identified as straight; the second set of interviews comprised men who identified as gay. It should be noted that the question of sexuality related to whether the participant identified as straight or gay; no one taking part identified as either bisexual or as MSM which has been the identifier in a few of the studies mentioned earlier in the introduction and which, as discussed earlier, does not necessarily relate to social identifiers such as being gay. No health-related questions, such as HIV status, were asked as it was felt that these would emerge during the interview if they were felt by the participant to be of importance to their behaviour. Free expression was encouraged and after a verbal description of the study, a number of open-ended questions were constructed to give minimal direction to the discussion and included questions on knowledge of smoking, past and current behaviour, ideas of masculinity and sexuality, attitudes to smoking and social influence (social norm, social support and modelling). Views of current services were also investigated as well as what they would envisage to be an appropriate support service. Sample questions include "What are your main reasons for continuing to smoke?" and "How do you feel about stopping smoking?"

These questions were intended to act as a facilitator to discussion rather than a rigid direction. For example, if the participant spoke about an area which was due to be discussed at a later point the researcher encouraged the participant to expand on the point at this time to make the discussion flow more naturally for the participant. However, the degree of probing depended on the participant and the areas that needed further elaborating during the interview.

All interviews were undertaken by the researcher and were audio-recorded. The interviews ranged from 40 minutes to 55 minutes. After debriefing, all participants received a £20 retail voucher as an incentive to take part.

2.3 Data Analysis

The researcher transcribed the interviews using a software package, MacSpeech Dictate. Identifiers were ascribed to the straight participants (SP1, SP2, etc.) and to the gay participants (GP1, GP2, etc.). This ensured the confidentiality and anonymity of the participants.

This research involved investigating consequences of actions, social interactions and the effect of these on social processes, therefore grounded theory was identified as a suitable methodology (Willig, 2001). According to Willig (2001) the aim of this methodology is to produce a systematic representation of the participants experience and understanding of the subject under investigation.

This approach results in a dual approach. On the one hand, by focussing on the social processes, it can be said that an objectivist approach is followed in that the researcher tries to identify and map these social processes and relationships and their consequences for the participants. On the other hand, by focussing on the participants experiences a more subjectivist approach is also taken as more concern is paid by the researcher on "... the

texture and quality of the participant's perspective rather than its social context, causes or consequences" (Willig, 2001, p44).

By combining these two approaches it is hoped to not only capture the lived experience of the participant but also to explicate the quality of this experience in terms of the wider social processes and the consequences of these processes.

Grounded theory procedures are bottom-up and inductive in nature relying on the process of identifying categories, making links between these categories and establishing relationships between them before a core theme or theory is arrived at. Although this reality is located, (grounded) in the data and identified by the use of a degree of creativity, the researcher also requires an awareness of the effect their input may have on this process resulting in the application of reflexivity.

Grounded theory requires data to be collected until all concepts and categories are saturated (Corbin & Strauss, 1990; Glaser & Strauss, 1967) and no new categories arise.

The analysis of the data was conducted by the researcher rather than being predefined by a coding paradigm as with content analysis and so a social constructionist approach was followed (Charmaz, 2006) as the researcher interacts with the data. This social constructionist approach overcomes the debate over whether categories and theories can 'emerge' from data (which plays down the creative role of the researcher) or be 'discovered' in data (that something is uncovered by the researcher that is already there) (Willig, 2001).

Constant comparative analysis between the properties of emerging categories allowed both uniform and diverse dimensions of the codes to be observed as well as sub-categories present in the data. This allowed the development of a theoretical account of the general features of the topic.

This was achieved by:

1) open coding to establish the categories

2) axial coding to interconnect them

3) selective coding to establish the core categories (Strauss and Corbin, 1990).

Phase 1: Open coding. The transcribed material was read closely initially to become familiar with the data, without preconceived codes. During the second reading, the data were examined sentence-by-sentence and initial thoughts, associations and responses noted in the margin. Upon third reading low-level descriptive titles, themes and categories emerging from the data were recorded line by line (Willig, 2001).

Phase 2: Axial coding. The categories which emerged from the transcript in the open coding were then listed and scanned for relationships or shared meanings between the categories and verified against the original transcript to ensure the categories were congruent with the participants meaning. This facilitated higher-level analysis and more abstract sub-categories to emerge from the data.

Phase 3: Selective coding. This stage involved identifying and delimiting that core category or meaning which made sense of the whole data and integrated the main categories, becoming an over-arching category, contributing to a parsimonious theory (Glaser & Strauss, 1967).

Other techniques used to add depth to the data analysis included negative case analysis or instances in the data that do not 'fit' the emergent category. This was also enhanced by the researcher using theoretical sensitivity and theoretical sampling in order to progress from the descriptive level to a higher analytical level within the confines of the original data set (Willig, 2001).

Throughout the analysis the transcript was repeatedly read and re-read to keep as close to the data as possible. After each interview for data collection, memos were recorded of emerging categories to allow for progressive integration of lower and higher level categories (Willig, 2001).

2.4 Reflexivity

Reflexivity on the part of the researcher promotes validity of this subjective unquantifiable approach and reduces the limitations on the meaning that they may impose on the analysis. Data cannot speak for itself, therefore it could be argued that what emerges is by necessity guided by the researcher. Without reflexivity the findings could be open to claims of bias imposed by what the researcher brings unconsciously to the analysis. Dey (1999) has questioned whether categorisations constructed by the researcher in grounded theory can ever capture the essence of a concept entirely. Thus, making the location of the researcher explicit in relation to the participants in the construction of the findings is important.

In this respect, I was aware of my position and the effect this may have on the findings from a number of perspectives.

Working for a Stop Smoking service I was aware of potential mixed messages I could be giving when trying to recruit participants whether face to face at events or in follow-up telephone conversations with leads provided from any of the additional recruiting methods described earlier. When talking face to face at events I was careful to only discuss the research once I had had a thorough conversation with the potential participant about smoking and the services available to help them to stop; if they were 'sitting on the fence' and wanted time to think about referring themselves I did not mention the research. For those who were certain that they did not want to stop smoking, once participation in the research project had been broached with the potential participant I was very clear in verbally reinforcing that there would be no pressure placed on them to stop smoking. This was reinforced further in written resources such as the poster and participant information leaflet.

In addition, not being a smoker and as a gay male who does not perceive himself to conform to socially constructed expectations of hegemonic masculinity I was aware of imprinting my own beliefs onto the findings.

To this end a grounded theory epistemology was considered to be the most appropriate methodology to follow and the least likely qualitative method of analysis to be influenced by the researchers' viewpoint. I saw my position as a relative pragmatist rather than approaching the process with a realist ontology. This was intended to reflect the situation in which the participants are situated in order to contextualise the data. I did not have preconceived ideas, or presuppositions, of cause and effect, but rather expected a diversity of interpretations through psychological phenomena which were not reliant purely on one factor, for example socioeconomic status, but relative to a number of factors.

This was in comparison to the extended interpretation such as possible with Interpretative Phenomenological Analysis (IPA), or Discourse Analysis (DA), which may be claimed raise questions by inferring meaning and not taking the data at face value. The implication with these methods could be that the researcher presumes to know more about the individuals' experience or reality than the participant themselves. It is also necessary to note that the findings from this data are by necessity open to re-interpretation and should not be seen as definitive; the construction of the categories reflects one researcher's own interpretation and labelling, which is also a function of the method of questioning and analysis used, and is not the only 'truth' (WIllig, 2001).

CHAPTER 3

RESULTS

This chapter presents the findings and the overarching theme established from the grounded theory analysis of the data. The theme, or theory, that emerges centres around the complex process which men employ in order to explain and normalise their decision for not only starting to smoke but also to continue with this behaviour. This theme can be encompassed as ***"Reducing the potential for cognitive dissonance, caused by the action of smoking, by rationalising, normalising and minimising intrinsic and extrinsic factors".***

This process is illustrated throughout this study as being dynamic, fluid and, on occasion, moving from rational decision making to a position that may appear to be incongruent to this rational position but which temporally offers the 'best fit' for the participant. Applying these strategies has the result of minimising cognitive dissonance and psychological discomfort that may otherwise arise from their behaviour (Festinger & Carlsmith, 1959).

In the following analysis, the data from each group has been analysed concurrently. Many of the findings between each group of participants, i.e. between straight and gay men, were found to be similar. However, differences have been highlighted where they occurred.

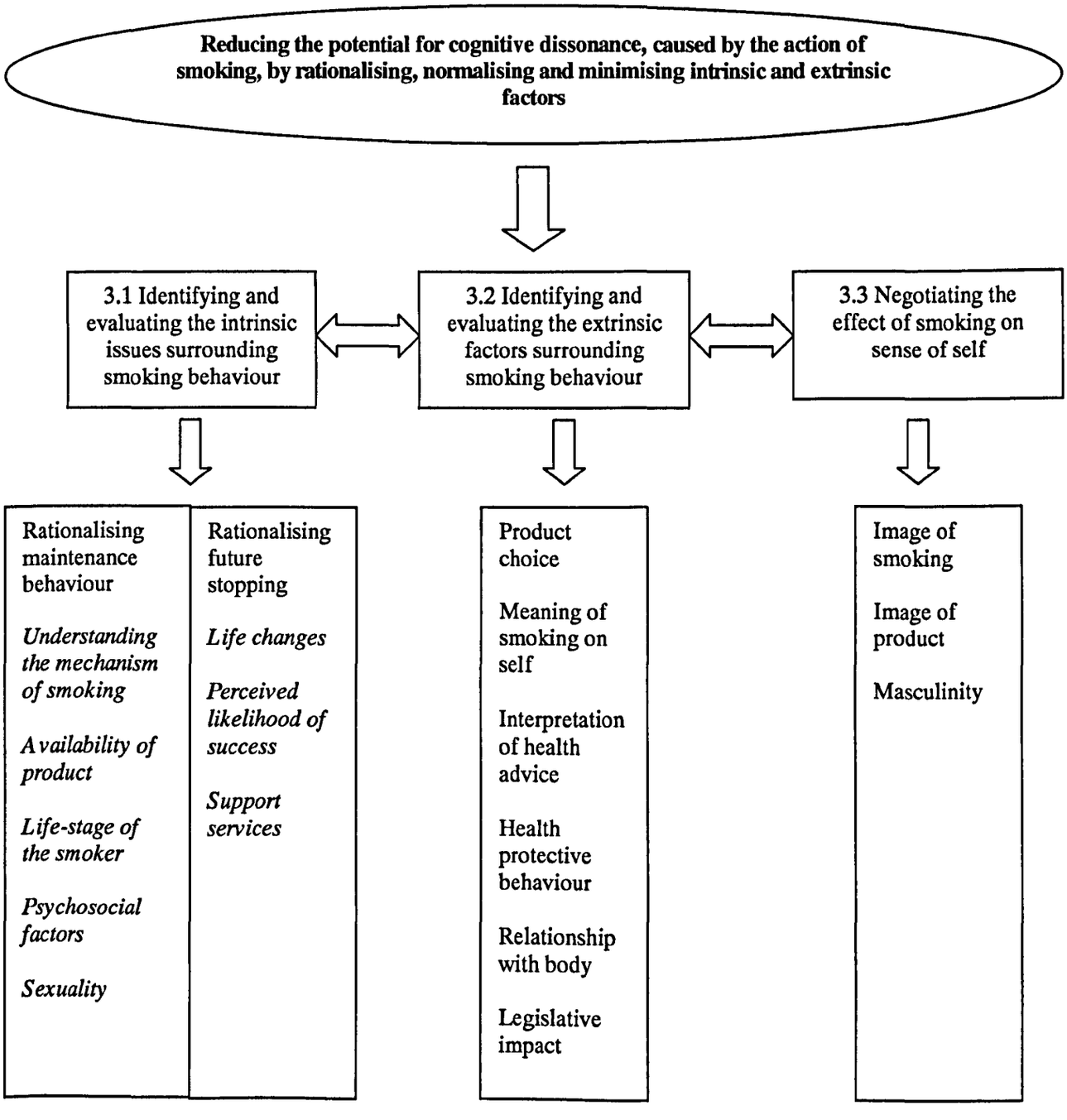
A core category represents a pivotal point of the theory to which the other categories relate and three emerged from the analysis of the data and have been conceptualised as:

- Identifying and evaluating the intrinsic factors surrounding smoking behaviour
- Identifying and evaluating the extrinsic factors surrounding smoking behaviour
- Negotiating the effect of smoking on sense of self

These core categories are described consecutively; each is illustrated by pictorial representations and are unpacked into sub-categories and in some, but not all, cases, are dimensionalised. Each pictorial representation is then followed by a summary of the key

points emerging from the transcripts. Quotes and excerpts have been added from the transcripts where they will aid exposition of the essence of what is being conveyed. The quotes and excerpts have been prefaced by 'SP' to denote a straight participant and 'GP' to denote a gay participant, followed by their identification number, eg. 'SP1' indicates straight participant 1. The line number is also included to identify the location of the quote within the transcript.

Diagram 3.1 Overview of theory, core categories and categories.

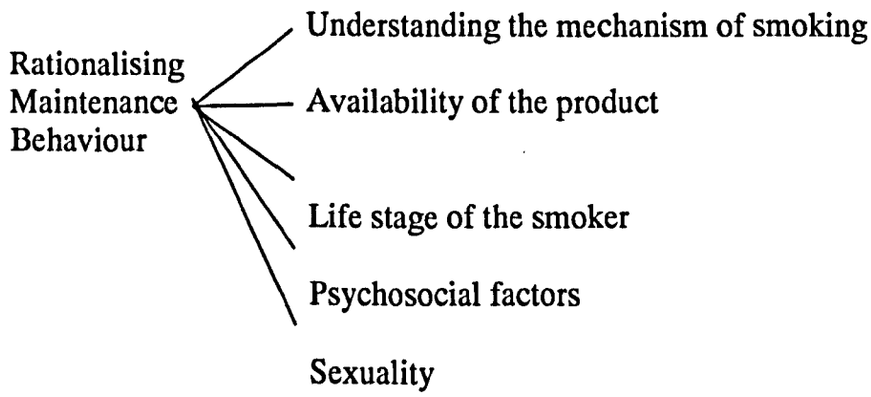


3.1 Identifying and evaluating the intrinsic factors surrounding smoking behaviour

3.1.1 Rationalising maintenance behaviour

Once the behaviour has been initiated, either as an early onset smoker (below 16 years of age) or as a delayed onset smoker (over 16 years of age), there are a number of factors that have been identified by the participants that are perceived to support the early maintenance of their smoking. Such perceptions can be summarised as rationalising their behaviour and can be seen in the following diagram:

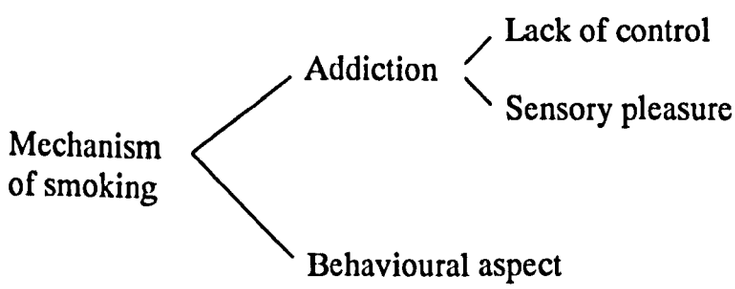
Diagram 3.1.1 Rationalising maintenance behaviour and its sub-categories



1. Understanding the mechanism of smoking

There was a recognition by the majority of the participants that as well as being their personal choice to engage in smoking that their behaviour is also governed by a dual process of nicotine-induced addiction and the behaviour that, for most, becomes an automatic habit. This can be seen in the following diagram.

Diagram 3.1.1.1 Mechanism of smoking and its sub-categories



The following quote helps to underline the belief that there is not only a behavioural aspect to smoking but also an addictive aspect.

SP3 L148 *"I became familiar with the act of smoking and with the nicotine"*

The temporary sensory effect of the nicotine is seen as affecting mood and also an indication that the addiction is becoming worse that illustrates an understanding of how nicotine affects the body. There is also a sense of losing control over the habit:

GP5 L174 *"Before I had the ability not to need a cigarette... when I go without now I have bigger mood swings"*

GP7 L251 *"... the way it feels, like the sensation that the nicotine has... It's like 'God, that's what I needed"*

GP7 L390 *"I guess it has something to do with nicotine or whatever in your brain... you know when you're done your body will feel happier, not in a depressed way but less stressed"*

This addictive quality also results in each cigarette having a different meaning or an individuality; although the cigarette offers a similar physical 'rush' each rush is experienced differently:

GP1 L436-438 *"... they are all very different, no one is the same... the rush makes your head spin and it's an interesting high... "*

Individual differences are recognised and compared:

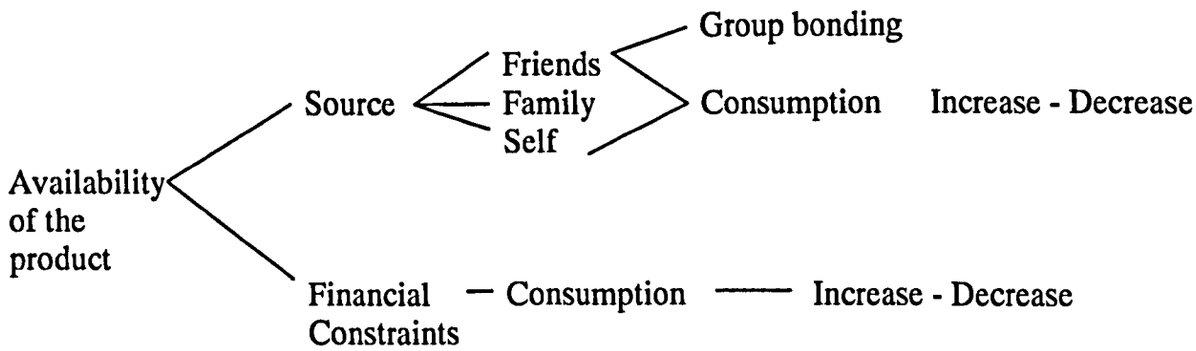
GP3 L259-263 *"Dating and relationships I find very stressful... whereas some people it doesn't seem to affect them too much... It takes me a while to deal with it, get over it and move on... I definitely smoke over that period"*

This helps to identify personality differences and the way different people cope.

2. Availability of the product

Once initiated, in order to maintain the smoking behaviour accessibility to tobacco is obviously an important issue. Routes to obtaining tobacco are illustrated in the following diagram.

Diagram 3.1.1.2 Availability of the product and its sub-categories



a. Source. For some, whether straight or gay, sourcing tobacco tends to be more opportunistic when initially maintaining their habit:

SP2 L33-34	*"I don't really buy cigarettes that often, I tend to blag them off people"*
GP1 L17	*"... I'd just nab a cigarette off a friend or something... "*

This behaviour was learned early in their smoking career and continued into adulthood; the implication is that not only is the smoking habit itself set for some from an early age but the form of access to tobacco is as well. In addition this opportunity to 'blag' them from a social circle is increased where the majority smoke which also encourages the maintenance of the habit.

While encouraging maintenance for some this is also a means for others to keep their consumption to a minimum that enables them to identify themselves as not being a hardened smoker:

SP3 L178-181 "and for at least a year I was regularly taking cigarettes off friends without really buying them which is quite a familiar thing, taking them off people. So I'm not a proper smoker. And the reversal is when you claim you're quitting and it just continues still"

This approach helps to rationalise their behaviour, reducing cognitive dissonance, while also adding to the sense of not being a 'serious' smoker, or even at the other end of the continuum, identifying as someone who is trying to quit when in fact the only thing that is happening is that they do not have access to tobacco, e.g. due to geographical isolation, living in a rural community.

Sharing resources, in this case tobacco, also acts as a reciprocal group bonding technique:

SP8 L6-9 "...I had friends who smoked....I would have a cigarette. One of my friends cigarettes... and occasionally I would buy a packet just so that I didn't have to ponse off them all the time"

SP4 L57-59 "...I didn't have a lot of money to buy stuff back then... so it was always on offer as a group kind of thing"

Similarly for the gay participants this was also a means of group cohesion:

GP6 L42 "yeah well me and friends would chip in and buy them altogether do you know what I mean?"

This sharing of resources was done to the extent of using anything available at an early age (12 years), while also recognising that smoking was something to be done furtively:

SP6 L27-29 *"... we used to wait for his dad to finish and then while it was still lit we used to go outside and pick it up and smoke it around the corner... so technically dog ends"*

SP5 L19-21 *"I think possibly the guy who I smoked with was able to get it from his dad, that might have been a reason"*

GP4 L17-18 *"... my mum was smoking so I used to nick one or two from her pack"*

Ease of access of tobacco products from shops and parents was not seen as a problem:

SP4 L65-68 *"... even if you were young, and you just told yourself that you are older, you could just walk into a shop... then people could get away with it a lot easier. It was also taken from parents and stuff like that"*

SP9 L161 *"I can't remember actually but I think at that age (16) you buy them"*

GP5 L21 *"I looked older for my age so I bought my own"*

The implication in these statements could be that by merely behaving like an older person increases their confidence, making it possible to pass as an adult, that in turn increases their success of buying tobacco under age. However, in spite of this perception, it is also understood that even if the laws had been stricter then other ways to access tobacco would have been found; tightening the age of sale of tobacco legislation is seen as an incentive to smoke:

SP4 L75-78 *"... in fact if the rules were less strict it wouldn't be such a novelty... so it's seen as some sort of taboo people will go for it more, like anything that's not legal"*

As such, the legal considerations had no effect on their behaviour while under age; even if the law is tightened, it is recognised that others in the community might counteract any benefit.

These 'others' are recognised as an alternative source of cigarettes:

GP6 L16-17 "when I got a bit older I would just go and get them or standing outside a shop I'd get someone to go in"

GP6 L13-14 "there was a man and a woman used to sell them cheap on the estate right... they used to sell them to anybody"

For other smokers accessibility governs what form of tobacco is smoked:

SP5 L17-19 "Cigarettes weren't readily available when I was that age (10-13)... I didn't know anybody who smoked cigarettes... so that might be a factor of why I went for a pipe"

Geographical isolation compounds this:

SP5 L5-6 "I grew up in the semi-rural area with a lot of open spaces in a little community"

In contrast to the earlier comments of GP6 there is also an implication that in a small rural community other options for acquiring tobacco were also limited. This situation and a lack of freedom or access to shops also minimises the number smoked for other participants when younger:

SP6 L79-83 "... a big part of it was that I grew up in a place that didn't have a shop so around 16 or 17 when I became mobile I then had the ability to be in my own space"

b. Financial constraints. Where for some the financial cost of smoking is aversive, for others this argument holds no sway. A cost benefit analysis is undertaken; by reducing the number smoked there is a recognised cost saving by smoking less tobacco, although this cost saving is not seen to be very consequential compared to savings or protection for their health:

SP3 L510-511 "If you are prepared to do it (cut down) for your health, to smoke 3 a day, I don't really mind taking that hit on your body then money is irrelevant"

Stopping is seen as being motivated for financial reasons only, although this may be complicated further for those who admit to relying on others to 'blag off' (provide cigarettes) as seen earlier when discussing the source of cigarettes. Short term strategies to cope with financial problems also include a reciprocal agreement with friends to maintain the habit:

GP2 L317 "I'll just bum cigarettes from friends... you return the favour when they need it"

For these smokers, the salience of financial consideration is lessened, and not such a driver to stop. For this section of the smoking population it would appear that taxation and other financial pressures would not encourage cessation, although it could be surmised that at some stage even this source may be removed once the cost of cigarettes is too high for them to give too many away.

Limited financial resources either due to unemployment or low pay also raise the question that smokers can prioritise tobacco over other things:

SP1 L221 "... but I always make sure I've got enough money for tobacco"

Alternatively, this reduced financial status can also result in changing from a branded cigarette to rolling tobacco:

GP5 L91-92 "I discovered roll ups and found they were much cheaper and so it was easier to maintain smoking"

This realisation helps to produce insight into a range of reactions to smoking such as its

futility and the exertion of reducing a feeling of control over one's own behaviour. However, this is quickly followed by rationalising this behaviour by social comparison with others who may have other habits such as drinking alcohol in a trade off between one behaviour and another:

SP1 L230 "But other people spend money on, I don't know, I suppose being unemployed people have other qualms like buying alcohol. I don't really drink that much to be honest. So the money I do have goes on tobacco"

From a wider societal view there is a more practical point expressed; the money which is spent by smokers on tobacco products is seen as an investment in future health care costs:

SP8 L423-424 "...if you smoke and you expect the NHS (National Health Service) to look after you then you've got to pay the tax on it"

Money is also not a direct motivator for some to stop although when put into a list of priorities it is not necessarily at the top:

SP8 L436-439 "Money is not the be all and end all... if it got to the point of choosing between food and smoking then ...I would have to stop"

There is also a philosophical argument going on with the ideology of consumerism:

SP8 L448-451 "...there's not actually a lot of things that I want that money can buy...I have everything I need. I mean, what would I spend it on?"

This introduces the sense of smoking being a reward as well as a coping mechanism, reinforcing the view that he has no intention to stop.

The financial aspect of smoking can also be an incentive to stop, although access to cheaper cigarettes affects this decision and the idea that this makes it ok to smoke:

GP2 L253-259 "... in recent times it's been ok because I've got them from abroad... and so the financial boundaries haven't affected me as they should... right now I'm spending about 50p per packet... "

This also affects social behaviour as a smoker:

GP2 L264 "it makes me much more free and easy with them"

However, for others smoking is all-important and strategies are developed:

GP4 L429-430 "It doesn't matter how little money you get paid you always still find a way to smoke... so you cut I'd down or stop for a short time"

However this is not taken as an opportunity to stop smoking permanently but is looked at pragmatically:

GP4 L434-431 "But when I know that I can, I'll straightaway go back to smoking. My brain is not at the stage that I would want to give up"

GP4 L444 "... you just have to cope with it"

As such, for some, enforced cessation is not successful long term.

There is also a dynamic relationship with the cost of cigarettes; similar to the prioritisation seen earlier price elasticity is also relative to income where Maslow's hierarchy of needs (Handy, 1981) comes into play where smoking is seen as a leisure activity that could be stopped easily if necessary:

GP2 L278-281 "If it's a case of sacrificing you know buying a pair of shoes that I need or going to the pub... that would be a real sign for me to stop and I would probably stop quite quickly"

GP7 L551-552 "They (cigarettes) would definitely be last... the more enjoyable things like alcohol and cigarettes would have to go, it depends how much money I've got"

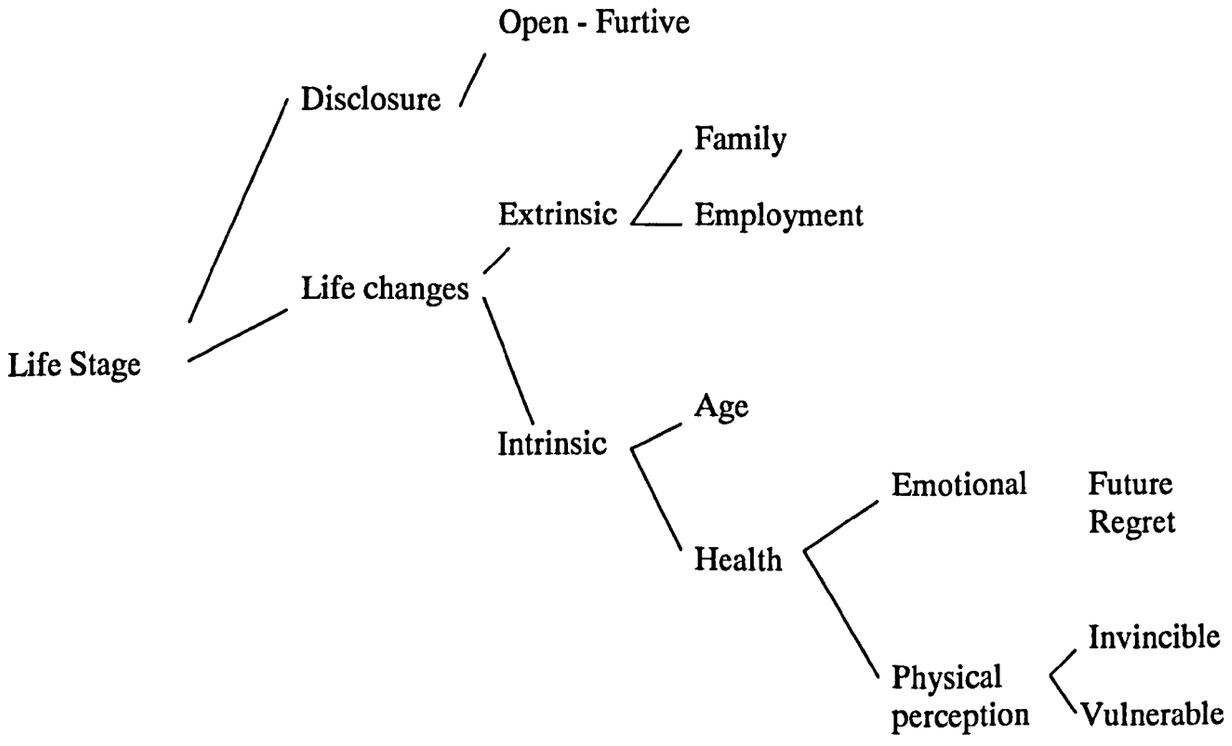
This also affects how useful a tool the price of cigarettes is to encourage people to stop.

This cognitive awareness of the futility of smoking can be seen and regret shown:

GP2 298-299 "... thinking about it if you need something and you spend the money beforehand on something like smoking that would be pretty crappy"

3. Life stage of the smoker

Diagram 3.1.1.3 Life stage and its sub-categories



a. Disclosure. Once a younger person has started to smoke there is a concern over

disclosure, or of others finding out about this new behaviour. One mechanism is comparing themselves to other smoking siblings; actions to hide their own smoking behaviour enables some smokers to position themselves as 'clever' smokers in comparison to their siblings:

SP6 L69-72 "They knew my sister did but I was better at hiding it... my sister got caught because she used to smoke out the window and stupid stuff like that. I would do it less frequently but always out the house"

SP9 L187-188 "...you think you're getting away with it with mouthwash and toothpaste and stuff, but, but you know now that you obviously stink"

In this latter example, it is also able to see in retrospect the futility of this action, although at the time it was thought to be effective.

As well as these strategies, smoking regularly was also encouraged by increased independence and mobility at an older age (16 years) that limited the chance of being caught:

SP6 L83 "...I suppose no risk of getting caught if you're 40 miles away or whatever"

This adds to a recurrent image of smoking being seen as an illicit behaviour. For some this was not admitted to until an older age (21 years) and it is couched in terms akin to 'coming out':

SP6 L69-70 "I had to tell my parents, I think it was my 21st birthday I told them"

However in some circumstances age is not enough of a driver to be honest with others. Different parental attitudes have had an effect, especially for the gay participants. For most of the participants, parental attitudes softened as the participant got older, but when that parent holds strong religious views where smoking is seen as 'dirty' such views are enough of an issue not to disclose their smoking:

GP3 L61	*"...she would probably react quite bad ... so it's just not worth telling her"*

For this participant who has stated that the coming out process was difficult due to the religious views of the parent a parallel is seen with regards to smoking; the emotional effort required would be too much to be honest with her.

b. Life Changes.

i. Extrinsic. As has been already been seen, changing circumstances have an effect on many aspects of smoking. An important change for an individual occurs when leaving home; mindsets change so that someone who may have been antismoking earlier now becomes more ambivalent to the dangers:

SP1 L122	*"... I just wasn't going to achieve anything by not smoking. If that makes sense. I know I'm not achieving anything by smoking but, I don't know... "*

Moving away from home also gives the freedom to change behaviour:

SP6 L11-13 "I had my first few at 12and I never properly smoked until I moved to London when I was 18 or maybe 16 when I started buying packets of cigarettes instead of picking them off the floor"

SP6 L102-103 "...being able to smoke in a bedroom was a bit of a factor...So I probably went up to about 15 per day yeah"

This geographical change not only gives the freedom over where it is permissible to smoke but it also affects access to tobacco. As someone gets older and circumstances change opportunities arise that encourages increased smoking:

SP4 L173-175 "... it is really more when I started going off to festivals and stuff like that am going to gigs and going out. You know, being able to go to a pub eventually when I was 18 and stuff like that"

In a similar way, having left home smoking increased in the short term at least:

SP6 L95-97 "There were times when I would wake up to have a cigarette and then have one with breakfast all that sort of stuff, but now I'm a bit calmer about it"

There is a sense of the freedom someone experiences on first leaving home which eventually subsides.

In such a variety of situations it appears that despite previous internal mechanisms for not starting to smoke and lack of susceptibility to external influences such as peer pressure, what has changed is exposure to external pressures. This is especially the case with the pressure of changing routines. Despite realising that there is nothing tangible to gain from smoking the effect of nicotine addiction is invoked to attempt to explain his habit:

SP1 L135 "... obviously I am addicted now and I know that because I wake up and I, you know, need a cigarette really"

The pattern is set and repeats itself as one gets older and life changes are experienced; such factors increase the number of cigarettes smoked and the consequent effect of nicotine exacerbates this need to smoke. This continuing increase reinforces what was found earlier in relation to the participants' understanding of nicotine addiction. As well as this addiction there is also an inevitability expressed that consumption will increase:

SP9 L203 "... you know, you build up a tolerance and your body demands more nicotine"

What is remembered is starting smoking and gradually increasing consumption over the initial years although the rate smoked could also be situational:

GP4 L91-93 "...over the years it has obviously increased... and years from that it has easily been 50-60 per day"

There appears to be an implicit assumption that increasing the number smoked is inevitable, although the addictive effect of nicotine is not mentioned. These statements illustrate that the control of the smoking is being passed from internal mechanisms to external mechanisms that act upon the individual, moving control away from the person, the subject, to the addictive nature of the cigarette, the object.

Other life changes affect smoking behaviour; someone with an interrupted smoking career began smoking tobacco products in alternate formats at later age, but not cigarettes until an even later age:

SP5 L48 "I stopped smoking a pipe at around 13 or 14...I didn't smoke anything else until I was around 19"

This also coincided with moving to the UK from overseas:

SP5 L49 "When we moved to the UK I tried my first joint... but then again I never smoked cigarettes"

The idea of the effect of the macro culture is also raised. Pub culture has historically made smoking almost a prerequisite of going out and is recognised by a non-British participant:

SP5 L211-214 "the biggest change that I noticed when I first came over here is how many people smoke in pubs... You go to the pub, have a drink and you smoke. It's all tied together"

Such socialising is also seen as an excuse for increased numbers smoked:

SP4 L306 "it's usually if I binge, if I chain smoke whilst drinking or when I'm out or something like that"

In the former statement, while an analogy may be made with bar culture in this participant's home country (the USA) there is still a recognisable difference between the two cultures:

SP5 L221-223 "I can remember going to bars in the States... and it didn't seem to be that smoky or that many smokers. And I myself wasn't smoking then either"

This last statement adds weight to the comment as the implication is that a non-smoker as he was then is more likely to notice smokers and smoking.

The situation, typically socialising, is also important to an increasing volume of cigarettes smoked, up to 50 per day, for gay participants:

GP4 L98- 100 "I did a lot of clubbing a few years ago, for about 2 years... "
GP2 L106-109 "I'm not a very heavy smoker and although when I'm out I can get through quite a lot normally up to 20 to 30-it depends how long I'm out for. It's as if there's a need for it while I'm out... "

Maintenance is not due to social pressures to smoke but because the social setting, for example clubbing or gigs where most people smoke, make it difficult to stop. It is also seen as a sociable thing to do rather than due to need:

GP2 L173-175 "It's not a case of going out especially to smoke -of course you're going out for one but the act of going out for a cigarette is much nicer when it's a social thing you know what I mean?"

It is also the norm in this group:

GP2 L178 "... it's just part of what we do"

Although some people feel in control when they go out with non-smoking friends there is the realisation that when out with these people this may not necessarily be the case:

GP2 L191-193 "... it is a bit of a struggle yeah, sometimes when I want to smoke I say 'let's go to the next pub' because I know when we go to other places I can sneak a cigarette in".

Despite this strategy there is also the realisation that the need for a cigarette can be over ridden in favour of the social need:

GP2 L200-201 "You hold off – it's a bit uncomfortable but I can do it because I'm with my friends and I want to hang out with them"

For others there is no set pattern to their smoking pattern:

GP5 L85-87 "... it's fluctuated over the years... it's gone up and down, I've stopped and then I started again, like it turns full circle"

This shows how smoking is dependent on a wide number of intrinsic physical and emotional factors, e.g. mood, and also extrinsic fluctuations, e.g. the weather:

GP1 L574-577 "... it's just an association and it's ... umm I mean for an example when I go back to Paris I love walking down the streets with a red Marlboro or a white Davidoff and I feel 'hey I'm in Paris' that's cool, it's all good and I suppose that's part of it too – insignificant things really... "

This helps to illustrate how some people are led by mood and emotions, not just the

habit and addictive nature of the behaviour, to encourage maintenance of the behaviour:

GP1 L64 "Today's a good day. I haven't smoked much, no. Mainly because I am very hung over"

Although he does not want to quit he still refers to this as a 'good day' that indicates conflict with continuing this behaviour. This is also shown by comments regarding the fact that all his social group smoke:

GP1 133-135 "So I find smoking pleasurable... I'm surrounded by people who smoke... It's a vicious circle"

In comparison to those who see their consumption increasing, as well as the direct impact on a potential decision to stop smoking for some smokers bodily feedback also helps to limit the number smoked. These limits are helped by the recognition of the physical effect of smoking:

SP5 L306-308 "... if I smoke more than 5 or 6 a day I will think 'wow, I've had enough' because it starts hurting the back of my throat"

SP6 L344-345 "when you have too many it just goes down really badly and you think 'no, this isn't worth it'"

This implies a value judgement on their behaviour that may or may not be enough to proceed with the behaviour. This enjoyment rather than need also indicate a degree of control over the habit:

SP5 L316-317 "I enjoy it and ... I think I can control it to the point of not smoking any more"

SP6 L131 "I think I do really enjoy it and that's it"

Other external events also facilitate maintenance of smoking. One example is being unemployed; with the constraints this raises, smoking is one small pleasure which may also be affected by social reinforcement of a partner smoking. This is used as an excuse to continue smoking for the time being. This gives the impression that he is aware that this may not be the case forever and that change may happen in the future. As such, he recognises that consciously his current smoking status is time limited that he believes will end when in employment as well as due to other life events and can be seen in the following extract:

SP3 L772-774 "That's something which in my head happens after I turn 30, having kids. Having a job that I took seriously enough to give up cannabis and tobacco would be a pretty good job enough to be committed"

This also indicates a degree of prevarication; he realises there is self harm involved in his decision and yet still intends to put off the decision to stop to some point in the future.

ii. Intrinsic. Age is a large driver to feeling happy to be a smoker because smoking is seen as a stage of life to go through:

SP1 L141	*"...that's because of my age...you think you are invincible obviously because I don't think it's going to affect me now. But obviously I know full well as I get older the more I will regret doing it... "*

In this case there is a decisional balance made between the immediate feeling towards smoking and the potential future feelings. This may be compared to current feelings towards smoking from another participant:

GP4 L310	*"I don't think I see it as a mistake because I don't regret starting"*

This also introduces the paradoxical way that people reflect on their choice to smoke; they

tell themselves that they are invincible, that smoking will not affect them and yet underneath this they do realise that not only are they fooling themselves on this effect, but as they become older there will not only be the health effects to contend with but also the emotional effect, in particular, the sense of future regret.

Added to this view, there is also a fatalistic element to life when younger smokers look to the future. This takes on an almost abstract view that is seen as being a generally held view by people in this age group. There is a complex inter-relationship of beliefs; while recognising their potential susceptibility there is also a parallel denial of health deterioration and/or the relevance of this to the participant:

SP6 L178-180 "... when I talk to my friends... nobody seems to care about themselves until they get past 30... "

SP6 L187-193 "Since I was 18 I've assumed I wouldn't actually live much longer than the age I was then... it really does seem a general thing... it stops at about 30 you realise ... 'I'd better do something about it'"

GP1 L179-181 "At my age I don't consider that I have a reason to prioritise my health. I have enough faith in my body although I probably shouldn't"

This final statement shows the idea of invincibility in ones own body tainted with an air of realism, 'I probably shouldn't'. This is expanded to a sense of fatalism:

SP6 L193-194 "... it's taking it further than not just considering your future, it's actually being like denying you have a future"

This disconnect continues and is brought into sharper focus by making reference to future, albeit an unhealthy one, which is simultaneously discounted:

SP6 L205-206 "It's like total disbelief that I'm going to be 60 and with a heart condition"

SP6 L208-209 "The risk of long term damage to your lungs and stuff isn't a factor"

There is then an interesting age progression change in attitudes, from the 20's when a future does not exist to the 30's where the future is inevitable. This results in a more fatalistic attitude expressed forcefully by others for whom these attitudes are more ingrained having already passed the age of 30:

SP8 L245-247 "...there is no such thing as immortality, there are no guarantees, there are no rules. If your number's up your number's up so you might as well just enjoy yourself while you can"

SP8 L368-371 "...I don't buy into this fantasy... that immortality is desirable... It doesn't matter what you do, you are going to die, I mean non-smokers die every day"

Not only is this fatalism linked to smoking, it is also seen as something which non-smokers also have to manage in their lives.

For others who have stopped at some point in their smoking history, despite a number of years gap between their smoking initiation and this initial smoking cessation it is possible for an older person to reinitiate, or restart, and maintain smoking tobacco that is helped by the behaviour of others:

SP5 L95-97 "It first started off with just a couple of puffs off my wife's cigarette whenever she lit up"

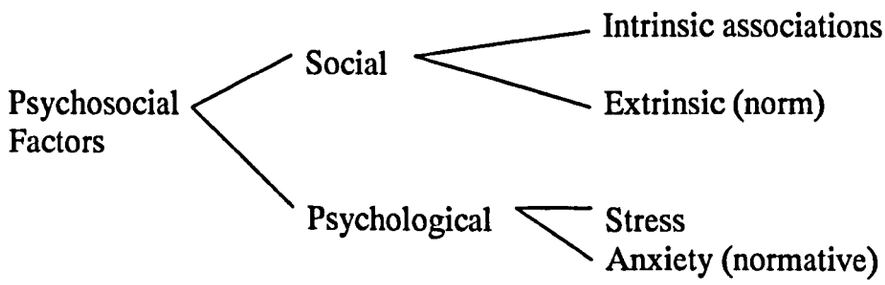
This indicates that it is possible to exert a degree of control over this 'new' habit, however, like many smokers, this progressed and there is an attempt to minimise the number smoked by identifying potential external triggers, that again acts as a way for the person to absolve themselves of any control:

SP5 L101-106 "So it just sort of started with a couple of puffs here and there... Now I only smoke about 5 or 6 a day... if I am out socially... I tend to smoke more when I am bored... or if I am pressured by anything"

4. Psychosocial factors

The psychologically associated behaviours of smoking are also important to the enjoyment and consequently support maintenance of the behaviour. These can be seen in the following diagram.

Diagram 3.1.1.4 Psychosocial factors and their sub-categories



a. Social. The following extracts are common to most smokers and encapsulate the associations created by smokers to specific behaviours.

SP1 L270 *"I quite enjoy having a cup of tea and a cigarette... "*

SP2 L63-65 *"I mean it's always good for me personally to have a cigarette after I've eaten or... like erm, yeah, I don't know, just after I've done something I like to have a cigarette... "*

SP10 L56-57 *"... cigarettes in the morning, I'm waking up, coffee and cigarettes, it's like traditional"*

This expands the idea of a ritual or habit attached to smoking, as the behaviour is a marker that a particular action has ended or is beginning. It also helps with contemplation and planning for the individual:

SP10 L74-76 "It's like you're on your own you know when you don't have a conversation with anyone because you're smoking so you just thinking what's going on"

However this does not apply to all smokers which marks the behaviour as very individual:

SP4 L 248-250 "... some people I suppose it is just at those times like after food or with a drink but I would definitely not say that about myself"

While for others socialising increases the number smoked:

SP5 L155 "I think I smoke more when I'm out with other people and I'm having a drink"

This effect is not dependent on the smoking status of those around the person:

SP5 L165-166 "... I'd say excuse me guys, especially after a meal, go out and have a cigarette and come back in"
SP9 L277-279 "... it's also quite context specific, we might go out for a meal and then a couple of us might get up and go out for a cigarette. It's not a really big thing"

There is also a difference exhibited in the level of control someone has over the habit. Situational determinants indicate a 'take it or leave it' approach to smoking in certain circumstances. For example, whether due to parental expectations or where others are not aware of a persons smoking, the behaviour can be refrained from:

SP5 L175-178 "... I go to my parents house... when I am there... I go for a minimum of 3 weeks, and I have gone for 3 weeks without having a cigarette"
SP9 L286 "I can go through long steady periods without smoking at all"

In the case of this latter statement, to explain this in terms of addiction during these periods an analogy is made between smoking and exercise:

SP9 L295 "the energy goes into exercise... so the endorphins replace nicotine"

b. Psychological factors. Smoking is also used to deal with physiological symptoms such as stress and anxiety. For example, being unemployed or dealing with the stress of constant job application rejections. It helps deal with disappointment and such situations may result in smoking more. This is also an automatic response and seen as being the norm for many to smoke:

SP2 L486-488 "...I notice when people get stressed out or upset at something then they'll say 'give me a cigarette'. And I do it as well, sometimes"
SP8 L415 "when I was doing my tax return a lot of cigarettes were consumed in the process of that"
SP10 L50-52 "Every time there is a problem, sometimes I am smoking 2 or 3 a day, sometimes a pack, it just depends how stressed I am"
GP1 L490-493 "... it's the whole psychological thing because I've known people, knew people who just don't believe in the unhealthy effects of cigarette smoking and lots of them have lived to be very old smoking lots and lots of cigarettes and they just wouldn't acknowledge the fact or they wouldn't worry"

This implies that the negative effects of smoking can be dealt with by positive psychological thinking it is seen as a state of mind or attitude rather than definitive biological effects. This could be down to personality type as someone who worries a lot, who get anxious, may not be able to achieve this mindset:

GP1 L522-524"...I think stress and worry tend to affect me and yes cigarettes right now help to relieve that stress but I am sure that if I continue smoking for a while I will get very stressed about what I am doing to my health so it will turn around"

This also illustrates the dichotomy of thoughts that smoking brings up; in the short term they are used to control stress even though the person knows that long term they will actually add to stress levels of fears over health issues. This is perceived to be an easy coping strategy. Of interest is that someone who starts smoking at a later age presumably had developed other strategies during their non-smoking years to cope with life stressors. However, it is not always possible for them to either recall what these were or perhaps they are no longer age-appropriate, such as the example given as playing football in the street with your friends. In addition, by turning to smoking they were presumably not effective coping strategies. This helps to explain that it is not always possible for older people, even in their twenties, to develop new coping skills, or perhaps they have no interest in other coping styles to replace something which is enjoyable in the here and now. The person may have a limited repertoire of coping strategies; once found these do not change:

SP1 L795 "Maybe eating. But no, no. Just smoking really"

SP7 L 382-383 "I can't really think of anything else, it's just smoking really"

Other drivers to remain a smoker and deal with life's stresses are living arrangements. For example, living in a squat results in a constant fear of being evicted; having a home is a basic requirement in Maslow's hierarchy of needs (Handy, 1981) and consequently makes this a stressful motivator to continue smoking;

SP2 L494-497 "I get kicked out of houses a lot which is really a massive pain in the arse. And that kind of thing and, erm, I don't know. Coming back and the house has had a party and it's been trashed and that kind of thing, you know"

Housing is such a basic requirement that it is not possible for this person to think of alternative coping mechanisms:

SP2 L507-508 "Smoking's easy, you know what I mean. Like, there's other people who would cut themselves or fight someone or something like that you know"

These alternative coping strategies are seen as being more destructive than the effects of smoking in the immediate term.

The effects of smoking are minimised but in specific emotional states can be increased:

SP5 L101-106 "I only smoke about 5 or 6 a day... if I am out socially... I tend to smoke more when I am bored... or if I am pressured by anything"

This is seen as an efficient coping mechanism and the addiction is consequently rationalised:

SP5 L116-118 "... it will take me 10 minutes to smoke it but then that will last me for a few hours until I need my next one"

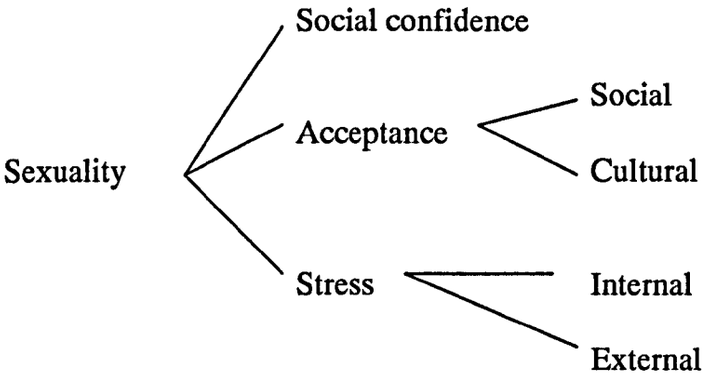
Smoking is also seen as having a positive effect on bodily functions and helps to maintain health:

SP5 L133-137 "... when I have that first cigarette in the morning it starts my bowel movement... possibly deep down in the back of my head it might be because my body has possibly got into the groove that I have a fag and then I have a shit"

This is seen as a positive effect of smoking but it is not sure if this is a conscious or unconscious understanding by the participant.

5. Sexuality

Diagram 3.1.1.5 Sexuality and its sub-categories



One aspect that may be seen as different between the two groups is using smoking as a way of coping with the first partner. In comparison to the straight participants this has been as a result of inexperience of what is expected of their first gay relationship:

GP3 L85-87 "... with me and a lot of gay people at that time they kind of started a bit later than the rest of the population dating stuff and all that for obvious reasons"

This is generalised and the implication is that there were social pressures that had to be managed in terms of sexuality and resulted in later initiation due to a new relationship with his first boyfriend. However, in the case of this participant this is recognised as being at yet a later age compared to the norm for society, whether straight or gay:

GP3 L4 "...I'm a bit unusual as I started quite late when I was 23... "

In this example, smoking is not necessarily cited as a way of coping with the pressures of being gay; it appears that the decision to smoke is more to do with a lack of confidence in any relationship than coping with negative societal experiences:

GP3 L88-89 "...I was probably unprepared for it you know, he was a smoker, and I think he offered it to me and I says 'Oh yeah, why not' so it was as silly as that really"

This was not only with the aim of being accepted as part of a new 'community' but because he was simultaneously rejecting his former 'community' and way of life in order to become his own person:

GP3 L94-96 "I came out of the Jehovah's Witness religion around that time because they don't accept gay people anyway..."

This is part of forming his new identity as a gay person:

GP3 L97-99 "...it was the kind of whole growing up and becoming who I was as opposed to what my mother wanted me to be ... sorting through all those different kind of issues and asserting my independence"

A similar situation is found from a cultural viewpoint:

GP5 L230-231 "...I was brought up in an Afro-Caribbean background so predominantly ... quite homophobic"

In comparison to GP3 above, this participant started smoking 10 years prior to 'coming out' as gay. It is important not to confuse 'coming out' with a lack of any early pressure to smoke due to coming to terms with one's sexuality. Since this point in time, his peer groups have also changed:

GP5 L254 "I just immersed myself in a culture where there was a lot of smoking"

A major life event of acceptance for who he was led to making smoking a coping

strategy:

GP3 L115-117"... this is what adults do... it was a combination of reacting and being unprepared for peer pressure and stuff in that context"

Starting to smoke 6 years before coming out also helped cope with this period:

GP6 L147-148"... smoking helped me deal with it (coming out) ... it helped me not to worry about what people thought or whatever"

This was especially in the case of potential negative reactions from others:

GP6 L210-213"... if people took it bad and they didn't say what I would have liked to hear... it makes you feel better, even if you are upset it stops you feeling too upset"

However, looking back this is recognised as being an unconscious decision:

GP6 L149 "... I suppose I never thought about it though to be honest"

Recognition that smoking prevalence in gay culture was high normalised this situation for some; they did not really question it but instead saw that there were multifaceted reasons to smoke:

GP3 L121-126"... loads of gay people smoked more than the general population... it might have been to be accepted by the community as well... and I haven't really been to too many gay pubs before. ... it was a lot of different things... to fit in, it was a bit of fun and a bit normal, a bit accepted"

Other behaviours are also conflated into the gay 'lifestyle' for some:

GP3 L205-206"... there is also a culture around gay people smoking because I think that drugs are quite big in gay culture as well"

GP5 L270-271"I think there is a strong link between lifestyle like going out clubbing, drinking and doing drugs to not caring about your health... I think it's more in the gay community"

Even when it is recognised that gay men smoke more, within this group there is room for social comparison with others to minimise the number that a heavy smoker (30 a day) smokes:

GP6 L 245-246"I mean I smoke a lot more when I'm out... but you know some of them are lighting one after another ... "

However, this is not the case for all of the gay participants, the following excerpt does not mention sexuality as reason to smoke, but does reflect a common pathway experienced by many young smokers in the general population:

GP6 L112-113"I left school at 15, left the area, got new friends, started drinking, going out drinking and then that makes you smoke"

There is a sense that there is no control over this with the behaviour facilitated by other substances being present.

Smoking's utility is seen beyond a tool to deal with being gay:

GP3 L132-133"... I think I found it an emotional prop but I think also for stress because I do suffer from that anyway"

Smoking is seen as a more positive approach to dealing with one's identity as a gay man

when a gay sibling's approach is discussed:

GP3 L239	*"I think his way of dealing with it is by not dealing with it actually"*
GP3 L228	*"He's very wrapped up in his career and stuff"*

A general view is expressed of why gay men smoke more than straight men:

GP3 L150-151 "I think generally gay people go through a bit more difficulty in becoming accepted... smoking bridges the gap in some way"

Timelines again emerge as an important factor when discussing sexuality and smoking and differences in the influence of time are commented on to explain behaviour:

GP3 L84-86 "...with me, I don't know about the younger generation these days who are gay... and with a lot of gay people at that time, they kind of started a bit later... "

However, while the general view is that younger gay people have it easier because of legislative changes in order to improve equality there is recognition that this has pros and cons and that prejudice is now more covert:

GP3 L167-170 "... there's still a lot of stuff that's more closeted... there is still prejudice and I think gay people immediately pick up on it. It's still there although it's not as openly prevalent as it used to be. A bit like racism... "

There is an analogy made to other minorities and this sense of oppression is also used to explain extremes of behaviour around smoking, alcohol and drugs:

GP5 L279-286 "I think any segment of society which is oppressed, when that oppression is released there is a sort of backlash... it becomes easier to accept negative behaviour or unhealthy behaviour because it's all in the guise of having a good time and making up for lost time"

While also being a coping strategy this is again seen as normalising the behaviour.

There are also links to stressful situations due to parental expectations

GP3 182-186 "They always expect their kids to be straight... Even if you take prejudice out of the equation... that creates stress anyway because it's like who wants to tell their mother and father that they're probably not going to have grandchildren"

For this particular participant the issue is further clouded by other variables such as the guilt felt as a gay person arising not just out of this parental disapproval but also other aspects of upbringing:

GP3 L212-213 "There might be guilt about hurting your parents... but I think that was more about my religious upbringing"

Depending on the quality of the relationship, the need to satisfy parental expectations can be greater than meeting societal expectations:

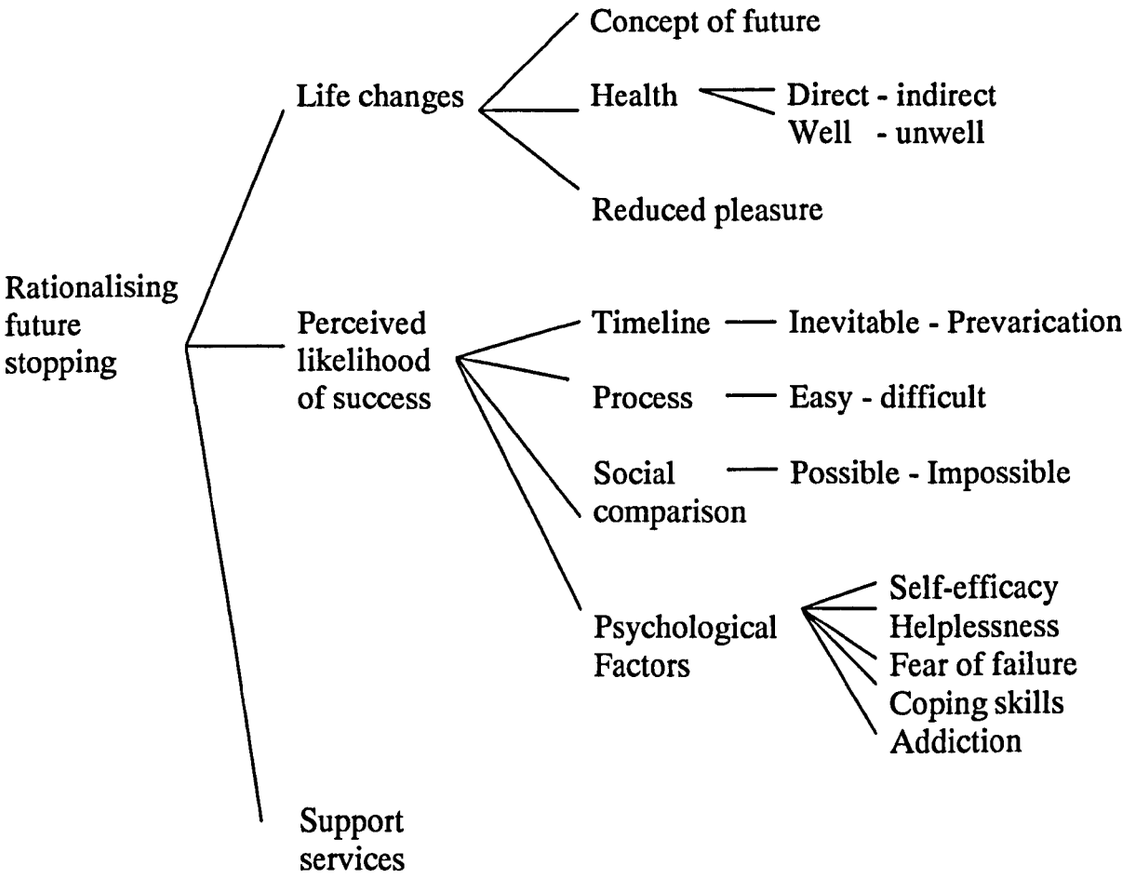
GP3 L194-195 "... if your parents accept you you almost don't care what anybody else thinks... "

3.1.2 Rationalising future stopping

The men had identified as starting to smoke between the ages of 13 and 22, with the duration of smoking lasting between 3 years and 25 years. As such a varied number of

aspects were described that may result in the recognition that it is time to stop smoking and the overall categories arise out of an attempt to rationalise the behaviour that the men continue to engage in.

Diagram 3.1.2 Rationalising future stopping and its subcategories



1. Life Changes

The initial factor arising from the concept of future revolves around changing roles in life, including having a family. The desire to be a role model for others helps to make the effects of smoking more concrete for some, especially the wish that children do not follow the same path, which introduces the idea of a 'natural order' of events that everyone follows:

SP1 L175	*"I bet all parents say that"*

This desire could also indicate a degree of dissonance in past decisions to smoke. However,

this is not evident in the majority of cases and does not appear to indicate regret.

Such milestones, like starting a family, are recognised as being a reason to stop smoking:

SP9 L379 "certainly if I have kids... something like that, quite radical"

Stopping is still located in the future and this use of 'radical' refers to the situation rather than the difficulty that may be felt in stopping. It could indicate how important smoking is seen in their life at the moment.

However, for some, thinking of these future events is too much to assimilate and as such the milestone needs to be relevant in order to be effective:

SP2 L120 "But I don't think I am going to have kids, I couldn't even have a dog right now"

This indicates that the person is not able to think of responsibility for others at this stage and so this may not be relevant to encouraging behaviour change. For this person, to think of stopping would require an alternative major change in their life as illustrated in the following which encompasses a drastic change but one that is relevant:

SP2 L179 "Maybe if I change my lifestyle drastically but right now I don't see that happening for a while"

There is no timescale for stopping, it is just located in the future, even with a concrete life changing event being considered:

SP8 L472-474 "It would have to be a question of coming to a point in my life when I say 'no, I don't want to do that anymore. But it wouldn't be because of health scares"

This example highlights the difference between 'want' and 'need', and a sense of self-control or self-determination, influenced by factors changing. At this point, health is not viewed as a major factor to stop smoking. There is also a sense that one 'ought' to stop smoking rather than a belief that one 'should'. This results in a paradox in behaviour:

GP3 L418-420"...you think that I should stop smoking and then you tell yourself 'arent you a good person for thinking that?' And then you have a fag. It's almost like self reward"

However, for some, looking to the future may not be as straightforward and the consequences of the potential effects of smoking are minimised because the participant cannot actually see anything to stop for. This idea of 'need' again arises; to stop for oneself is not always a sufficient driver:

SP10 L212-218 "...I think 'Now I'm 30, I think I have 4 or 5 years to live so there's no reason'...I don't want kids, I don't want a wife, yes it's quite depressing so I really don't think that I need to stop it"

This indicates an external locus of control due to current life circumstances and is expanded upon in the following excerpt:

SP10 L226-228 "... living in a squat, working cash in hand, all the time in the street life, I can't see a future. I'm not trying to sound like suicidal, it's just why, because smoking for me it's a little bit relaxing"

In comparison to these ideas of particular future major events happening which will encourage cessation, others do not have a specific time to stop. To this end it will be more random. Imagining a time in the future is seen as being self-defeating with the consequence of making the process more difficult for them:

SP4 L283-284 "... if you say I want to quit for the New Year or something it can make it a lot harder... "

Health status may be perceived as being either directly or indirectly due to smoking and can result in conflicting thoughts:

SP4 L292-294 "... sometimes I get like bad chests and stuff like that. Normally it's not from smoking that's from being ill but then smoking as well probably doesn't help"

Although this link is made between smoking and health it may not be strong enough to stop, and although he notices changes in health on a day-to-day basis there is still an element of denial when considering any link between the two factors.

For some, stopping is related to a sense of being in poor health, as they don't smoke when they are ill but then begin as soon as they feel well enough. This enforced cessation however does not encourage a longer-term quit attempt.

However, for others this is also enough of a spur to stop smoking and images of death are envisaged:

SP8 L184-186 "... I'd had a really bad dose of bronchitis, coughing my lungs up, and at the time I thought 'My God, this must be what it's like to die of lung cancer' and I thought, 'No I'm fed up with it I'm going to give up smoking' and I did"

There is also a distinction made between 'normal' and 'abnormal' amounts to smoke. In comparison to the health effects experienced when smoking a 'normal' amount, excess smoking also raises the subject of stopping when there is a demonstrable effect on health:

SP6 L136-140 "... it will often be on one of those days where... we'd been out and had a load of cigarettes and a load of drink and then you wake up with a bit of a chest or whatever... it would be a good idea if we carried it out beyond a day"

There is awareness that, physically, they may have pushed themselves too far with the quantity smoked. This physical manifestation encourages the person to want to try more than an unplanned attempt to stop smoking (in this case stopping for a day) which is the strategy employed in the past to quit smoking.

Health effects are minimised and they are constructed as being annoying or inconvenient rather that something to be changed:

GP5 L99-101 "... when you get older you notice the physiological effects on yourself for example, running for a bus, shortness of breath... getting to that stage is a lot quicker than when you're younger... "

GP3 L431-433 "... I have had a few health problems associated with smoking which have really pissed me off and I'm thinking If I give up smoking then I won't have to put up with that"

Rather than stopping completely, this led to cutting down the numbers smoked which solved the problem:

GP3 L442-444 "I cut down a lot... it just completely disappeared... and the doctor told me it was that probably anyway"

This effect on health is seen to be more pertinent when it is coupled with another variable, age: in the following example this is also linked to other behaviours such as

drinking and the combined effect on the degree of hangover was seen as an immediate change in their ability to cope with the effects of their behaviour:

SP4 L 331-332 "It was as if my body was telling me 'you're 21 now and you have to stop"

Again, this links to an idea of stages in ones life mentioned in the previous section and this is seen as a cue to move to the stage of stopping smoking. The expectation of adverse health effects are also important and are again linked to age:

SP9 L247-249 "... I think as you get older you know there is greater awareness of your physical nature... to look at health"

GP2 L364-366" ... it's not really something you think about when you are a teenager or in your early 20's... you kind of live for now and don't really about it (sic)"

While the quantity smoked has been shown earlier to affect one's identity as a smoker, i.e. 'either a social' smoker or a 'heavy' smoker, when discussing health it also helps to minimise the threat to health which is felt by the smoker:

SP5 L358-359 "Maybe deep down I'm thinking I don't smoke enough to be in that position, maybe naively... but it's not affecting my health that I'm aware of... "

SP6 L329 "I guess only smoking 8 a day reduces my chances of getting anything"

This helps to illustrate how some smokers may need a concrete, observable health effect to change their behaviour, although no conscious thought is used to think what would have to happen to them to change their behaviour:

SP5 L369 "bloody hell... I have no idea, I have no idea"

For others the effect of the health changes may not be valid if they cannot remember what their baseline health condition was before they started smoking:

SP10 L178-179 "I never thought about it. I even don't know if I was better when I wasn't smoking"

However, although immersion in smoking may have made someone not consciously aware of any health changes, again there is an underlying sense that smoking is not good for you:

SP10 L183 "Health, I don't know, I'm feeling ok. I know it's bullshit but I'm feeling ok"

There is also an innate sense that medical advances will be available for a cure. In addition to general health conditions one condition that has been more of an issue for gay men has been that of HIV/AIDS. The progression of that condition and its treatment has changed may also have had an effect on smoking behaviour:

GP5 L326-327"... breakthroughs in medicine have made the gay community very laxidasical about the disease and reduced the fear... "

It is also hoped that there will be similar advances in medical treatments for smoking related issues:

GP5 L473 "Well, I'm a real bugger for believing in medicine and science and I'm kind of relying on that to save the day... they cracked the genome so it's a matter of time"

Serious health problems and consequences are 'removed' from the individual when thinking about stopping:

GP7 L165 "... if I knew someone like died of it, maybe I'd think about it, something life altering like that"

For others, the health effects on others is not a big enough driver to stop smoking immediately:

GP3 L74-75 "... one of the reasons he (dad) decided to give up was his coughing was getting worse and if he didn't nip it in the bud it would progress"

GP4 L424 "If it didn't suit me at the time I don't know if it would still have an effect"

This results in a number of views; this behaviour is normalised but a specific external reason is needed to stop this self-destructive behaviour, for example children, for whom you need to 'stay alive for', a provider role which is expected by society. Generalising smoking to age and the traits exhibited by this age group help to explain the delay in stopping, even when health consequences are known:

GP1 L172-175 "Well the thing is that, I'm like most people especially my age, we are self destructive and we don't prioritise that and as we... You need a reason to prioritise your health. You need for example when people have children that's a reason to prioritise your health because you need to stay alive for them"

GP5 L467-468 "If I have kids you can't really be a smoker around them and endanger their health and endangering your health because you would want to be there for them"

Pre-existing health concerns are also possible reasons to stop:

GP1 L466 "To start being realistic about my asthma because it's much better... I still have asthma"

This is an acceptance that although managed, the illness itself is still there. However, despite being aware of the effect of smoking concrete evidence of physical damage being done is still needed before being willing to consider stopping seriously:

GP1 L471-472 "... the smoking is really not good for it and basically if I got my lungs checked out and it was proven to be the case that it was getting worse then I would have to stop... "

The concept of future and age was also highlighted by the gay participants, possibly more explicitly:

GP2 L251 "I don't intend smoking well into old age... "

Health as a function of age is also seen as a reason to continue smoking for some as these health effects are perceived as a concern for older people, where a favourable comparison is drawn for younger people who have time to repair any physical damage:

GP3 491 "... I'm still young compared to relatives who have died so I still got time to give up if I wanted to. I'm not at deaths door stage quite yet"

GP7 L150-151 "... I figure I'm young enough that if I quit when I'm older it won't be so bad"

Without a direct concern for specific health issues, there is a sense of a natural progression, as if there is a time to die. For these participants, setting deadlines to stop smoking are not an effective tool and leads to prevarication:

GP3 L497-498 "I used to think that by the time I hit 30 I would have given up. But I'm 35 now... so I have kind on given up on that"

GP6 L397-399 "... well I am 27 now and I used to think 10 years ago that by the time I'm 25 I'll stop smoking... but that is just rubbish"

Overall, for most there is a sliding timeline of stopping depending on life events. However, there is also a cut off point when it is seen that stopping will definitely happen:

GP2 L351-354"... when I settle down... I'll want to quit whenever that is whether I am 30, 35 or 38. Disregarding that I guess I will definitely want to stop by 40".

GP7 L160 "about 50 for me"

For others, there is also an acknowledgement of a concept of being 'too late' to stop:

GP1 L480-483"I mean it seems like a good idea, that seems like a good age, because you are still very young but if you leave it too late then I mean I suppose the effects could be ... I mean... horrible ... I dunno ... that's the mindset I'm in. I believe my body can take it"

This reinforces the idea of invincibility, or perhaps an over-optimistic viewpoint, of the ability of the body to either repair itself, to survive, which is exhibited by both groups.

Most participants are aware of health messages offered regarding smoking by the NHS and other bodies and there is a feeling of saturation and the need for the message to be put out differently:

GP1 L609-610"... cos I've heard it all, I know or at least I think I know, or I've been told, I probably need to be told in a different way because that message is not getting through"

This may also be reinforced by health messages from professionals that may encourage continuance for some:

GP7 L213-214"... I had a nurse say I should stop. She said you know I'm young enough that the effects shouldn't really be as much than if I was older"

However, this approach may be misinterpreted and impose a timeframe for smoking:

GP7 L232 "...It's like a get out of jail free card you know, you've got a little bit more time"

The suggestion is that the message should be more personalised although it is difficult for most to pinpoint something relevant; it would have to be life stage appropriate or reduce the idea that a young person's body is as invincible as they think:

GP1 L632-635 "...the fact that I have faith in my body...I consider that I am normally healthy...I should be able to push my body a bit until I am 25 and then I will change my mind but I might be wrong about that"

This comment introduces a degree of doubt in comparison to other, earlier, comments, and indicates that if either their social circle or a partner was to stop smoking this would have a positive effect on someone's desire to try to stop:

GP1 L617-618 "...cos I wouldn't be surrounded by people smoking and nobody likes smoking by themselves"

This implies socially isolating smokers would have an effect on encouraging them to stop.

There is also inevitability to stopping for many:

GP3 L502 "My reasons are gradually running out not to do it...It's going to come but to actually say when I just can't"

GP5 L196-198 "For me I guess the big 3-0 is the age when you really need to start thinking about it...and I think 40 is quite important in terms of mental and physical health"

Age is also contextualised by social norms; one participant compares himself, aged 19, with someone who is 6 years older, age 25:

GP1 L146-150 'The one who is 25 has just stopped smoking... when we go out he is not smoking... he used to smoke 10 a day... it comes with age to say 'actually now I should probably stop smoking'"

The idea of distinct chronological 'stages' of life are also introduced; these stages are linked to when things are possible and not possible:

GP5 L204 "You can't confuse your 20's with your 30's and 40's"

These are based on a life plan of perceived achievable goals:

GP5 L218 "These are decisions I've made for myself... where I want to be, life and stuff"

The category of pleasure relates to the smoker realising that smoking has become 'normal' and they no longer experience the pleasure and enjoyment, or the 'hit', from the cigarette:

SP4 L292 "It's just become something normal, like breathing"

SP4 L284-285 "Usually it will be if I feel that I have been smoking too much and not enjoying it as I should be"

The anticipatory effect of smoking a cigarette also differs depending on the time between cigarettes, as the 'rush' is more intense. This is also a requirement to think about stopping:

GP1 L453 "I always said that I would stop smoking when I lost that rush... "

Once the initial excitement of smoking wears off for some it soon becomes a habit indicating that its' utility changes over time:

GP1 L101-104 "to be honest it's a pastime. It's a thing to do when you're waiting for something or I think the best way to not smoke is to remain active constantly. If you are waiting for something or if I'm drinking then I will smoke but I don't know if it really adds anything"

It is the enjoyment factor that prevents thoughts of stopping:

SP5 L329 "I don't want to (stop). I enjoy the cigarettes I have"

However, the loss of this enjoyment would be a driver to stop:

SP8 L459-460 "... it would have to be a personal decision. I think I would have to get bored with it and to think I'm not enjoying this anymore"

This sensory and emotional response is matched by a cognitive awareness of the habit:

GP4 L162-164 "... you don't always enjoy them, you might be halfway through and you think 'well, why did I light that one?'"

However, this awareness does not necessarily result in extinguishing this cigarette:

GP4 L168 "... I might as well smoke it because it's lit – I only enjoy about 40% of the ones I smoke"

2. Perceived likelihood of success

As well as identifying a valid reason to stop, as has been discussed in the previous sections, perceptions also vary between participants of the likelihood of them stopping to smoke successfully. The initial sense is of the reality of stopping being difficult:

SP10 L232-233 "Of course in the first few months it would be difficult but later it will be great"

This view may also be tempered by the effect of the social group in terms of the effect a social grouping may have on any thoughts towards stopping. For example, in a group of friends where the majority smoke, this is described as a 'vicious circle'; the social group itself encourages everyone to continue and it is seen that just one person is required to attempt to stop in order to break this 'vicious circle':

GP1 L141-143 "I suppose it depends on who, sort of, breaks first and puts their hand up and says 'actually I don't want to smoke'. But perhaps maybe in a few years time"

Conflict between the intellectual understanding of the possibility of stopping and the reality of stopping is also raised:

GP3 L467-468 "...people do give up and they don't die... the other part of me says its going to be difficult... so then I put a wall up..."

However, a participant who does not know anyone who has just stopped smoking removes the possibility for social comparison for success and consequently adds to the perception that it may be more difficult to stop in theory than in reality.

Previous attempts at cessation and how the outcomes of these attempts are rationalised are also important:

SP9 L222-226 "... it was quite difficult. I didn't really have an understanding of the mechanisms of addiction... it was not really knowing what to do or how to control or how to manage your feelings around addiction, that was a struggle"

This sense of addiction is seen as being psychological rather than physiological:

SP9 L235	*"I think it was more psychological than physical"*

Previous experience of stopping has led some to realise that for them it is easy to stop;

SP4 L261-262	*"I just kind of made a conscious decision and I just didn't buy any tobacco"*
SP5 L316-318	*"I know that if I want to stop tomorrow I could... because I've done it already"*

However, for them automatic responses contributed to starting again while there is a mixed response to the sense of enjoyment either experienced or expected:

SP4 L 256-257	*"... I had a couple of drags on somebody else's. In fact once I had had that I didn't enjoy it very much, I found that it tasted a little bit disgusting"*

In comparison, others display a feeling of helplessness when it comes to stopping:

SP2 L6	*"... I've never really seen any routes for me to stop"*
SP7 L139	*"I did try many times but I just can't"*
SP10 L49-50	*"Just finish like that I thought it would be easy, like drinking, just like that, finish, but now it's not so easy actually"*

This final quote compares trying to stop this behaviour with other behaviour changes but realisation that it is not the same; smoking cessation is seen as more insurmountable.

In order to cope with the expectation of difficulty in stopping described in the previous section some men consciously keep the timeline of their potential for stopping more short term and use the addictive side as a reason to prevaricate the decision:

SP9 L356-366	*"I think it's very difficult to really, around the addictions, to think long-term so I don't put those conditions on me"*

For others stopping is not even considered an option for them; there is always a reason to continue:

SP10 L15-16 "...I think I'm going to finish but I never finish... more problems come and it's always cigarettes... I'm hooked"

Once more, the nicotine addiction is seen to take control of someone's behaviour. For others, there is seen to be a general pattern and trigger points smokers follow before deciding to stop:

SP6 L591-592 "...when someone gets to a certain point of a certain age they start looking after their teeth and health in general"

SP7 L164-165 "... maybe in a year or two – it is bad for health"

However, it is unclear when this time to stop will come; the timescale is unclear:

SP6 L593 "... I'll have that moment but I can't see what or when that will be"

In comparison to stopping 'forever', another approach is seen as accepting that there is no point in never smoking again; instead, the strategy is to reduce consumption from regular smoking to intermittent smoking. This approach is seen as a more manageable concept in which to reduce smoking habit:

SP4 L339 "I can't see a permanent stopping"

SP9 L365 "well it's unrealistic to say I'm never going to smoke again... to kind of apply a condition on oneself is a bit unrealistic"

Even this change in behaviour is located in the future and related to specific situations:

SP4 L 338-339 "I feel that I will probably still smoke from time to time like if I went out or something"

In comparison to the dichotomy of either complete cessation or a reduction in smoking, for others there is only one way that they can ever see themselves stopping which is a definitive end to smoking:

SP8 L125-126 "Anything is possible. Certainly I shall die one day and that will put paid to it. No, I think it's unlikely in the foreseeable future, I've got no plans to stop"

For this participant (aged 38 years) there is a clear decision expressed; he has no intention to stop smoking.

The process of cessation is open to many interpretations. An understanding that stopping may be difficult which is not based on any first hand knowledge of trying to stop smoking could result in an unrealistic expectation or fear of stopping. For some, where there is a perceived reduction of willpower with age, this combination also contributes to the prevarication of making a quit attempt.

When compared to others it would appear that almost everyone thinks they will stop at some point although this time can always be moved to a later and later age. Rationalising decision making to stop smoking is important because people have changing desires over time and because these are not consistent and they may result in a constantly moving timeline. This again highlights how smoking, and stopping smoking, is an individual journey.

This shifting timeline also helps people not confront the difficulty they may find in stopping and as such continuance of the behaviour is a defensive mechanism to avoid possible failure. Whether this is due to the behaviour, the level of addiction or other reasons is difficult to ascertain.

While stopping may or may not be difficult it is seen as an ideal opportunity to get rid of two habits:

> *SP3 L779-782 "Yeah. If I was to find myself in that situation and I was giving up cannabis I would try and give up cigarettes (a) because it's beneficial to my health (b) because it's cheaper and (c) because it'd be a lot easier to stay away from smoking weed if I quit cigarettes as well".*

Compared to other drugs, with cannabis and tobacco the person feels in more control of the dose and therefore the consequences of actions:

> *SP3 L831-833 "Yes and cannabis is the same. If you smoke it you can literally look at it and go 'oh that's two third's left' and I've had enough so I'm not going to finish it. I'm going to save this for later. Yes, control, control over your consumption"*

In comparison, smoking cannabis is also seen as a barrier to stopping – some do not want to stop smoking this substance but they realise that despite reducing the amount of cigarettes smoked it maintains the nicotine habit. This is also made worse when drinking, just as alcohol affects the numbers of cigarettes smoked:

> *SP3 L475-476 "But because the habit is still there if I'm pissed and I have packet of 20 I can go through them in the evening"*

This recognises the ease to increase back to, and sometimes higher, levels of smoking experienced before they had cut down.

When health issues are discussed, for some drinking is seen as more of a problem because of side effects of drinking rather than longer term health effects normally associated with smoking. These are normally conceptualised as short term and are more immediate in comparison to the long-term effects of smoking:

SP10 L263-267 "drinking is more easy to stop because your body is kicking you... sometimes you just cannot drink... but smoking is like it's not harming you too much like alcohol so I can smoke"

External circumstances also influence the way a smoker rationalises their decision to continue with the behaviour, especially employment. These extrinsic factors tend to exert pressure on other aspects of life and either have the effect of creating reasons to continue or reasons not to try to discontinue the behaviour due to limited alternatives.

Cigarette use may be affected by employment status and is seen as a way to rationalise smoking levels; reflecting on past behaviour when he was working, being occupied, helped to reduce consumption; when employed the rate was about 5-10 per day compared to 20-30 in more recent times when not employed (SP1). This is also affected by the place of work:

SP4 L 184-185 "I actually smoke less when I am working because, I mean it is a market stall and recent laws apply"

Alternatively the type of work may have the opposite effect:

GP4 L145 "I work in hospitality so that's another, loads of people in hospitality smoke"

The place of smoking, e.g. workplace as opposed to the home, affects the perception of the reason to smoke; it is seen as enjoyable at home rather than a necessity, despite the freedom to smoke working outdoors:

SP4 L187-189 "I would be allowed to smoke at any point if I wanted to but I try not to smoke as much at work just because I enjoy it more when I get home'

This perception helps to aid control of the behaviour; it leads to self-regulation of the number smoked, as do barriers that exist and prevent smoking at work. Whether these strategies are self-imposed or imposed on them they help to control their habit:

SP4 L198-200 "I go out to the front of the stall, any open air bit, because our stall extends right out to the back and it's basically separated by T shirts and shoe shops"

SP9 L15-18 "... what I tend to do is leave my cigarettes at home... it doesn't stop me from wanting them in the day but I try and keep it under control"

For another participant (SP1) this was also the case when working outside where it was possible to smoke at any given opportunity; boredom is an issue when circumstances change so markedly. Such variables affecting smoking rates draw questions over the reason to smoke, whether it is addiction or behavioural:

GP1 L410-417 "... if I am busy then I probably won't smoke as much because there's no need and I don't have time. If I am working on the other hand, ...it gives me a reason to procrastinate even more... having a cigarette break this is completely acceptable, ironically"

As well as an excuse for a break in the working day this is also a way of procrastinating what he perceives as unpleasant tasks, work, and it legitimises inactivity; an analogy is made with a more healthy leisure activity which has the same effect:

GP1 L428-429 "... it clears your mind, it's basically like running. It gives you time to think,, to think things through and to dream... "

GP6 L232-233 "... it helps you get things in your head sorted out... once you've got it sorted out in your own head you're alright... "

Smoking is seen as an opportunity for escapism from a busy lifestyle, whether it is work or clubbing:

GP4 L220-221 "...your life was just never ending, there was no time for yourself... like quality time, enjoying your own time"

This is even the case when other co-workers smoked; the fact they were busy reduced the impact of social influence to smoke and the effect caused by this socialising was actually a facilitator to not smoking; just socialising with co-workers was enough not to require the cigarette.

In other cases, where smoking is used as a form of relaxation, other work colleagues can impact on cigarette consumption where the social norm is to take breaks together and where it is seen as a way of building a team relationship, increasing social cohesion:

SP2 L563 "...actually it is kind of important because everyone would go out for a cigarette break at the same time"

GP4 L209 "At work it's a chance to catch up, who's doing what and why, gossip"

Just as a habit of smoking is often begun in earlier years so this behaviour becomes an habitual event during work hours:

GP5 L425-426 'That link carried on through jobs, people used smoking as a social thing, just carried on from there really"

There is also the power of suggestion:

GP4 L149-151 "...even though you don't always necessarily enjoy it, but you would still sort of smoke because 'oh, they are lighting up so I'm lighting up'"

GP5 L424 "At work I latched onto the fact that people smoked to get away from work and they socialised"

In comparison, for others this is not the case, just as in the example above of smoking while working:

SP4 L 213-215 "...one of my main friends (at work)... if he goes off for a cigarette I don't necessarily go because I don't always feel like I want one"

In this last quote there is a sense of choice being possible rather than a need to conform to norms. Although there is no obvious effect of having a variable quantity of cigarettes (in normal circumstances), allowing the smoker the choice to take it or leave it, it is recognised by others that in times of stress at work the automatic response is to reach for a cigarette as a coping strategy. This is also conflated with the effect of socialising so that the physical effect, which is affected by nicotine, is perceived as being due to stress, is dealt with. This illustrates the psychological effect cognitions have on behaviour:

SP2 L59 "It's either stress or a very social thing to do"

GP3 L252-253 "If I was very stressed I would definitely smoke more than when I'm not... there's definitely a pattern there"

GP7 L386 "when I'm feeling stressed I'll definitely smoke more"

GP4 L144 "...an excuse to get out and have a little break, to get away from the hassle"

However, even in stressful situations there is an element of self-control involved:

SP4 L 224-227 "...I wouldn't normally smoke because I'm stressed... I wouldn't use that as an excuse"

This self-control seems to be more manageable during working hours leading to the physical need for tobacco being weaker than at other times:

SP4 L232-233 "I mean I spend about 10 hours a day on the stall, with no proper break... but I am quite happy not to smoke for that period"

What does become apparent is that for some the utility of a cigarette changes. Although a coping mechanism, whether smoked in negative times (stress) or positive times (happy) the utility of the cigarette is seen differently; a behavioural explanation for stress, an addictive explanation when the person is happy:

GP3 L289-290 "... if I am not stressed I'll still smoke but I won't feel the need for it. I think it's more the nicotine craving when I'm not stressed"

GP6 L138-139 "... like you are stressed out, pissed off or whatever you describe it like, you can just have a fag and it calms you down a bit"

GP7 L578-579 "I'll normally smoke for pleasure... but if I'm pissed off with anyone I'd also smoke then"

For some, important influences on the decision to either continue or to stop smoking are related to one's personal relationships, although this external locus of control could be a way to displace responsibility for one's smoking:

SP5 L376 "I think if my wife was to quit for good I would quit. I think that would be a good reason"

GP7 L171 "... I might try to give it up for them... I wouldn't stop if it wasn't for them"

As well as this modelling, if a partner were to encourage someone to stop this would be seen as appropriate, is actually expected and, for some, experienced:

SP7 L286 "... they should actually say something (to stop smoking) yes it would be fine for them to do that"

GP3 L331-332 "... he doesn't like the fact that I smoke and that's kind of making me feel that maybe I should give up"

However, this may again help to take responsibility away from them for making this decision and being forced into taking action, introducing the concept of whether the person has an internal or external locus of control.

The effect of a partner is also a factor when considering health issues, especially when they raise these issues:

SP6 L141-143 "... when it comes to the health thing she'd like me to do so and so because when there's someone else in your life... health and etc becomes more important... "

It would have to be perceived as a serious relationship, especially for someone who is looking for 'definites' in life, a sense of future:

GP7 L183-184 "... if I cared for them enough and I though the relationship would go somewhere...but you never know"

In comparison, for a participant who had identified starting to smoke upon entering his first relationship, embarking on a new relationship can also be a spur to stop smoking:

GP3 L361-362 "... he didn't like that I smoked and so I said 'right, I'll give up' and I actually managed to give up for 3 months but then I started again"

The trigger to start again was boredom, but it did not mean the end of the relationship:

GP3 L366-367"... I was getting to know him a bit more... although we were together for 7 years"

This position indicates that some men are heavily influenced by others' opinions, the power of which change, and can be dependent on the stage of the relationship and how confident the smoker feels within that relationship; positions on smoking can change in an established relationship, once the initial contact and the relationship has developed.

For others health issues may not have the desired effect their smoking with a partner who has had a relative affected by a smoking related disease:

GP6 L 328-333 "T've been with somebody who's mum died of cancer right... he's dead against it... but I didn't indulge him because I thought there's not a lot I can do about that really mate... we've all got our flaws and this is mine"

Overall, it is evident that health is just one of many aspects that have to be in place before thinking about quitting and the situation is summed up succinctly in the following extracts:

GP3 L341-343"... a multitude of reasons that seem to be setting me up to take advantage of some psychological window where I would be able to give up smoking"

GP3 L398-399"... sometimes the importance of those factors might change, health may be more important than money and then the other way around"

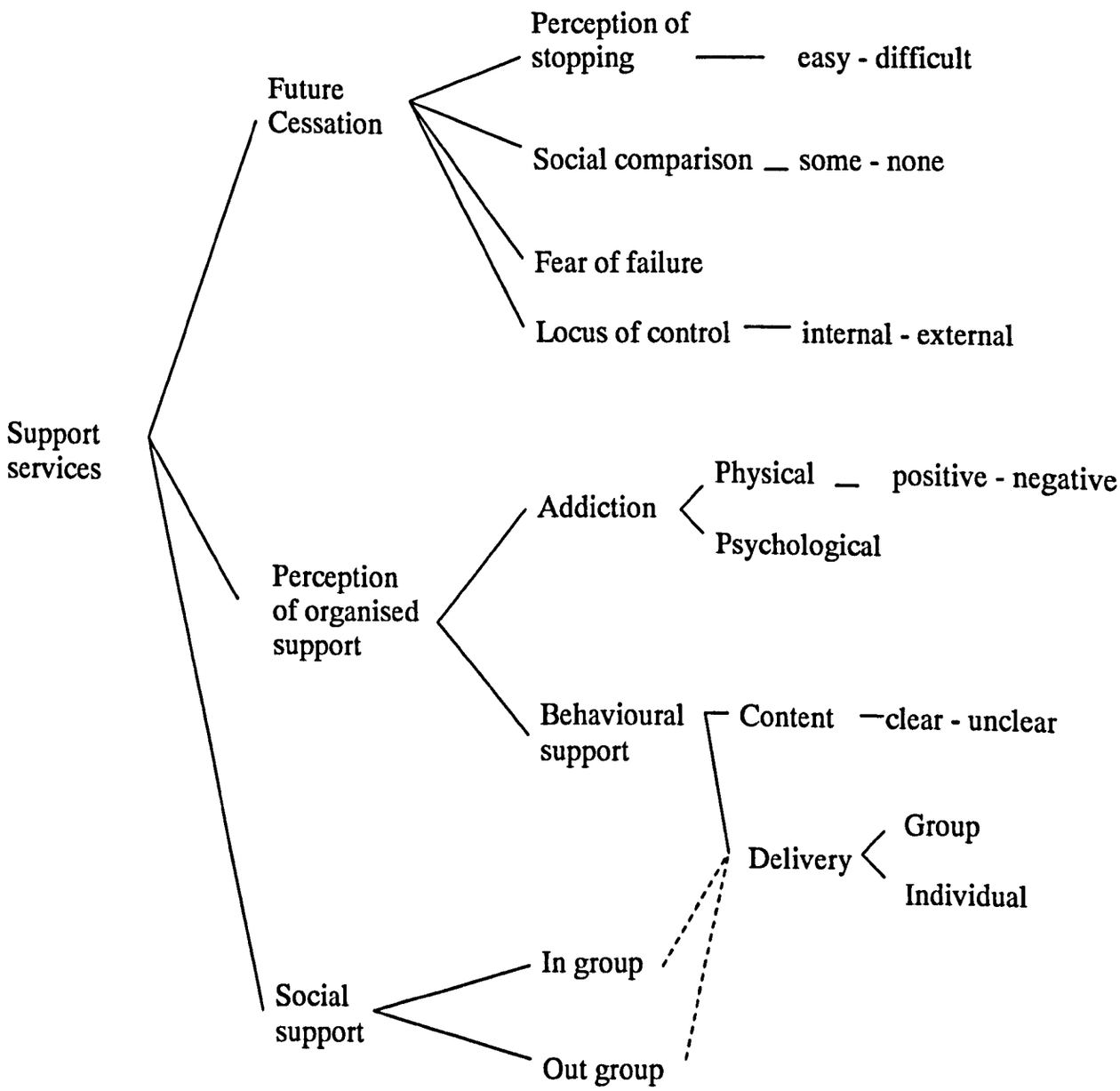
The sense of an awareness of prevarication over stopping is palpable:

GP3 L411-412"Maybe that's just a psychological trick not to, you think you're going to but really you're not"

3. Support services

In order to discover why the men did not want to quit, the question of their views on not only stopping in the future but also the help available to stop was sought. This led to a construct of the future for the participants. Overall, awareness of support services offered, predominantly cited in the data as being provided by the NHS, is high as is the realisation that it may be difficult for them to achieve a non-smoking status by themselves.
The main categories to emerge can be seen in the following diagram.

Diagram 3.1.2.3 Support services and its subcategories



a. Future cessation. As has been discussed stopping for most is an unknown quantity as they have not tried to stop before and/or have no social comparison available, the views they hold could be self-handicapping and put someone off trying a quit attempt. This possibility illustrates that there may be a need for the person to be more realistic when thinking of the process of quitting as it could lead to catastrophising the experience of stopping:

SP1 L849 "It'd be excruciating"

This perception could affect any future attempt at quitting. It is conceivable that given the many other barriers which have been proposed by the smokers to explain either not trying to stop or the prevarication of the time when they might try, this unrealistic expectation may be enough for them to not try at all. There does appear to be a more positive reaction to the possibility of stopping from those who know others who have stopped. This opportunity for social comparison can give a realistic idea of whether or not they will be able to stop:

GP3 L350-351 "My dad attempted to give up smoking 3 or 4 times and he did eventually do it"

GP4 L293-294 "My mum gave up after smoking for 40 years, cold turkey, she just gave up one day as if she'd never touched them"

In comparison, others have a simplified unrealistic impression and think it would be easy to stop, even though there is either no prior experience of trying to quit or just previous short-term experiences of not smoking:

SP2 L150-151 "I don't think it'd be that difficult for me personally. I mean, got up today and haven't had a cigarette yet and I'm not thinking about it"

SP5 L432-434 "I don't think I would need any help to be honest with you. I think I got willpower enough to say 'Right, tomorrow I'm stopping" and not to pick up another one"

SP8 L465-466 "... I spend a lot of time doing things and then suddenly decided it's not important and stop doing them, so smoking could be one of them"

Not only do these experiences indicate a degree of impulsiveness on performing a quit attempt but the themes of basing stopping on one short experience and willpower are perhaps a naïve approach, and not necessarily realistic bases for future attempts, may adhere to the male idea of 'just doing it':

SP5 L438 "I suppose when you get down to it you just have to say no"

SP6 L604-606 "I think I would just make that decision (to stop) and say 'No more'. I have to deal with absolutes... "

SP7 L443 "... I just want to do it on my own"

This willpower is thought to be enough despite the experience of not successfully quitting in the past:

SP6 L610-612 "I've kind of had half-arsed attempts before, I think for a week... but I don't think I've ever really put myself into it – I suppose it's the male control freak thing"

Despite knowledge about the difficulty of stopping, support seeking for some is still seen as a second option because:

GP2 L668-670 "... I've done it on my own in the past I'd like to think I can do it again and so I will try and do that for myself and then I would admit a small defeat if I couldn't"

This emphasises the masculine perspective of stopping as being a battle between the 'self'

and the 'other' to gain mastery, a sense of pride:

GP5 L362-364 "Because I've given up in the past... I just think that I will rely on my ability to give up but what I cannot rely on is my ability to stay off"

GP7 L593 "I should be ok. I mean last time I stopped I found it easy but I started again because I missed it"

There is a sense that men have to be in control and not seek help. It is also evident that effort has been lacking in the past; they are not 100% behind the idea of stopping itself. Despite acknowledged past failures some still want to try to achieve success on their own, although they do not seem to address what they would do to stop smoking again. However, there is a tacit acceptance that they may eventually require additional support:

GP7 L609 "Yeah, if I needed it I would definitely ask for it (support)"

b. Perception of Organised Support. While acceptance of support, including medication, is affected by previous experiences and perception of the quit attempt, for some, although having stopped successfully alone on previous occasions, this perception of stopping also changes over time. This acceptance is borne out of a realisation that the behaviour and addiction are now more embedded with the expectation that that the next attempt to stop will be harder:

GP2 L614 "...yeah it's only been about 3 years (since the last attempt) but it all adds up doesn't it?"

A difficult previous attempt also makes it more likely to use a service:

GP6 L485-510 "I thought 'right, that's it' and after a day I could have died but that's just because I knew I wasn't going to have anymore so I could have cried... if I was trying to stop, I'd want help, definitely"

Although it is recognised that the level or intensity of addiction changes the control over the behaviour due to the length of time as a smoker some still feel in overall control of the habit and that stopping would not be a problem:

SP4 L573-576 "... if I would do it I would probably do it cold turkey. I don't like the idea of patches or anything of the nicotine products because If I'm going to pump my body full of nicotine I'd rather be enjoying it"

SP8 L490-491 "I tried that Nicorette chewing gum, I had to have a fag to get rid of the taste"

For these participants the aesthetic of the medication, in these cases nicotine replacement therapies (NRT) is seen as a barrier that encourages them not to use it. This is also influenced by others' opinions:

SP4 L 600-601 "I know somebody... and he was using an inhalator thing and it was disgusting. It was really horrible, I had a little bit"

In comparison, NRTs are seen as a weak replacement and the person feels that it would just be delaying the inevitable:

SP9 L419 "I just think that's (NRT) extending the denial; it's a bit like methadone, you know substitution. You either stop or you don't"

However, the utility of using NRT products acknowledges the degree of addiction and the concurrent lack of control a person has over it. This is seen as impacting on the

overall outcome of the quitting attempt:

SP4 L578-581 "... it's almost like you have made a decision that you are addicted... I would like to think that I could make a conscious decision to stop. I think it would be a lot easier that way"

SP8 L496-498 "If you want to stop you can. If you don't really want to and you were doing it because you feel you ought to you're not going to manage it"

For some men this makes stopping a more cognitive, intellectual process rather than just a physical reaction or choice and is recognition of gaining control over the addiction, which in itself is a typical male trait. However, this perspective does not rule out other treatments being used in order to help them to stop, such as hypnotherapy, which are perceived as addressing the habitual aspect of smoking more directly than other nicotine based pharmaceuticals:

SP4 L588-589 "... so if I didn't think (through hypnotherapy) I wanted one after a cup of tea or after a meal I just wouldn't want one in general

In addition pharmacological support offered is also not seen as appropriate to the needs of some:

SP4 L613 "I'd actually rather go and buy some lollipops"

The duality of support offered, i.e. medications and behavioural support, is not clear in the minds of some. There is mixed knowledge of services:

GP2 L647-648 "... there is a lot of help out there... you get free this that and the other like patches and all the rest and so I might"

GP6 L537 "I know I would want support but I don't know what they do, it depends what they are doing"

When discussing their understanding of the support message itself, the medical help offered in terms of drug therapies is understood; however the term 'support' is itself a grey area that in comparison is not easily understood. The implication of this is that 'talking support' or 'behavioural support' is too abstract a concept for the majority in this sample; it needs to be more concrete. Due to this ambiguity or misunderstanding the effect they think any form of 'support' may have is minimised especially when they have no social comparison or reference point of someone who has experienced the support:

SP1 L876-880 "I can't imagine just talking about not smoking... I just can't imagine how just talking to me about stopping smoking will help in a particular way, maybe it would because I have never tried it"

In this case there is an apparent need for reassurance over both the content and the efficacy of this approach; in comparison others have not expended any energy thinking about what support would be about although they have a fair idea of the medications available.

c. Social Support. While responsive to the idea of support there is also an inability for some to verbalise what that support would look like apart from the support of someone close. This concept of support is discussed in the context of others' opinions and the friends who smoke are also seen as not being in favour of the idea of stopping together in a group:

SP2 L604 "I couldn't see that happening with my group of friends. They are all kind of like me you know"

This helps to illustrate the closed nature of some men in terms of what they are prepared to talk about together. In general, there is either an inability or a reluctance to

discuss personal issues openly. Similarly, when the idea of group support is moved away from a social setting of personal friends to one of a group of strangers, negative connotations are attached and they would prefer to try to quit on their own. However, when reflected upon this is seen as more due to personal issues rather than socialising issues such as not being good in social situations with strangers. This is reduced on a certain level by being in ones own 'in' group but everyone else is seen as the 'out' group:

SP2 L620-625 "Erm, just these kind of.. How to describe it, these kinds of social situations. Like going to, I don't know. Just like, ok, for instance, going to a job interview and you're there in a room full of fucking people that you've never met before and they are all chatting away and everything like that. I hate these situations I've got to tell you. I've got my friends, I hang out with my friends and the people that I know"

Doubt is also expressed due to past negative experiences of attending group support. Where stop smoking services have been approached in the past and where the encounter did not work out favourably responsibility for this failure is put on the service. However, this is the opposite stance to the image portrayed by many of the participants for taking control or being in control of their smoking and/or their stopping smoking. This raises the question of whether self-control is situational or behaviour specific.

One strategy employed to try to make sense of their own potential failure is to minimise the effect of foreseen failure by belittling those who do manage to stop smoking:

SP3 L948 "The only people who are successful ex smokers have never really started I'd say"

While this may on the surface appear to be an unrealistic attitude it may help to reinforce a sense of self for not having been a successful quitter either in the past or potentially in the

future. This may be a strategy to minimise or normalise their own failure. In addition, when considering quitting as a dual process (medications and behavioural support) this participant does not want to get support from anyone apart from receiving medication. However it should also be remembered that this is the attitude of someone who does not want to stop at the moment and is a 'happy' smoker. It is however also recognised that this opinion might change if he was ever serious about stopping:

SP3 L974 "I might change my mind if it came to it but right now, no I wouldn't do anything like that (support)"

This could also put off future use of support, as having people who have been smoking for different lengths of time, e.g. 6 years and 30 years, is perceived as having a negative impact:

GP5 L375-376 "... that doesn't work because you are different ends of the spectrum so you kind of think 'I'm not that bad in respect to my habit"

This is used as a way of minimising their own condition. Rather than being an incentive to stop it allows denial to take over once more:

GP5 L 387-388 "... you kind of think that that will never happen to me and I will never be that bad because I will probably stop before I get to that point"

This position is further generalised:

GP6 L410 *"I guess most people will be 'It won't happen to me'"*

As well as these negative points that may influence the decision of attending a group, sexuality is seen also being an issue when deciding to attend a group:

GP3 L511-513"... I'm not very comfortable talking about the personal stuff... that might be because of my background because being gay you learn to cover up the fact that you are gay"

This reluctance could also be due to a need to be in control of the quit attempt and only accessing help when it is required:

GP3 L517 "On my own terms rather than on their (services) terms"

In addition, although not caring what society as a whole thinks about sexuality, in a group situation there is felt to be potential for conflict, which may be a result of his experiences when 'coming out'. This is the only reason stated for gay only groups:

GP3 L612-614"... there wouldn't be any of this 'what is the rest of the group going to think about me if they find out I am gay'"

In comparison gay groups are seen as increasing social barriers; there is a sense that the participants would prefer to be grouped by their smoking behaviour rather than due to their sexual orientation:

GP5 L394-396"I don't think it would be beneficial to be separated just because of one thing in my character. It's like quotas for things like race... positive discrimination does not help"

To the argument that people may feel wary of saying they are gay:

GP5 L 400-401 "I just think it's better to be treated as equals... it shouldn't be that important"

GP6 L542 "It wouldn't bother me to be honest"

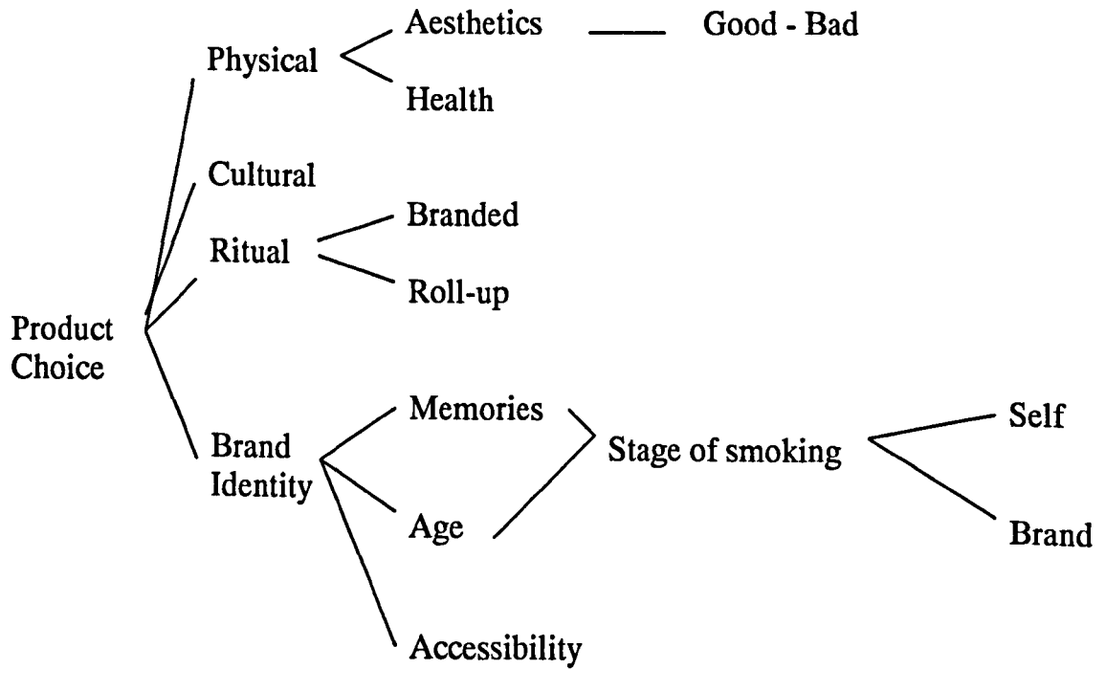
It would appear from these extracts that for most of these men being gay is not an issue for them with regards to stopping or seeking support.

3.2 Identifying and evaluating the extrinsic factors surrounding smoking behaviour

3.2.1 Product Choice

This section deals with factors influencing the choice of the type of cigarette smoked. The main categories can be seen in the following diagram.

Diagram 3.2.1 Product choice and its subcategories



1. Physical

The type of tobacco smoked may be influence by a number of reasons. One reason that emerged is previous cannabis use. For example, the taste for a particular type of rolling tobacco used is maintained when the habit of smoking cannabis is transferred to smoking tobacco alone. It is recognised that despite the difference in flavours and the aesthetic properties of the tobacco smoked, this is still seen as the vehicle to provide the addictive substance. As such the tobacco is seen merely as a utilitarian product.

In comparison, the reasons to smoke pipe tobacco are linked to sensory effects rather than it's utility:

SP5 16	*"I liked the smell of it"*

The sensory effects are also important when choosing between ranges of the same brand of cigarettes, e.g. lights:

SP7 98	*"I can't smoke regular ones, they are a bit harder (on the senses)"*

This is also linked to comparative health knowledge influencing the choice of lights:

SP7 L103	*"yeah lights are better actually... I guess it's because they have less tar"*

This specific knowledge and belief helps to minimise the risk of smoking for this smoker. At other times the effect of the tobacco changes behaviour as in the case of moving from branded cigarettes to roll ups:

SP3 L225 "They produce a much harsher reaction to my throat and my sinuses and they are more expensive"

2. Cultural

For some participants the tobacco smoked can for some be a way of identifying as a certain type of person which may be altered by culture as shown by the following quote of someone who has lived in England and France:

GP1 L23-26	*"In England almost everybody smokes rollies because it's much cheaper. In France unless you're a socialist and you want to hang out in cafes quoting Marx all day then you don't smoke rollies. That's the difference"*

This indicates a form of political identity in France whereas the cost implication in England may imply a class difference. However, it is also recognised by the participant that this has

changed in the UK with increasing costs of smoking, as well as adding to the experience of smoking:

GP1 L41-45 "... because cigarettes have become more and more expensive I guess people further up the social scale ... see rolling as the thing to do... and its more entertaining... part of the ritual... "

This also introduces the idea of the habitual, ritualistic side of smoking behaviour that will now be discussed.

3. Ritual

As well as the aesthetics and cultural aspects influencing product choice, increased tactile and sensory pleasure are additional reasons cited to explain smoking rolling tobacco. This is likened to a ritual:

SP6 L115-117 "Apart from the price, you get double the pleasure from it I suppose because I like rolling as well... I think it has something to do with the whole ritual"

SP8 L99-100 "... the ritual of it, you aren't necessarily conscious of it, but yeah"

However, without this ritual the cigarette would still be enjoyable:

SP9 L112-114 "... if someone gave me a roll up I would still smoke it with as much relish, as long as it wasn't contaminated with any THC (Tetrahydrocannabinol) type stuff"

This also indicates a differentiation between tobacco (nicotine) as an addictive drug compared to psychoactive drugs that are perceived as being more harmful. The effect of nicotine is minimised:

SP10 L305-310"... it's still not harming myself like real drugs... I tried spliffs, skunk, grass, hash. I cannot feel anything... for me it's much more better smoking normal cigarettes"

For this participant there is no differentiation between rolling tobacco and branded cigarettes. In addition, there is also the impact of memory on the enjoyment of smoking with the realisation that this is similar to a parent:

SP6 L117-120 "...I think my dad smokes roll ups as well...I've got a tobacco tin just like him, I think that's got a massive...I think that's got something to do with it. Weird"

4. Brand Identity

The type of tobacco smoked also varies with age and accessibility and allows a remembrance of smoking careers depending on life circumstances. It is evocative, used as a snapshot of time:

SP3 L212-217 "I started off smoking tobacco in spliff's. Then when I started smoking cigarettes it was being given Marlboro lights by friends. Then when I started smoking myself it was buying tobacco for spliff's then rolling my own out of that as well. Then when I went to university and I got a loan it became 10 Mayfair smooth every single day. And then after about a year of that I went back to rollie's"

This indicates that once the choice of tobacco has been made, i.e. rolling or branded, many factors influence tobacco choice including their subjective position in terms of being secondary to other drugs, its accessibility, social influence and finance.

This level of detail about the brands and type of tobacco smoked offer another timeline to someone's smoking career as it defines a period in time. It is evocative for a smoker just as hearing a particular song may be an evocative influence for others. It could also indicate a serial habit that is influenced by finances as well as products chosen by third parties. This is used to rationalise their behaviour:

SP3 L261 "I mean because as you get the taste of something by sharing what you have with friends"

This is one explanation for engendering brand loyalty. The brand of cigarette also has connotations for the image the person is seeking to portray. An example was given in relation to smoking Marlboro Reds:

SP3 L312-315 "To people who are so dismissive of their health and so, you know, un-phased by it, that they'll smoke the harshest and most unpleasant cigarettes"

This portrays some brands as being worse than others with the concept of their effect on health being on a continuum. For this smoker this helps to minimise his own smoking; there are worse things he could smoke. These images are also seen as representing specific sections of the population who may enjoy risk more than others:

SP3 L329-330 "I'm thinking of East London music scenes, for example, and smoking harsh cigarettes or rockers in Camden smoking harder stuff"

These brands also have a financial indicator attached to them that is not necessarily lead by social class:

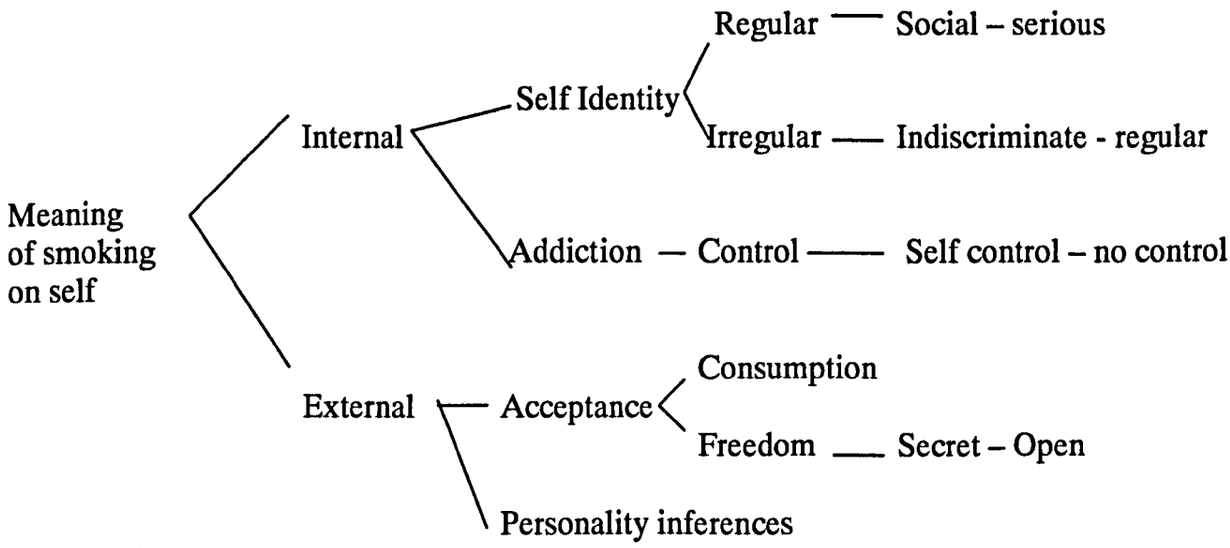
SP3 L337-339 "I mean you've got your cheap brands and their associations undoubtedly are working class in the sense that it's not even poor students buy their Marlboro Lights but things like Richmond's"

There is a hierarchy within tobacco products and even the more expensive brands require perseverance due to some having a harsher taste. This in itself is reminiscent of starting to smoke initially as it normally takes time to get used to the taste of cigarettes.

3.2.2 Meaning of smoking on self

It is important to distinguish between identity and image and their respective effects on someone's smoking. Image can be said to be a conscious, mental representation or construction of an earlier sensory experience. This is not a copy but an 'as if' picture (Reber and Reber, 2001). Identity can be said to be a person's continuous self, an internal, subjective concept of oneself as an individual (Reber and Reber, 2001). In this context image could be said to be an external attribute whereas identity could be seen as an internal attribute. Subtle differences in meaning that emerged from the data can be seen in the following diagram.

Diagram 3.2.2 Meaning of smoking on self and its subcategories



1. Internal

Some smokers differentiate between beginning smoking and having an irregular pattern of smoking with becoming a more serious smoker. This change in self-identity may occur up to a few years later. This indicates 2 distinct periods of a smoking career or smoking identity; smoking irregularly at first then regularly; indiscriminate social smoking compared to regular social smoking, for example 6 per day compared to 20 per day. The volume is dependent on the situation.

Some identify as a social smoker, and minimise the importance of smoking to them. The quantity that engenders this distinction also varies between participants:

SP7 L82	*"I'm just a social smoker"*

SP9 L205-206 "I consider myself a heavy smoker like when I go on holiday and sometimes smoke a whole packet, but normally it's no more than 10 a day"

GP5 L144-146 "...I am a social smoker or a boredom smoker or if I'm stressed...I wouldn't say my natural vocation is to just smoke"

Irrespective of the quantity they may smoke for some smoking is part of their overall identity:

GP4 L468 "I think it's part of me, I think people would find it weird not seeing me smoking"

For others there is no link:

GP6 L296 "I don't think it adds or takes away to be honest...I don't look at others and think that if they smoke or not it is relevant to them"

Identity is also split between 'what I do' and 'who I am' and not necessarily the norm for his gay friends. This helps to differentiate between action and identity:

GP2 L491-497 "Saying it's part of my identity is too strong an emphasis on the idea of me as a smoker...it's very much part of my routine as opposed to it makes up some part of my identity. It doesn't really factor into me as a gay person"

The perception of being addicted to nicotine is important to the sense of identity. Even when smoking 10-15 per day the impression is given of having a relaxed, non-addicted, attitude to its importance in their life:

SP2 L78 "I don't let it bother me if I don't have any cigarettes"

This also introduces the idea of perceived behavioural control as it indicates control over the habit despite the habit being developed. This perceived behavioural control is helped by a lack of aversive cravings for the nicotine that for most smokers lead to withdrawal symptoms that require coping strategies to be employed in order to relieve them and to counter the desire to smoke:

SP2 L83 "I get a little bit of craving every now and again but nothing that I can't ignore"

The implication with this is that there is an unconscious level of decisional control in deciding to smoke another cigarette or not. For others, there is a more pronounced sensation; if kept busy it is possible to ignore the need for a cigarette although this does recur, and it sounds like someone is being attacked:

GP2 L122 "... then it comes back on you about half an hour later"

2. External

The participants experienced different levels of acceptance of their smoking that affects the extent of their smoking. For some, tobacco smoking is a secret. It is also believed that raising the subject of smoking directly with family would result in increasing their consumption of cigarettes:

SP3 L457-459 "... the reason I've never broached it is because I know that would mean I'd either have to quit which I don't want to do or it would become an open subject and I'd end up smoking more"

This could be construed as either a conscious strategy to smoke less or as an unconscious way not to have to confront his behaviour; a form of avoidance. The main thing

arising from this conflict is that whichever the reason, he does not want to quit smoking entirely. To maintain the 'secret' requires a degree of self-control to keep the number of cigarettes smoked to a minimum that are also seen as being at a 'safe' level. There is a sense that smoking is perceived as 'bad' by others otherwise the perception would not be that he should quit.

The importance of self-identity as a smoker is minimal for some and is not a large part of identity. This can be due to the actions of others; for some, whether it is the smoking of a peer group or of family members, smoking becomes the norm. In this situation, once started, parents can become laissez-faire, reducing barriers to smoking:

SP2 L480	*"Once I started they sort of let me get on with it"*

It appears that there is a difference between self-identity and the more objective opinions of other people, leading to a realisation that others may identify someone as a smoker:

SP6 L469	*"It says something instantly about you doesn't it?"*

It is also seen as having an effect on establishing and/or defining relationships. Whether this a positive judgement depends on the person and can be a test of friendship:

SP6 L476	*"I suppose it's a test of our compatibility"*

For a single person it can also be something that they may be willing to change for a potential partner, again indicating an effect of locus of control. This would result in a social construct of intentions leading to action and calls into question the extent to which smoking can be considered a part of someone's identity rather than just something they do:

SP7 L306	*"Yes, it's good for myself. I will definitely stop if they ask me"*

SP8 L467-469 "If I were to find myself in a relationship... who really wanted me to stop smoking then I could see myself stopping for that reason"

This sense that smoking does not have a great impact on identity is also dependent on the amount smoked, indicating that there may be levels of strength of identity. In this context, smoking is not seen as a big part of identity when the person smokes just a few a day resulting in sub-definitions of smoking, similar to those seen earlier with a 'serious' smoker and a 'social' smoker:

SP5 L409 "They (family and friends) would identify me as a smoker but... they don't see me as an habitual smoker"

This is dependent on social norms and the classification within discrete groups of what constitutes 'habitual'; it could be a positive or a negative label as it could result in the smoker misperceiving their level of risk.

The identity of smoking is also influenced by the occupation of the smoker. In this sense, smoking has been stereotyped for certain jobs. However, this is also changing over time:

SP8 L225-228 "I mean I'm sort of an actor of the old school you know, hard drinking, hard smoking, that type, but the young people they are terribly health conscious and you know, they drink mineral water"

This is seen as a comment on their character and personality, similar to reasons for initiation, similar to rebellion or risk taking:

SP8 L232 "yeah, the pusillanimous fuck wads. They're very boring"

When looking at the importance of smoking as a descriptor of someone's identity there are many things that are perceived by the participants as being ranked higher:

SP5 L411-412	*"It comes quite the way down the list of things they would say to describe me"*
SP7 L319	*"Smoking is pretty much last"*

However, this could be a strategy for them to minimise their habit.

Meanwhile it is also considered as a value judgement, a form of social disapproval:

SP7 L238	*"If I stop smoking they will probably think I am better"*
SP7 L243	*"... they see it as dirty"*
SP10 L446	*"... I mean they think 'what an idiot' smoking"*

One strategy to avoid such judgements, to avoid being associated with it, is to try to keep the habit as private as possible:

SP9 L261-265	*"... I don't think it's something that I would wish to be associated with. Certainly it's not something that I think forms part of my identity.*

This strategy helps to overcome such judgement by others and their inner conflict with the habit; hiding it and rejecting any claim to it forming part of their identity. Most do not appear to have a strong self-identity as a smoker and so it is unclear whether this would result in them being more open to others seeing them as a smoker or whether this is an attempt to keep a part of their character a secret, or private.

There is a sense of what smoking implies about a person, and this can have an effect on social and personal relationships that can be either positive or negative:

GP2 160-162 "...when I go to gigs or go clubbing or things like that and the majority of my friends are smokers and it's the non-smokers who are left behind and it feels like all the sad ones are left inside"

Non-smokers being jealous of this perception mirror this sense:

GP4 L502-505 "They (non-smokers) almost get jealous because smokers... always end up in situations where there are lots of people out together and then they all of a sudden are just meeting new people and laughing around"

In a similar way, smokers may have a negative image of non-smokers:

GP4 L506-508 "I do find non-smokers a bit boring because you find again there is something missing... no connection at all"

When looking for a new partner a judgement about that person is also attached by the smoker leading to a paradox: despite being a smoker themselves they see that smoking has a value judgement attached:

GP3 L302-304 "...I actually like the idea of dating somebody who isn't a smoker as it probably means they are a bit more principled"

In a similar way he is concerned about what smoking says about him and the effect this might have on a potential partner:

GP3 L304-306 "...if they don't want to know me because I am a smoker I could be missing out on a nice person for a habit that just costs me a lot of money and is quite annoying actually"

Others have used smoking as a form of choosing a partner and length of relationship:

GP6 L313-317"... they say 'do you have to smoke that' and I'm 'yeah I do'... they don't last very long"

This illustrates the strength of the need for personal choice; this has no effect on him wanting to stop:

GP6 L323 "I'll stop when I want to stop, that's the only way people will do it. I don't want to stop"

The negative value statements of smoking which have been reported are also applied to aspects of a gay lifestyle (for some):

GP3 L311-315"... there's a lot of immorality... there's a lot of sleeping around... and it's quite difficult to find a gay person who's principled in terms of they want a relationship... and they are not going to sleep around if they get the opportunity"

In comparison, non-smokers have more positive qualities:

GP3 L317-320"... they kind of take responsibility for themselves... tend to take more care of themselves and that seems to be superimposed into other aspects of their lives... "

This idea of smokers being less principled is also applied to the general public where it might be seen as a barrier to socialise. Shows the varied effect of smoking on socialising:

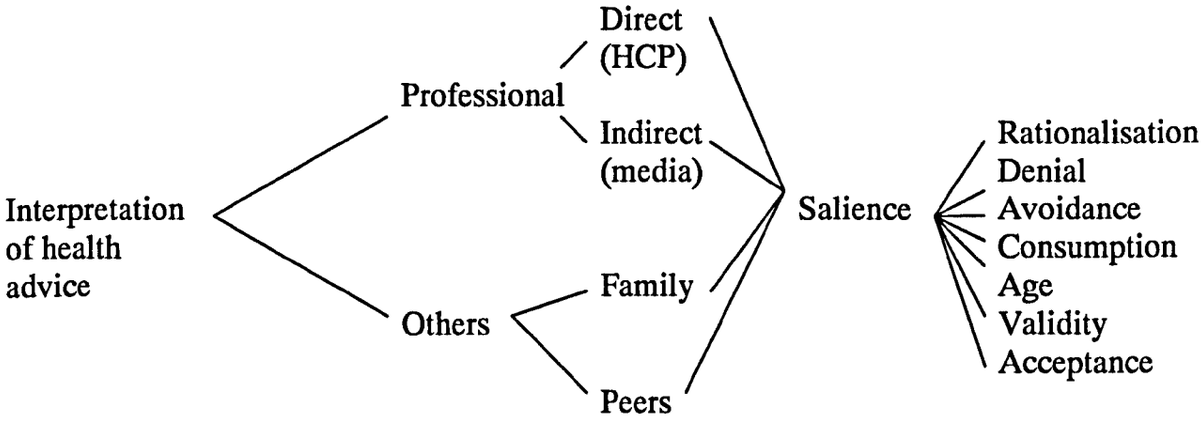
GP7 L338 "...people don't really trust people who smoke"

GP7 L346-347"...at a pub they said they don't normally hang out with smokers because smokers tend to be a bit dodgy"

3.2.3 Interpretation of Health Advice

The effect of health information on someone's smoking has been noted earlier in the section on stopping smoking. However, one aspect for the interpretation of this health advice and its perceived salience is the manner in which this advice is delivered and by whom it is delivered. There are many sources of health-related information and those identified in this study can be seen in the following diagram.

Diagram 3.2.3 Interpretation of health advice and its subcategories



1. Professional

The use of mainstream health services impacts the number of opportunities for relaying the requisite health messages:

SP1 L284	*"... obviously now it's drummed into you left, right and centre so you can't miss it can you?"*

There is a sense of it being conducted with a military style and, despite the frequency, the benefits of being told to stop smoking by healthcare professionals in this manner is disputed by some:

SP2 L136	*"I don't react well to people telling me what to do"*

The implication is that a degree of autonomy or a sense of control is required by this person and so information being presented in a didactic style may not be the best approach for some men.

Similarly, with the frequency of being asked about their smoking status, there is the possibility that the message is diluted and that the healthcare professional may not totally believe the message that they are required to give:

> *SP8 L106-107 "... it's part and parcel of the whole game these days. If you go to see a doctor that's one of the things they tell you because they've got to... "*

This may result in annoyance that his personal choice is not being respected as well as doubt over the actual behaviour of the person giving the information:

> *SP8 L114-116 "I do actually think 'just shut up about it' because it's by rote... I'd rather we just took it as read that I smoke and carry on"*
>
> *SP10 L188 "... but I don't know if all of them are still smoking as well"*

In addition, the validity of asking this question is disputed in terms of the reply given to the professional; when visiting the GP, smoking questions are asked but some lie to the healthcare professional. This is generalised to all smokers:

> *GP4 L395-396 "... I think we all automatically lie about how much we smoke because we're just trying to make ourselves look a little bit better than we actually are"*

The reported figure is acknowledged as being a conservative estimate; any binge nights are ignored and are normally associated with alcohol; this again could be a form of denial, of hiding the behaviour, and psychologically makes him feel better about his habit:

SP3 L656-658 "... giving a high average doesn't necessarily help them understand your health situation any better. And at least this way you feel good about it at the same time even if it's still not accurate"

SP3 L663-666 "there is without a doubt an element of self denial because that's how you carry on with the habit which is incredibly unpleasant and incredibly bad for your health. And we all know that. It doesn't mean it's not worth doing... "

This also indicates an awareness of the negative effects of smoking; the fewer smoked the less impact it is perceived they will have on them.

In addition, the content of the message being conveyed is important. For example, when someone is aware of the health dangers of smoking it is important that messages are not patronising; the implication being that the person delivering the information should aim or tailor their message to the smokers specific level of knowledge or awareness. A participant, paraphrasing his practice nurse, gives an example of a more acceptable 'script':

SP6 L153-155 "... 'We know there's no point in us telling you that you know to give up, like you know it's bad for you and we are not going to preach ... but we have good facilities when you do'. I thought that's a nice attitude to have"

As well as being respectful, this is interpreted by the smoker as a more subtle approach to getting someone to stop:

SP6 L159 "... just letting the seeds sink in"

In comparison, some messages are tailored to be more valid to the person in terms of their occupation and how it would benefit them as can be seen in the following extract aimed at someone in a stereotypical, physically demanding male-specific employment:

SP10 L201-201 "They say to me, 'ok, if you're working outside on a building site it's much more better for your body if you don't smoke'. Typical things"

The requirement to approach the subject in order to make it relevant is also seen as important regarding health advice in schools. One participant remembers such advice as:

SP3 L43 "Drugs information... but none of it was, it was just general problems with it. Suffice to say it didn't stop me starting"

However, while often they are not able to say what would make it more relevant it would appear that for some reason it is not reaching, or seen as valid, to the audience.

Not all of the participants had accessed healthcare services and so had not been exposed to health professional messages. In these instances, secondary sources are important and the effect of wider media messages appear to have been effective for some:

SP7 L135-136 "I've seen adverts in TV though, that's why I thought I would try to cut down (but not quit)"

Just as the importance of the appropriateness of the message with health professionals and in schools, this is also the case with this wider media exposure. For example, a participant compares two advertising campaigns:

SP6 L171-172 "... there's a lot of scare ones where they drain a vein... the fishhook one got me ... that got me because ... I like to think I'm in control... "

However, while remembering this imagery, this feeling of being in control of the behaviour, whether continuing to smoke or stopping, does not necessarily extend to taking control of

their health:

SP6 L 217-219 "... when it comes to health it isn't the same... that is something that will happen if it happens"

The concept of oneself being a rational and thoughtful being is important to the participants, but it appears that the choice of either ignoring the message or denying the relevance of the message is also important:

GP2 L574-577"... I like to think of myself as relatively literate... when you see a message... it does make you think but you just forget about it within a few seconds... "
GP7 L436-437"It's a good message, I've seen the picture of people on cigarette packs you know with half a lung hanging out but just don't relate to it"

This is despite the acceptance that this course of action may be detrimental:

GP7 443-444 "I block it out and I go 'that won't be me', I just think that's not going to happen to me. Even though it could I pretend that it won't"

However, like many of the previous issues discussed, this behaviour is again rationalised as being due to age:

GP7 L448 "I just think I'm young enough right now that I can continue smoking and quit later on"

For many, there would also be a lack of influence of famous people or role models recommending cessation and is again a function of age:

GP2 L547-550 "I'm a bit old for that... I know all about the risks. I think it's (a celebrity advising to stop smoking) really patronising"

GP5 L449-450 "I'm more self confident in my own decisions. I don't think George Clooney would have any effect on me saying I should quit"

GP7 L409-411 "I didn't really watch that much TV or go to the movies... and the bands I listen to are against smoking"

One participant also suggested the use of celebrity or famous people to encourage smokers to quit:

SP2 L650 "... like, get Gordon Brown (Prime Minister when interview took place 2010) to endorse cigarettes and maybe people will stop"

A more intimate persuader, being able to identify with 'someone like me' may have an effect and offer encouragement to question and reflect on behaviour:

GP2 L551-553 "If all my friends... were to quit smoking that would make me think 'okay, I'm the same age as them, we lead the same lifestyle' it might make me reflect on it a bit... "

2. Others

Whatever the source of information, whether this is via a health professional, parents, peers or media, the result may still be denial and avoidance of the message and the effect of smoking on health. This is also affected by the behaviour of the person giving the message; for example, the following participant reflected on the mixed messages sent by parents who emphasised the effects of smoking on health yet continued to smoke themselves. As one becomes older and more independent this approach loses its salience.

Avoidance strategies are also illustrated by reference to the behaviour of a third party as well as the smoker themselves:

SP1 L289	*"Well yeah it's funny, my girlfriend, because obviously on packs of tobacco now they have the image don't they, and she cuts them off"*
SP2 L99	*"I know a few people that just put black tape and put it over the pictures"*
SP2 L94	*"I know all the health things, they put it on the packs now. Now they got pictures as well"*

These strategies may reduce the effect of the message by denial of the impact of smoking on themselves, although the action could indicate that the message is uncomfortable and so to some degree is being assimilated by the viewer. However, this course of action requires less energy than cognitively processing it and then changing one's behaviour. Added to this, the participant relaying this example does not identify as the target audience at this moment in time:

SP2 L89	*"Well, I mean, right now I don't really want to quit. It hasn't got anything wrong with it for me"*

The risk to self is also deflected to those who smoke higher numbers than this particular smoker that gives the impression that his sense of risk susceptibility is lower in comparison to others:

SP2 L126	*"I think those (messages) are aimed more at the people that smoke like 20 to 40 per day"*

An added problem that health messages face in their reception is where they sit in relation to the persons' experiences. For example, having knowledge of someone who has

been physically affected as a result of smoking can also be rationalised and/or ignored as not being relevant:

SP5 L353-354 "...my uncle died from lung cancer. I do know the effects of it and my relative died from lung cancer but he smoked like a chimney"

SP6 L319-321 "...my nan... she smokes like a chimney... and she is my only surviving grandparent she's about 80"

GP4 L342-344 "... a lot of people... they've done it for years, and they've lived until 90 or almost 100 so I don't see why"

In the former example the outcome is minimised because he smokes less than this relative, whereas the latter example is discounted because she is still alive and this introduces a fatalistic element to smoking and common heuristic is applied.

Similarly, although aware of media campaigns against smoking there is also the sense that someone needs to have first hand experience of a health effect before making a choice to stop smoking:

GP5 L114-116 "I think that me and a lot of the population learned from doing it, they learn from their mistakes ... "

Both of these positions detract from the influence of health messages. The risks are cognitively processed and accepted but discounted or avoided as not relevant at this point. For those who have thought about it, any smoking related illness in someone close to them would however make it concrete and have an effect on them:

SP9 L387 "...I would think 'bloody hell, this is not a game'"

Prior to this the person is in denial:

SP9 L395-399 "... it's such a powerful characteristic you can minimise, disguise... rather than actually confronting yourself openly and honestly... I think that's where the difficulty lies"

This approach is easier to operationalise and it is easier to take this route. However, despite this insight and degree of reflection many continue to smoke. In addition, in the previous examples of second and third degree relatives who have survived smoking related illnesses the 'survivor' is given an heroic quality:

SP6 L323-325 "She had a mouth cancer... but she got over that. She had an operation to sort it out. Invincible"

This sense of invincibility also fits into the view that some men have of themselves when it comes to questions of their health. It could also link to the social trait of not blaming someone who recovers from an illness, even when caused due tot their own behaviour.

For others there is also a degree of realism to some of their health beliefs:

SP8 L239-243 "... my aunt... was 63 when she died and she never smoked a day in her life, didn't eat a lot of red meat, didn't go to pubs so there is no passive smoking, barely drank, did all you are supposed to do, got cancer, died at the age of 63"

The strength of this analogy to living an otherwise 'healthy' life is enhanced when comments are made regarding a person who is perceived as being instrumental in introducing the smokefree legislation:

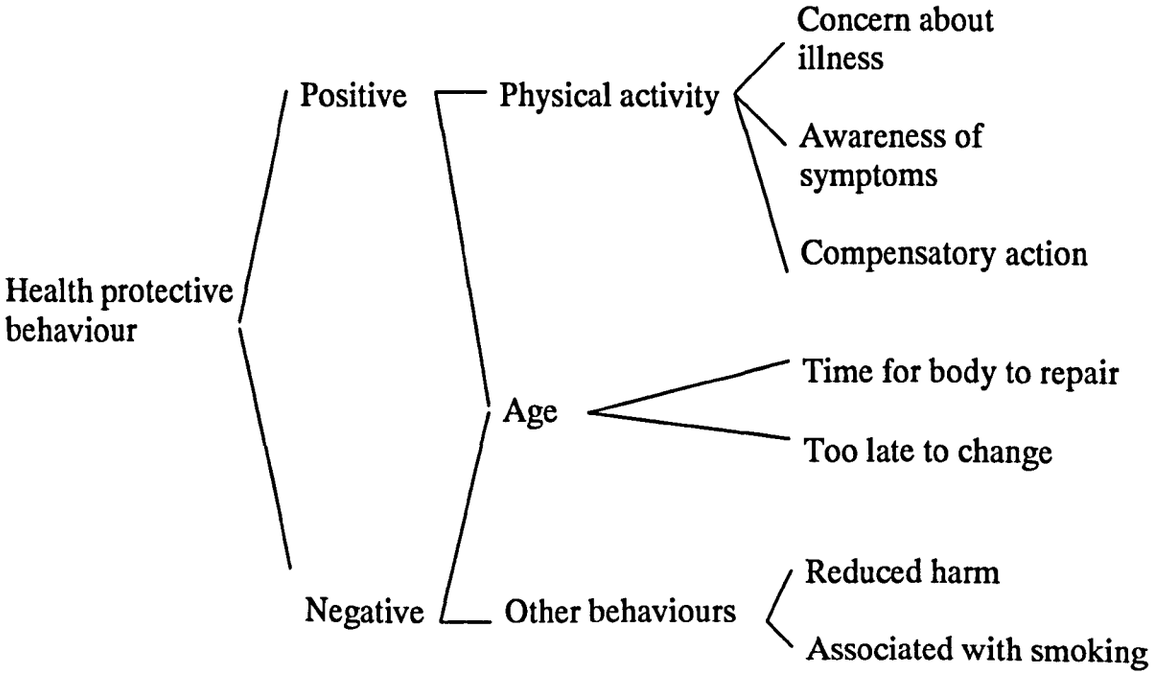
SP8 L407-408 "... a fanatical anti-smoker and long distance runner who died... at the age of 63 of a heart attack. There is a God"

This view helps make justify his own, less healthy, behaviour as well as expressing frustration at external factors which have impinged on his way of life and which are out of his control.

3.2.4 Health protective behaviour

As well as either seeking advice or being given advice another aspect to consider is the subjectivity of risk-taking with the uptake or initiation of health protective behaviour, summarised in the following diagram.

Diagram 3.2.4 Health protective behaviour and its subcategories



1. Positive behaviour

For some participants an early interest in physical activity was expressed as contributing to delaying the onset of smoking but not precluding it. However, despite starting to smoke later than some, for example age 18 years, and continuing to engage in a degree of physical activity, physical health changes are nonetheless noticed over time. Although these changes in personal health are identified as being due to smoking their effects are mitigated by most of the participants and are rationalised in terms of their severity:

SP1 L342 "... it's not bad enough to seriously think about stopping"

There is an awareness of day-to-day functioning not changing although one idea for this is due to him not pushing himself physically, contradicting his own belief:

GP2 L379-382"... I'm quite a fit person generally and I haven't noticed any real differences... I don't jump about and play sports... where I probably would have been able to notice that it was hitting me quite harder"

Others also engage in health protective behaviour such as exercise e.g. cycling, as part of their wider lifestyle. In these instances although sometimes a symptom such as a cough is noticed and cognitively explained by smoking, it is discounted as a mild health issue. This prompts the question for them that maybe they should stop smoking. However this is not acted upon as a matter of urgency but is minimised as being partially due to the physical activity they are engaged in:

SP2 L292-293 "It's kind of always been that way. If I run for a really long time, then I might be a bit wheezy or I have a cough for a couple of minutes, that's it you know"

However this effect is not seen to affect their physical performance and the activity is seen to cancel out other unhealthy behaviour, such as drinking, as well as the smoking.

For others, the physical manifestations are noticed and it is enough to start thinking about making a change:

SP7 L194-195 "... when I play cricket and badminton I noticed that I lose a lot of my of stamina, I cannot play too much time, probably because smoking"

GP4 L361-362"... if you start getting out of breath and can't actually do much exercise then you will probably start thinking 'Okay, well something is causing it'"

SP9 L29-31 "I do a lot of running and cycling and what I tend to find is if I have been smoking quite a few there is a noticeable difference, even if I don't smoke the day before... "

For these participants, these signs and symptoms are seen to be affected by the level of smoking and may consequently lead to changing their behaviour and cutting down the number of cigarettes smoked.

Physical activity is also recognised as being engaged in while in the workplace, rather than being limited to planned sport per se:

SP4 L 452-454 "I would count 10 hours a day on my feet as exercise because there's lots of running around, heavy lifting... "

GP3 L482 "...I tend to get a lot of exercise in my job... it's quite physical"

Such positive behaviour is seen as justification for continuing to smoke:

SP4 L456-457 "...they kind of balance themselves out.

GP4 L345-346 "I am trying to keep fit in other ways like running and cycling so trying to keep some sort of balance"

SP9 L255-257 "I don't drink, I don't do drugs... so I think 'well I've got to do something'. I'm not into shopping, I'm not into gambling. Things are quite balance... "

Perceived balance in other aspects of life are seen as allowing something unhealthy, as a reward for good behaviour:

GP4 L368 "you have a bit of a treat at the end of it if you like"

GP7 L472-473 "I suppose if I quit smoking I'd be really healthy, but I guess overall my lifestyle is pretty boring, not very risky"

This is generalised and comparison is made to others:

GP2 L401-402"...I just maintain a general level of ill-health – yeah get the flu and stuff, generally a bit unhealthy"

For these people the effects that smoking may have had on their physical activity was not considered when they started to smoke.

Whether participants acknowledge smoking as 'risky behaviour', when other risky behaviours are engaged in they are contextualised in terms of perceived danger:

GP2 L468-470"...you know a bit of cannabis but never to the extent that I have to talk to Frank. I always practice safe sex – no, I'm not risky at all about other things"

This analogy to 'Frank' also acknowledges the existence of other support services.

In a similar way alcohol use is normalised and its effects minimised. This is achieved by making reference to descriptors used by most smokers to identify themselves as either a 'heavy' or 'light' smoker:

GP7 L454-455 "Obviously alcohol but I guess that doesn't count. I mean I'm not like a heavy drinker"

Physical activity and healthy eating are also seen as aspects of a health lifestyle but despite this there is a claim to no general concern for health:

GP2 L484 "...I just basically do what I want and don't really think about it"

GP6 L365-368"...I eat what I want, I'm just lucky that I have a high metabolism...drink when I want...I don't exercise. I mean I walk everywhere but I don't go to a gym or owt like that"

The participants would appear to get on with life and not concern themselves with health until something goes wrong; however in the previous quotes GP2 claims both to not 'really think about it' but in the earlier quotes also claims to practice safe sex and indulge in limited cannabis and raises the idea of a perception of problem behaviours. This could be a source of dissonance. In other quotes there is a perception of risk limitation; other behaviour is seen as being in moderation and so is not thought of as risky:

GP6 L391	*"It's ignorant behaviour but I don't think it's risky, no I don't feel at risk"*
GP6 L415	*"If I knew a lot more maybe I'd think about it but I don't really want to"*

2.Negative

Continuance of smoking is encouraged due to doubts that are raised about the efficacy of the level of health protection expected from changing behaviour. Such reasons include age:

SP10 L370	*"I don't think a body is going to recover from that maybe it is because I am getting old"*

For others there is also a sense that any damage caused by smoking can be undone. This timeline of thinking about health and rationalising behaviour is evidenced in the following statement:

SP6 L254-256 "... after 5 years of a bit of destruction I'm thinking about getting back on track... you assume you will fix at some point... "

As such, health protective behaviour is not seen to be necessary at a younger age.

When put into the perspective of wider lifestyle issues, the perception of smoking has a mixed response. For some it is not the unhealthiest behaviour and is not the biggest priority

for them to change:

SP2 L317-320 "Er, it's probably not the worse thing that you can do, I'm just wondering. Well I don't know, like, alcohol kills how many people every year, you know what I mean. Er, I don't know, out of all the things that I had to stop it'd probably be second or third"
SP3 L540-542 "If I was to take my exercise and health more seriously from the perspective of the only exercise I was ever good at was running and it's very difficult to do that and to keep smoking. So if I was trying to take that more seriously and I was happy enough every time I went for a run I might have reason to smoke less"
SP6 L250-251 "I don't see smoking as my biggest problem... it's more things like eating and my more general lifestyle"

For others, there appears to be a mixed approach to health protective behaviour. Work may be all consuming and has a negative effect on taking part in health protective behaviour in terms of physical activity:

SP5 L389-390 "I don't do a lot of exercise because I'm too busy working and when I get home I'm too knackered to go to a gym"

Other aspects balance this view; alcohol is in moderation while he also eats well:

SP5 L396 "I eat very healthy food, my wife is a good cook and we have a good variety'

This participant, in comparison to many others has been influenced by the presence of his wife from a negative and a positive perspective. It could be hypothesised that without her presence he may revert to stereotypical male behaviour described in the introduction.

There are also ambivalent thoughts towards health protective behaviour; the aim is to

enjoy life:

GP5 L348-351 "I'm like a pendulum, I go from being really health conscious... to eating too much. Smoking too much, drinking too much... "

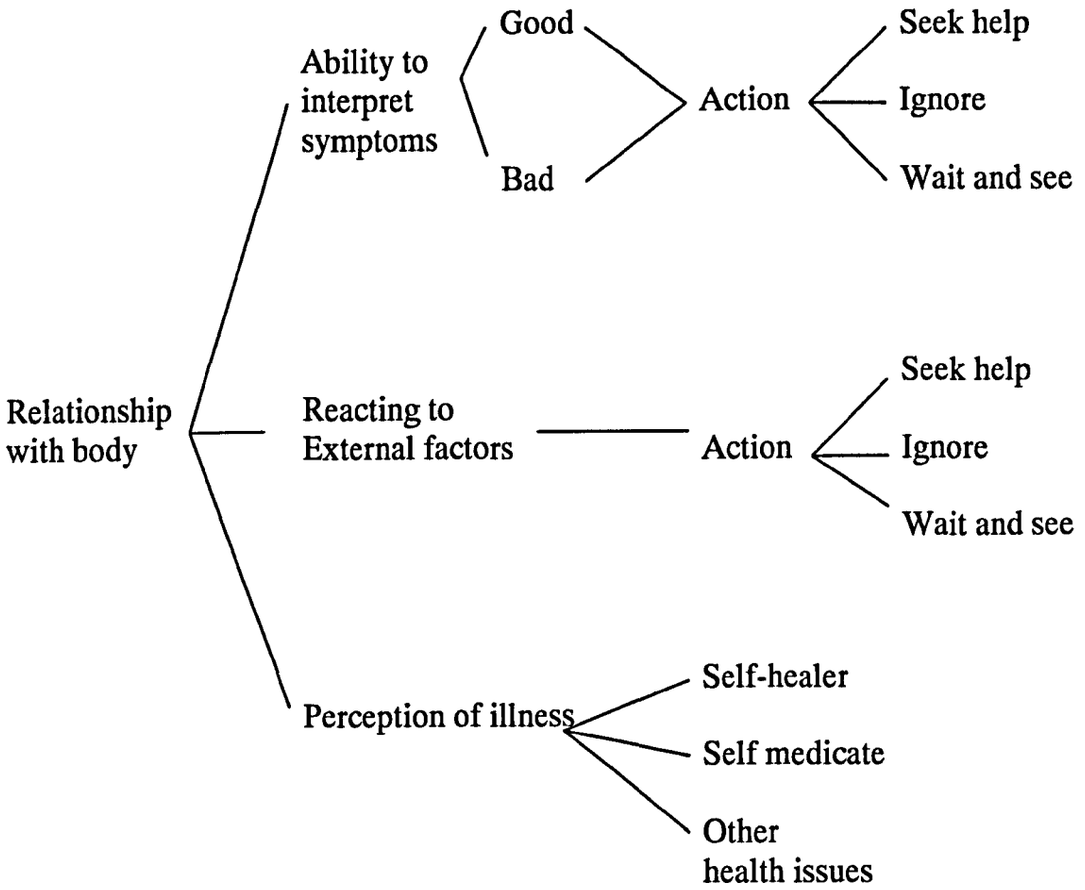
SP8 L331-336 "...I walk if I can. In terms of eating ...I eat very nicely. Whether it's particularly healthy I don't know...I just enjoy life and don't really worry about the health side of things too much"

While not necessarily being hedonistic, this feeds into a fatalistic approach to life that has been evidenced in others' attitudes towards smoking.

3.2.5 Relationship with body

When considering health effects or changes in one's body due to smoking it is also important to understand people's ability to recognise indications and symptoms that should be of concern as well as what action would be taken should they be recognised. When trying to identify these bodily changes there is a different level of recognition that is evidenced in the following diagram.

Diagram 3.2.5 Relationship with body and its subcategories



1. Ability to interpret symptoms

The level of attention to self and body vary for the sample. For some the ability to recognise symptoms encompasses a no-nonsense approach:

SP9 L345 *"I would definitely go to the doctor. It is more consuming to actually sit back and not do anything and worry about it than actually so and sort it out"*
GP7 L205 *"If I think there's an issue I always go to the doctor... why not, they are professionals"*

In comparison, others are not able to read symptoms and are unable to differentiate between potential symptoms of ill-health, or what is a 'good' and a 'bad' health signal:

SP1 L579-581 "I wouldn't know when to think 'oh maybe this is quite bad'. I often wonder when people suffer from throat cancer, I mean, what's the initial, how do you know, I suppose initially. I mean, I don't know"

A lack of knowledge of bodily symptoms to be aware of may immediately be construed as indicating a major illness. This could indicate a level of anxiety about such issues, indicating that personality types vary in relation to any behaviour. As well as physical symptoms this could also indicate an unconscious worry about his own health given the smoking-related health condition chosen to illustrate his point.

It is also acknowledged that a 'wait and see' attitude to seeking a medical consultation is recognised as not the best approach to take:

SP1 L597 "... it (seeking help) would be down the line. Which is a worrying fact isn't it?"

The participant recognises the potential impact and seeks validation and reassurance that this attitude is valid. For others concrete health concerns such as migraines or blood in spit would be recognised as a reason to seek immediate medical attention. Awareness that he knows his own body and recognises subtle changes would mean that he would not put off visiting a doctor. However, the positive impression of this behaviour is countered for others by:

SP2 L359 "I'm a bit of a hypochondriac ... "

Others try to cope with their symptoms before going to the GP. However the problem with this approach is identified; by waiting so long to present by the time they decide to seek help the problem may have gone:

SP4 L 411-413 "... as soon as I got to hospital the pain kind of went away, like it was a psychological thing, I felt like I was wasting everybody's time and they thought I was a hypochondriac"

However, this particular participant recognised that this sense of wasting time was an internal judgement and not one derived from any action of the healthcare professional. It could be said that rationalising their behaviour in this way could be seen as a way of saving their masculine identity. This is explained by an ability to recognise serious sickness as well as relying on self-management; for less serious illness waiting for an improvement is seen as an acceptable strategy. This could be seen as a realistic approach to health:

SP2 L366 "I mean, if I know that I am sick I will go to the doctors for sure. But if I know that the sickness will get better by itself then I won't bother"

SP8 L351-352 "Yes I would try and cope with it. I mean if I've got a cold or a virus there isn't much they can do so there's no point"

This could be described as a commonsense approach compared to conditions that are felt require more medical support:

SP4 L420-421 "...So you know, when I get really intense pain and it's kind of like debilitating that's usually when I'll go off for some medical help"

SP8 L353-355 "If I've got something that I know is going to take antibiotics to cure... I mean bronchitis, I've had that before and if it does get bad I would go to the doctors"

2. Reaction to external factors

The effect of others is also important in encouraging health-seeking behaviour. Despite signs of ill health a person may need a push to get help, making help seeking

behaviour more immediate.

SP4 L436-437 "... it was them going kind of 'that sounds really serious, you should go to the hospital'"

It is recognised that an absence of this external locus of control providing this 'push' would result in prevarication:

SP4 L 445-446 "I knew I was going to go for myself anyway but I would have gone the next day"

Such an outcome, procrastinating seeking medical, is contextualised by the introduction of a continuum to the perceived seriousness of the illness:

GP1 L274-275 "... it depends on how obvious it is. I definitely would, it would only make things worse if I don't check it out"

This recognises the potential negative outcome of not seeking medical attention although there is some confusion over symptoms to be aware of. This awareness is also a function of age:

GP1 L282 "... I'm a bit young to have anything of concern... I'm still a kid really"

However having a greater awareness is also seen as time related:

GP1 L285 "... but I suppose that will come too"

The use of healthcare services by males is also introduced as an issue when deciding upon action. Thinking of others is an issue and there is a hierarchy of importance; while calling the NHS helpline is seen as acceptable it is less acceptable to see a GP, although this

could also be seen as prevaricating going or not wanting to be seen as a trivial healthcare user:

GP2 L414-415 "...I don't like to go to the GP or doctors too often just because I think they are stressed out as it is... but I will happily phone up NHS direct... "

This is despite it being potentially detrimental to health:

GP2 L422-423 "... even if I don't know what it is I don't bother doctors until I feel really really bad. I'm sure it's a bad way to act"

This particular participant's action is mediated by having access to family medical support; however, this access still has a caveat in that he would only approach these family members for things that are 'not embarrassing'.

Taking control of one's own health is also mixed; although having a feeling of being in control of their own health some may also respond to others advice:

SP6 L560-562 "...I'm pretty good with health stuff like if I feel a bit dodgy I will go to the doctor without prompting. I was prompted this week by my girlfriend and so it's a mix of both"

This is compared to an abstract idea of self-reliance:

SP7 L251 "...I will look after myself"

Similarly in the gay sample a similar self-reliance was noted; it is not assumed that a partner would take care of them and make appointments:

GP2 L451 "... it's my responsibility to do things like that"

This is evidenced even when there is not personal experience of making GP appointments; other healthcare consumption is used to illustrate this point:

GP2 L458 "...I make my own dentist appointment you know"

Such a practical approach to dealing with symptoms of illness is also affected by other external factors. Employment is an issue; with regards to taking time off sick it is not felt inappropriate to take the necessary time off to recover, although the process is made more complex due to other factors:

SP4 L475-478 "...I would go to work...That means not wanting to call in sick because I've messed up so many times before that I've nearly been fired about five or six times...I would take a sick day if I felt that I could"

Such an approach is reinforced by:

SP4 L484 "...it feels that I've lost that right almost"

This introduces a sense that there is an external pressure to go to work that may or may not also be influenced by concerns for keeping their employment by compensating for past behaviour and to rebuild a credible workplace reputation:

SP4 L489-490 "...so I make it into work so that they can see me and if I was really sick they would send me home"

3. Perception of illness

The ability to differentiate between symptoms also varies depending on the person's construct of their illness. For example, applying a psychological approach is seen as having an impact in helping to minimise the extent of potential ill health:

SP4 L428-430 "... when I get flu I might take a night nurse and then not think about ... because as soon as I start thinking 'I'm ill, I'm ill, I'm ill' that's when I get properly ill"

This is in addition to allowing the body to heal itself:

SP3 L865-867 "On the whole, it does take me a while to get to the doctor. I believe in giving your body an opportunity to deal with things properly itself and if that's possible it's preferably to going to the doctor and getting medication which you don't need"

This also brings up the recognition that smoking does not aid this process. However, this period of cessation in order to aid recovery may be short term and they soon begin smoking again when better:

SP2 L383-386 "Actually, that's the one thing that sometimes smoking does stop a little bit. When I get tonsillitis... as soon as I get that then I always stop smoking and then in about a week after I have stopped smoking it'll go away...then leave it another week and start smoking"

Recognition of symptoms allied to smoking are also sometimes linked to childhood experiences. For example, SP3 noticed symptoms that were reminiscent of childhood health problems that were now linked to smoking rather than being a result of earlier health concerns. However, on a day-to-day basis it was not enough to make him contemplate stopping:

SP3 L128-130 "I think it affected me in the same way that the childhood elements affected me but it wasn't the childhood elements now doing it, it was now the smoking doing it but the way that my body dealt with the symptoms it was largely the same

It was only when they became more serious, or conditions deteriorated every couple of months that it would make him think of stopping:

SP3 L557-559 "every couple of months or every few weeks you feel really, really crap and you tell yourself you're going cut down on the smoking"

However, motivation levels to stop smoking recede once perceived susceptibility changes and the person feels better, minimising the strength of this health feedback signals; this situation then once more turns the cigarettes into a coping strategy to use because there is always something else to focus upon. This gives the image of the body having it's own self-checking mechanisms. In a similar way it is paradoxical that a person starts smoking after having a respiratory condition as a child; as his health improved he took up smoking:

GP1 L188 "I had very bad asthma and the more my asthma got better the more I smoked"

However, this improvement is not associated with stopping smoking; it was due to correct medication regimens being followed:

GP1 L190-191 "... it wasn't because of the smoking... my asthma was getting better as I was treating it"

There is also a perceived benefit of smoking on the function of the body resulting in some men not recognising bodily symptoms as being relevant to them. For example, a participant who is also a band member notices the effect on external factors such as the voice:

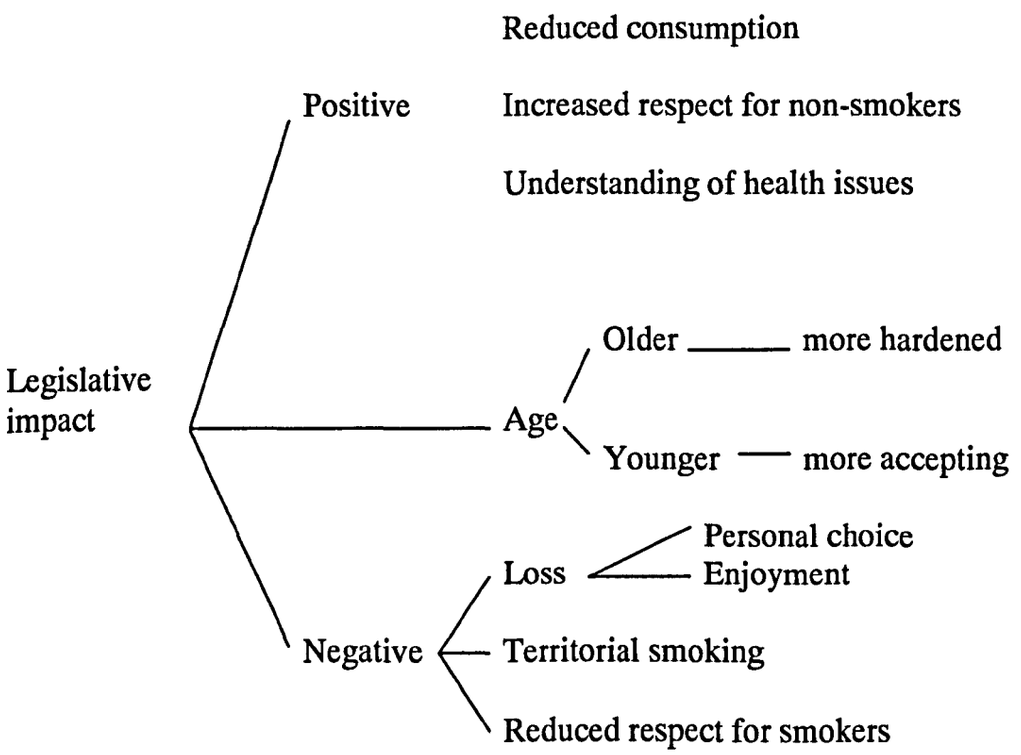
GP1 L235-236 "... strangely enough, most musicians and most singers smoke a lot. I mean the guy who vocal trains Bono is a terrible chain-smoker, terrible! Amazing voice though... "

This introduces the immediate potential effect of smoking on performance rather than looking too far into the future with other health concerns due to smoking. By making this analogy with other band members it normalises smoking as a cultural issue in this population while minimising the effect as it has a positive effect by making the voice distinctive.

3.2.6 Legislative impact

With the introduction of the Smoke-free (Premises and Enforcement) Regulations (2006) in July 2007 there has been an effect on smokers' attitudes to not only their smoking behaviour but also others' smoking behaviour. These can be seen in the following diagram.

Diagram 3.2.6 Legislative impact and its subcategories



1. Positive

For the majority of the sample the legislative changes have been interpreted as positive:

SP7 L431	*"It's good for everybody, you know people who don't smoke"*

For most of the participants, this effect has extended to their personal behaviour.

Despite initially thinking that the legislation had had no effect on their smoking habit, upon reflection there was the realisation that it had led to a reduction in the numbers of cigarettes smoked. This initial reaction could perhaps be an automatic, defensive response to an external pressure to reduce or constrain a personal behaviour choice:

SP1 L355 "Yeah, it didn't affect me. Well, not consciously I suppose. Maybe I did smoke more when you didn't have to go outside. I'm not sure to be honest"

This results in a degree of reflection of past behaviour that had not been consciously realised. This minimises the effect of the legislation, resulting in a contradictory message that even before the legislation they may have smoked outside when in public places.

When in others homes, social etiquette dictates that if asked by others not to smoke the participant would respect them and comply with their request without accepting their belief around smoking. This is not accepted passively but is done in the full knowledge of their position vis à vis health concerns and other negative effects of smoking:

SP1 L434 "It's understandable if they don't smoke, they don't want it in their house, that's fine... because they know the damage it causes"

SP8 L306-307 "I would never smoke inside someone's house without asking... If they object to me smoking then I would smoke outside"

GP7 L269-271 "...just to be considerate. You know they might not want their house smoky, but others have told me it's okay to be in the living room, watching TV and have a fag"

With changes in society the image of smoking has softened over time, in conjunction with the legislation:

GP1 L293-297 "Lots of people are very lenient especially since the smoking ban because it (smoking) doesn't really affect non-smokers in the same way that it used to...you don't end up stinking of cigarettes which is probably the worst thing ever"

GP5 L161-161 "It's generally frowned upon just for the smell and the effect in the house"

This shows that for many people, including some smokers, social conventions appear to be more important for behaviour change; the aesthetic effect of smoke on clothing and furnishings is more important than the health effects of passive smoking. It also raises the paradox that for some smokers there is a lack of fit between their knowledge and their behaviour:

GP1 L301-305 "... that's why I never smoke in my room. It's because it's disgusting. ...I think its promoted socialisation actually. Because people go outside for a cigarette they socialise more ... Non-smokers, I don't think it's pictured that badly. I mean everybody knows that it's unhealthy for the last 15 years... "

This respect for others extends to a persons location in regards to others, even when smoking outside:

SP9 L 43 "... I might stand downwind"

GP4 L489-490 "I would smoke somewhere else so I don't put them in a situation where they would be inhaling my smoke"

Reasons for this are broken down into two streams of thought:

SP9 L48 "...probably 70% etiquette and 30% health"

There are also positive aspects noted to a complete ban on smoking:

GP3 L587-588"... it would be a good idea if they completely banned it because then I would have to give up"

This is based on an understanding of the health effects that make the situation confusing from a rational viewpoint:

GP3 L592-593"... cigarettes apparently kill more people than a lot of these other drugs that are banned"

This position also indicates at least equivalence, or even a superior position, of tobacco with other drugs over the potential level of harm.

2. Negative

However, these positions are not maintained in private where, despite the health messages, it is a personal choice to smoke inside and this behaviour has not changed. For some, the effect of this could have resulted in a hardened position of smoking inside whenever possible, despite not being ignorant of the health effects for others. This position is also reinforced when current friends are smokers; these social norms help to maintain this behaviour.

Despite this stance, there is an interesting change in behaviour when in one's own space; respect for others dictates that behaviour may be changed to suit others' sensibilities. However, in order to maintain a defensive position it is stated that this would not necessarily affect the numbers of cigarettes smoked. The realisation that this is not very respectful of others also helps identify the potential conflict in his thoughts and raises the question of behaviour being based in external value norms of 'should' rather than 'actual' action. Ultimately the adult non-smoker is not passive in this relationship and has the choice of staying around the smoker in such a social setting.

For a minority of the participants these rules change when in one's own house and clear boundaries are set:

SP8 L309-311 "... if people come around to my house I make it very clear that I do smoke inside whether anyone likes it or not"

GP6 L448-449 "... if people are in my house I'll open a window but I won't stand there with my fag because I don't see why I should have to excuse my needs in my house"

With the argument for the legislative changes made around the health effects of secondhand smoke, the danger of this secondhand smoke is minimised in the eyes of the smokers when it comes to the issue of the effect of it on themselves. Secondhand smoke is perceived as a smaller risk relative to smoking and exposure to it is seen as a personal choice. For some this is a conscious decision based on other behaviour:

SP2 L200 "... I've got plenty of ways to die already"

However, when living with other smokers, although the participant may not want to avoid secondhand smoke based on health reasons, they do not want to be exposed to it for aesthetic reasons:

SP4 L361-363 "I'm moving in with two of my friends who are smokers but I think we all have an agreement that we don't want to smoke in the house so it's nicer to live in... "

For this particular participant, this allows intermittent conscious thought of the effects of smoking:

SP4 L369-370 "Sometimes I just realise, I have that click in my head that this is really disgusting, it's like walking into a fucking wall of smoke... "

However the reason for this reaction appears to be more to protect the home than health.

Where cultural norms have been against smoking these weaken with age but there is also a territorial sense to the behaviour:

GP2 L98 "It's like 'I am in my yard so I'll have a puff..."

This introduces the idea that people have a choice of whether they stay or not and reinforces an idea of 'territory', that when you are in your own place you can do what you like. In these situations it is the responsibility of others to fit in and respect this viewpoint.

These views change with age and the need for mutual respect and more likely to assert ones own individuality. The people present also affect such views. For example, this respect is age dependent for some; being in a parents' home would encourage some to smoke outside and comply with their policy:

SP5 L183-185 "I think it's because nobody there smokes... it's also out of respect for my parents"

This respect for others wishes may also be linked to a sense of shame, being judged or reverting to the parent-child relationship, which may temper the assertion of individuality:

SP5 L194 "... they aren't very keen on people smoking, I mean they didn't when I was growing up"

In comparison, if with the same age or peer group, especially if they are smokers, it would be more acceptable to smoke inside:

SP2 L167-169 "... if I was at one of my friends' parents house... maybe then I would (smoke outside) but most of the people that I know smoke and all the people that I live with smoke"

Changes in behaviour since the smokefree legislation are also recognised; what was once automatic (smoking inside) has been replaced by another automatic behaviour:

SP8 L256-257 "... now it seems, it would actually seem rather odd to light up even though that was second nature for me for years and years, and indeed to everybody, even though I would prefer to smoke inside"

On the whole, where a personal impact has been noticed, these barriers to smoking are seen as being easily managed:

SP7 L435-436 "If I want to smoke it would be bad but I just have to walk away and find somewhere to smoke"

However, there is a slight concern about the limit of the legislation on self-expression; this also varies in relation to cultural differences, not only between cultures but also within cultures:

SP6 L498-500 "... it seems like in America... it's not like it's just bad for you but it affects everybody around you...a social group would be more like 'God I cant believe you're smoking' whereas my social group is more like a little bit odd if you're not smoking".

However when compared with other cultures, even post ban it seen as more relaxed to smoke in the UK:

GP7 L538-541 "It just feels more comfortable smoking here, in the US more people come up to you, say you shouldn't smoke blah blah, but over here people still say the same thing but there are less of them telling you that"

This introduces the idea of social expectations. It is seen that legislation has affected

perceptions of smoking and changed social pressures:

SP6 L513-514 "It's a feeling that people are now less tolerant. It's the same as if you go into a supermarket now and you haven't brought your own bags... "

GP4 L483-484 "... if there is a person who doesn't smoke they generally these days seem to be like 'well, I can't stand smokers'... even people who used to smoke"

For some the effect of this new atmosphere, or culture, has lead to greater respect for people in the public eye, such as celebrities, for going against this prevailing climate:

SP8 L153-155 "... I take my hat off to anyone who's got the balls to smoke in public... I mean photographed or filmed smoking, just because this health fascism has got so great"

Although this view represented a small number in the sample, this also helps to demonstrate the strength of feeling against the legislation, as there is a degree of inflexibility recognised in the legislation. It is felt that there are places where the legislation should have been more flexible:

SP6 L529-532 "It's kind of shattered the whole atmosphere thing in a pub... I thought that going into a pub you would have signed an unseen agreement that you expect there to be smoke"

SP8 L193-194 "They've done something detrimental to the whole experience of going to pubs"

GP3 L582-583 "Well, it's like Moscow isn't it. It annoys me a little bit because some people can be a bit uptight even if you light up in the right place"

The whole aspect of the health message in these instances is forgotten about and the emphasis is placed on the wider experience that is seen as being detrimental or negative. Just as there is

a link between the pub and alcohol, there is a link for some between the pub and smoking:

SP6 L536 "... a pub and smoking are synonymous"
SP8 L191-192 "I mean you have to sort of have a beer and a cigarette. I mean they go together"

From a wider perspective, there is a clash between the rational cognitive being and the emotional being which only sees a sense of loss, where personal control has been removed and something has been imposed:

SP6 L544-549 "... my biggest annoyance with it is more political than health or smoking-wise... it's not so much the smoking debate it's more someone has, it's the control thing again, and forced it on me"

This has had a negative effect on an individual's intention to stop smoking:

SP8 L169-171 "...people trying to coerce me into something that is ultimately my decision to make. Nothing made me so determined not to stop smoking as the smoking ban"

Such an enforced change in behaviour due to the smoking legislation has also resulted in a romantic image of the past when more open smoking was allowed:

SP8 L73 "... this was back in the halcyon days when you could smoke in pubs... "

The method in which these changes are enforced can for some be seen as a lack of respect for personal choice. This can be seen in the following extract; the legislation is enforced by people who are depersonalised by the participant, and where the participant refers to the enforcers and the smokers in the third person, indicating them as the 'other':

SP2 L233-236 "Well I mean nowadays it's getting more and more socially unacceptable you know. They kick people out of pubs; they kick people out of most indoor public places. It's kind of like forced them out into the cold and maybe hoping that they'll stop because of that"

This has resulted in a depersonalised, industrialised image of some areas to smoke, such as outside a gay club:

GP2 L602-605 "... everyone is kind of penned together outside... you have to go in there and you have to smoke and then they march you out again so they can get the next lot through"

In this example, while the rationale behind the legislation is understood, the imagery used underlines the perceived need for adequate smoking facilities that at this current time the participant does not experience.

There is also recognition that although smoking is no longer the norm in the wider society it does have its own social group:

SP6 L 352-354 "I suppose we are a bit of a dying breed... although when we were out last night there must have been 80% of us smoking. Maybe that's just about the friends I keep... "

There is an image conveyed in this extract of a 'survivor' persona that is accentuated by the introduction of additional limitations on his behaviour due to the legislation. One aspect for smoking outside is that it changes the way people might socialise. This has had a mixed effect on the enjoyment of smoking and socialising:

GP2 L592-594 "... it's more of a hassle to smoke. In a way it's enhanced the social aspect because you are all outside together and it makes the act of actually having a cigarette more pleasurable"

SP8 L267 "... a lot of the people (outside) are the ones that I don't really want to talk to... "

There is also a less than favourable effect on socialising for some emerging from these extracts while in the following there is a common theme expressed; moaning about the changes:

GP6 L197-198 "... you all start moaning together... like 'God I can't believe we've come outside to have a fag' "

Despite questioning their continuing behaviour this does not result in a desire to stop:

GP6 L203 "No, it's not that bad, even though sometimes it's a nightmare especially in the cold"

There appears to be a division between the participants over the effect of having to smoke outside. For some, it is seen as being antisocial, although it is not clear whether this is more antisocial than smoking inside was:

GP6 L188-189 "... people go out and you've left people there because they don't smoke so they could be sat there by themselves... "

SP8 L278-279 "It's just that I'm not able to do it as congenially as I used to be able to"

Having to go outside to smoke when socialising is not seen to have affected consumption of cigarettes (or alcohol) but it has affected the quality of the experience and suggests a sense of loss.

In comparison, for others who may be older and who now socialise more at home the legislative impact is reduced, and has reduced the number of smokers in their social circle:

GP4 L125-127"...friends who I have, they all smoke at their houses so I guess we have... more nights at each other's houses"

GP4 L252-253"I think 70% of my friends used to smoke now it's about 50%"

For these participants an additional benefit of the legislation is highlighted which is seen as an advantage for younger people; it is felt that had this legislation been in place when they first came out they would have smoked less due to inconvenience of smoking outside:

GP5 L256-257"If I came out now I think I wouldn't be smoking more because it's cold... The timing is quite unique"

There is also a change in how people see themselves as smokers; pre-legislation it was easier to be a 'social' smoker:

GP4 L267-268"...people who genuinely didn't smoke sometimes they would just smoke with you because it was so easy"

While a social lubricant, this effect can be contradictory:

GP1 L310-313"...if you're in a club trying chatting up a guy and you're smoking and sometimes they're like 'oh you are a smoker' and you see they are a bit put off but then on the contrary sometimes they just don't mind ..."

GP4 L476-478"... all of a sudden you will have something in common and it's almost easier to actually probe into someone else's life and they are more open"

This implies an unwritten commonality between smokers:

GP7 L294-298 "...sometimes you go to somebody and say 'hey you've got a fag?' and they give you one...you realise you have the same things in common...you go to the pub, you have a drink or whatever and you start seeing them"

GP6 L168-169 "...You can use it as a point of conversation...when you first meet some people..."

This is also a protective mechanism to not commit 100% of emotional energy to a situation that could become uncomfortable, as if you are not allowing someone to see all of your character:

GP1 L348 "Yes, it's an accessory. I mean life is more fun with accessories"

GP3 L547-550 "It's like putting on a new hat or something...It's like a mask"

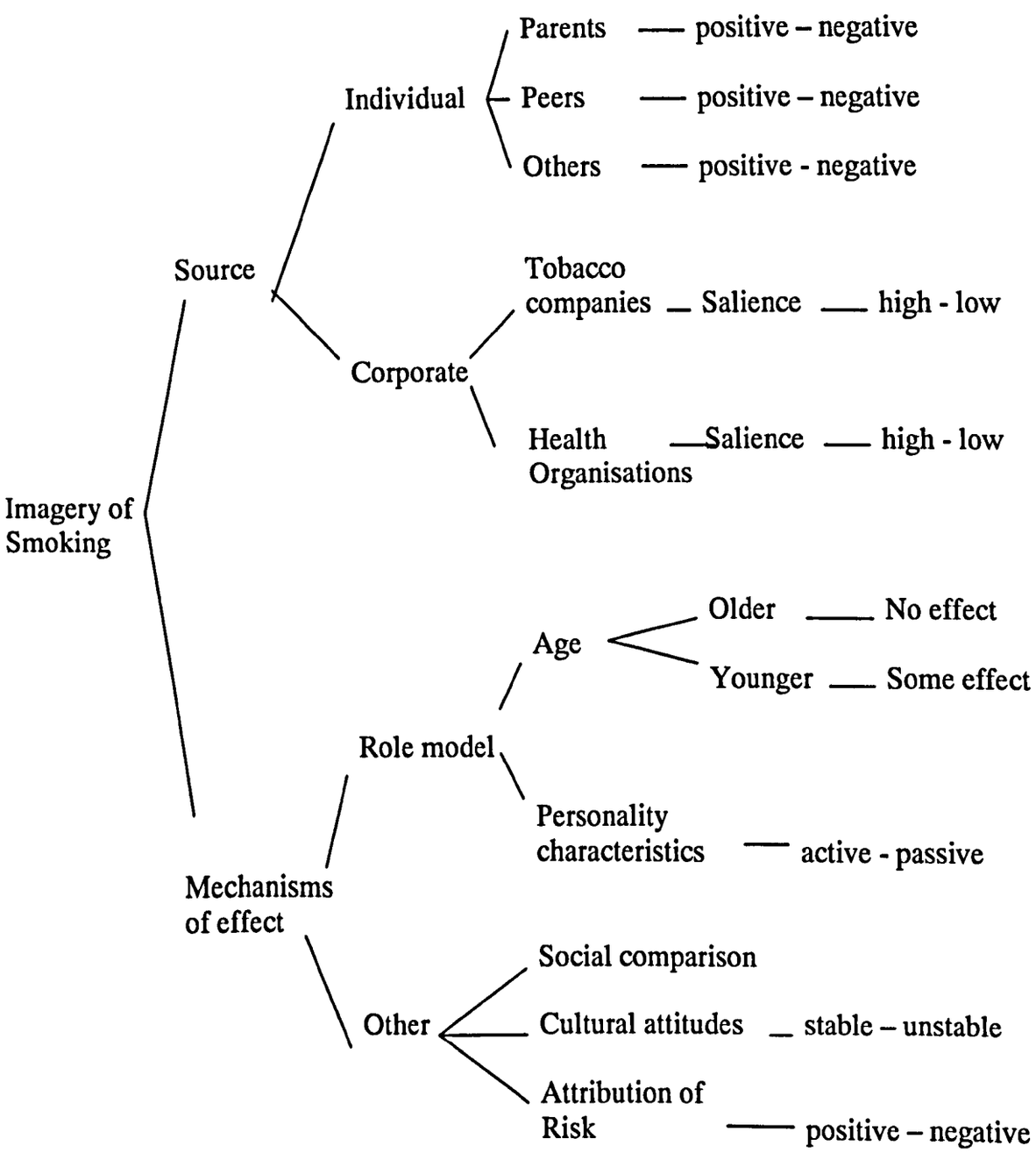
3.3 Negotiating the effect of smoking on sense of self

This section deals with the various images that have been portrayed of smoking from a number of areas that may affect the individual's decision to smoke.

3.3.1 Imagery of Smoking

There are a number of influences exerted on a person when establishing their construct of an image of smoking and can be seen in the following diagram.

Diagram 3.3.1 Imagery of smoking and its subcategories



1. Source

For some, growing up, seeing parent's smoke resulted in a negative image about smoking for a number of reasons including health concerns as well as the smell. However, across the sample there is a difference in the memory of the presence or representation of smoking in the media; it is at a minimum for most participants, with the exception of one particular advertisement for a specific cigar brand. In general, this is the extent of the effect

of the media and it did not emerge from the data to have a large effect on future behaviour.

As well as advertising of cigarettes or tobacco products there is a suggestion that the power of the imagery which has been used to date may not be sufficient to encourage either uptake of use or maintenance of smoking:

SP2 L426-428 "...I don't take my values from films, you know. I think that people who do that are idiots"

In this particular instance the participant feels impervious to the portrayal of smoking in films and disparages those who are influenced; it is merely seen as a marketing tool and the models or celebrity within the film does not affect him. However, what is recognised is that for a current smoker they may add to a sense of reaffirmation to continue with the habit once it has been initiated and it is a trigger to want to have a cigarette:

SP4 L621-623 "I had already started and so ... it just kind of gave me a slight reaffirmation that it was a cool thing to do at the time... I definitely see somebody smoking and think 'God that really means I've got to smoke""

In a similar way, potential pro-smoking messages were not consciously remembered for either the glamour of the person doing the promotion or of the glamour of the lifestyle commonly associated with such images. This also extended to other mainstream media such as music and film. As such the participant is not a passive receptacle for these images but able to differentiate between the medium and the message:

SP1 L485 "Obviously I like films and music but just because a particular person smoked that didn't affect the way I felt about it"

For others this imagery can raise an interest in smoking but just for more information

about the effects of the behaviour rather than as a direct cue to smoke. Someone who started smoking later in life evidences this:

SP7 L415 "I just didn't think about starting"

Prior to this point the participant felt impervious to the effect of the media-generated images. The importance of image and identity is generalised as important for all, although for some this may be time-limited:

GP1 L98-101 "Yeah I've definitely thought about it because I mean everybody thinks about that. It's like the whole 'do you look cool with a cigarette' like Marlon Brando... cigarette boxes look wicked and pulling out a cigarette and it's great. I suppose you get past that... "

In retrospect he realises how this may have appeared:

GP1 L114 "... it's completely ridiculous"

However, it is recognised that it also conveys an image:

GP1 L116 "It does give you a look, it's sort of a rebel look, kind of cool" *GP5 L299-301 "... there is a picture of decadence or a sort of glamorous side to smoking ... especially for the younger people"*

While accepting this may have been the case, it is not necessarily valid for at a later age:

GP6 L251-252 "... maybe it's good for the image, and they have that image with a fag in their hand, I don't know, but I couldn't give a toss – I did that when I was 10 or 11"

However, while not being linked to being gay, the initial positive image is reflected upon and there is a difficulty in identifying whether this image has been developed since

starting or whether it was the reason to start:

GP1 L549-551 "... it never played a part but it was... I'd almost consider it not as ... as a cause of smoking but more as an effect of smoking"

This indicates that having this image in mind after he started was more of an affirmation or reinforcement for his behaviour.

The sense that the image of smoking also adds confidence is also seen as a function of age; although this may be an initial reason to start it soon becomes a routine and is seen as being less of a psychological prop:

GP2 L508-510 "... I've been smoking continuously now for more than 12 years... you leave a few of those ideas ... you know 'is it making me look a bit cooler' and stuff like that"

2. Mechanisms of effect

Although the majority do not see the portrayed media images as a trigger to start, what smoking can add to a film is the sense of atmosphere:

SP4 L632-634 "... If I'm watching a cool film or something where people are smoking in it it's more associating it with the feel of the film"

SP6 L402-406 "I think for me it's more a kind of warmth thing... it's as if the cigarette isn't something that you are inhaling into your lungs, it's like having a lamp on, it's like part of the atmosphere that you create"

The idea of this sense of warmth, or a reassuring feeling, is likened to a sense conveyed with other media with an analogy is made with music:

SP6 L424-425 "It's the same reason I listen to jazz... it creates an atmosphere more than literally listening to what notes they are playing"

Similarly, for others smoking also helps achieve a feeling of escapism or isolation, as if one is an observer on life, especially in times of stress:

SP10 L503-504 "...you can just close the doors behind you and cut yourself off when you're smoking. It's like you are running away from yourself"

These ideas are generalised further, in an almost romanticised, idealised way:

SP6 L375-382 "...I think people in general seem to think they are in their own sort of film... when I've been under stress I think of ... an Alfred Hitchcock film or stuff like that and whenever they are in that situation they've always got a cigarette... "

This is a self-image rather than an image that they wish to portray to others:

SP6 L386-387 "... even though there's nobody there to see it... because I'm a tortured artist or something I have to have a cigarette and be in a dimly lit room"

This sense of atmosphere also extends to memories as a child:

SP6 L57-59 "... he (dad) set a nice atmosphere in which he used to smoke at home. I think there is something quite cosy about that and I think I was probably drawn to that"

When looking at the impact of smoking on the image of the person there is an interesting response when asked whether they notice other people who smoke:

SP1 L490 "Yeah, of course"

This indicates that this is considered a natural response and normalises social recognition and social comparison that, it is assumed, everyone engages in. This is particularly the case given lifestyle changes since initiation at a late age. For example, when trying to balance previous

attitudes towards, or against, smoking, in relation to now being part of a traditionally constructed smoking lifestyle, being part of a band, conflicting emotions arise:

SP1 L495-498 "...I don't think it's cool obviously because I know it's not but at the same time it doesn't seem to be as bad as, you know, like I don't see it as a bad advertising campaign. I see it more as a kind of positive than a negative"

This helps to illustrate how feelings and attitudes towards smoking are not constant but change with circumstances. This leads to an alternative perception that is culturally determined; in this case a band culture. Despite the health risks, or the perceived enhancements mentioned earlier with regards to voice quality, this makes the behaviour more acceptable to the participant due to the circumstances and these external pressures.

Considering the importance of this, being part of a wider industry, people accept the risk associated with the smoking behaviour in order to be part of the industry; it is felt that this almost inevitably will not change and the related risk is accepted as being part of life and not a deterrent to engage in the behaviour itself:

SP1 L517-519 "I don't know if anything can affect it because obviously hundreds of rock stars die of lung cancer, you know, so I don't think it will ever deter, you know. I don't know if anything can be done in that sector"

GP2 L134-136"...you go to a lot of gigs...I've got a lot more friends who smoke than non-smoker friends are generally they're the type of people that you meet yes generally a higher incidence of smoking there"

It could be posited that the use of 'you know' in the first extract implies a tacit acceptance and general understanding that this is just what happens and that it is almost unchangeable. However, it is also recognised that this might just be the case for his age group

(late 30's) reflecting on the effect smoking has had to date; it is not clear whether younger people might have a different opinion. Again, this appears to imply that age and timelines are issues which have an affect on when an image is set for a person beyond which point it would seem that change is not possible. These stages also have finite ends to them that may make them applicable until a certain life stage is reached or external influences have a greater effect.

In comparison to the previous image, for some this suggests that there is an age when a healthy self-image is replaced by an alternative, less healthy self-image that is accepted:

SP6 L230-233 "... up until the age of 17 I was really healthy and like into sport and stuff... since then it's just been a general decline"

This can be compared to someone who is put off continuing with sport because of the effect of celebrity on the image of the sport itself:

SP1 L697-703 "I won't go back to competitive sport... because I just can't be bothered... it's too much of a farce. A lot of the people, footballers are... dickheads"

For this participant although celebrity has not necessarily had an effect on either starting to smoke or stopping smoking, the negative imagery associated with celebrity has stopped them from engaging in positive health protective behaviour, although this could be an excuse not to continue with that behaviour. However, despite this viewpoint, it is recognised that for younger people these celebrities are role models for whom they have increased salience. This again highlights the time-limited effect of various influences on smoking behaviour.

The use of celebrities as role models for younger people in comparison to their ineffectiveness for older smokers is time limited due to older people having developed their own ideas and set of beliefs and so limits their influence on both maintenance and cessation:

SP3 L422-425 "I don't look up to that many people or the people that I do you are not really likely to see standing outside a club at 2 in the morning showing what brand they smoke. It's not really too much in my radar..."

SP5 L259-261 "It's not a case of seeing Mr Docherty out there getting arrested for doing drugs or anything. I'm not going to go out and start doing drugs just because he got arrested for it"

SP6 L421-423 "I think role models work for younger people, for me now it's like someone else being ill – you remove yourself from their effects. I mean my dad was a role model..."

Image of cool is also attainable from friends rather than to a famous person:

GP2 L523-524 "...you know you get pressure and stuff but it's from your friends and your peers, it's not from seeing Amy Winehouse smoking a cigarette or something"

Fitting in with friends is seen to be more preferable than conforming with more abstract or distance famous people:

GP2 L535-537 "...I was doing it to fit in... with my friends... when I was 16 rather than emulating famous people"

GP7 L416 I'm not really that interested in what they say I just like the music"

For others, celebrity is more of a driver:

GP5 L 49-51 "It wasn't registering as a wrong thing to do. It was media influences like TV and music... I used to listen to rap music and people like Snoop were smoking"

These are seen as more influential than family members

GP5 L62-63 "...you're parents aren't cool, but the music you are listening to and the people you are hanging around with are, their opinion matters"

While the strength of appeal of a role model is questionable for an older smoker, for some this is seen as being the case when looking back at role models when younger:

SP5 L270-272 "... they (celebrity) used to get stoned all the time, I mean there have always been people that were stoned out of their heads but it was never an incentive for me to go out and do the same thing"

Just as was seen earlier when considering how rock stars have died through their own risky behaviour this helps to illustrate that the same or similar pressures have always been present for young people, the influence of whom many successfully ignore.

Others' image of smoking, and their reactions, can also lead to a reversal of respect which most smokers afford to non-smokers. For example, the reaction of non-smokers in the street to smokers is a contentious issue. While some smokers view the restrictions and attitudes towards smoking as a restriction of their rights, it is felt that non-smokers sometimes act as if they, the smokers, have no right to smoke at all. This results in a general negative reaction from the public:

SP2 L213-215 "...I've been walking along the street smoking a cigarette...I've had someone come along and cough at me"

GP7 L309 "people will cross the street to get away from it, it doesn't help your image that much"

GP6 L277 "it's a bit looked down upon sometimes. You know people are always on to you about trying to quit..."

There is also a sense from employers that the image of smoking is not positive or acceptable:

SP4 L537-539 "...I mean if they got down to it they would probably prefer it if I stopped smoking but they know it's my choice"

SP10 L206-207 "My boss is usually not like 'it's better for you to stop, but we're not saying to you to stop because it's your life, do what you want'"

As well as this unstated and inferred concern for the well-being of an employee this smoker is also aware of the image they portray when at work of the business as well as of themselves:

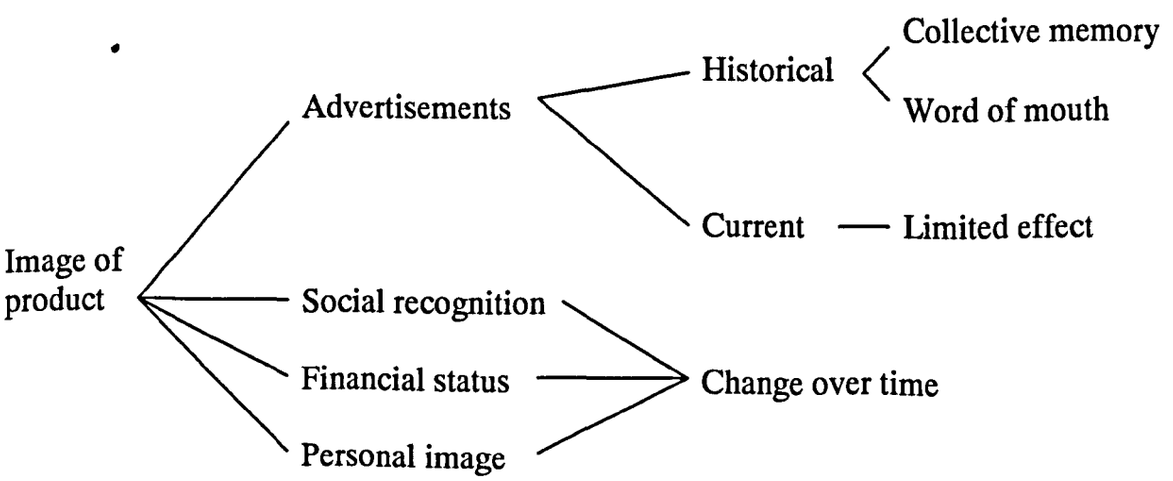
SP4 L544-545 "...to maintain a professional environment it does help not to be smoking while you're serving a customer...I just don't think that's a very good image"

As such he notes that there are appropriate times and places to smoke. The implication is that he realises the negative image that smoking gives to the establishment.

3.3.2 Image of product

As well as the image of smoking and what this conveys, the image of the product itself is also important when deciding whether and what to smoke. Linked to brand identity these can be seen in the following diagram.

Diagram 3.3.2 Image of product and its subcategories



There is evidence in this sample of smokers that for some the image of the product itself would be important especially those who may be susceptible to brand image. However, image alone may not totally be reflective of the product being attractive for all:

SP3 L433-435 "what I mean about Silk Cuts is that its because Marlboro tastes like half the other similar range cigarettes out there that advertising does the job of pushing them in front. But if it's really crap or if it's incredibly good, advertising doesn't really make a difference because people make their own decisions"

Comparing these two products indicates that a person wants to be portrayed as in control of his own choices and not susceptible to external influences. As such the role of advertisers is seen as helping consumers make their choice when a product does not stand out on its own inherent qualities; image helps people value their intangible qualities.

Brand loyalty arises because the cigarette smoked is perceived as what is fashionable or 'cool' to be seen smoking. This can be as a result of direct peer behaviour:

SP3 L279-283 "When you are 15 or 16 you smoke Golden Virginia because that's what you see everybody rolling up and you smoke Marlboro Lights because that's what you see everyone buying. I still got onto those because other people I knew were smoking them. Everybody I knew were buying them because that's... its like buying Stella"

GP1 L121 "I know some people who smoke certain cigarettes just because of he way they look"

This shows the influence of social comparison and an analogy is also made with other products, in this case alcohol, which are also perceived to add to the image that is desired to be portrayed:

SP3 L290-291 "Having a brand which you smoke is also clearly part of being a person who's taking things very seriously"

Values are attached to these brands:

SP3 L306 "I'd say there are certain brands like Marlboro Reds which have their attachments... "

This aspect of 'attachments', such as image, raises the interesting question of where they originate; are they a result of advertising imagery or purely cultural references? If it is an historical reference (due to the age group of a number of the participants and consequently too young to have been exposed to advertising in the U.K.) and so limiting the effect of mainstream advertising, it may be assumed that such attachments are located in the collective memory, especially for younger participants who would not have been exposed to direct advertising.

However the effect of advertising can be seen in the responses of an older participant where a traditional image is perceived:

SP5 L229-230 "It was the Marlboro man, you know that was embedded in my head, on his horse with a cowboy hat, smoking"

For this participant as well as his age this may also be due to him being an American, making this particular imagery more culturally specific and presumably relevant. However, while remembering this he still claims it had no effect on his smoking behaviour:

SP5 L239-241 "...It was just a brand at that time and even when I came over here (UK) you always see it in motor racing and things like that"

This expressed lack of an advertising effect is the same whatever the medium and is generalised to other advertising:

SP5 L250 "...I don't buy into the advertisements"

This also links in with, and corroborates, the lack of media effect recalled earlier in response to role modelling. For others, the historical element is more of an element encouraging them to smoke and the change in culture over the years since they started to smoke is recognised:

SP9 L171-173 "...the marketing, the rebellion, the portrayal, the normal advertising mechanisms that in those days were pretty strong around smoking... it was a very different culture"

However, it is not possible to break this down into the individual effect of one medium; it is perceived as the mass media effect that pervades in peoples consciousness. These external factors may also be influenced by those closest to the person while growing up, such as parental choice of cigarette brand. These are inter-twined with the mass media effects:

SP3 L391-393 "It's hard to know what's on, you know, the television programmes years later but I remember the TV adverts I think and because my Dad smokes Silk Cut's that's the first cigarette brand I was ever aware of"

This also helps to show the perceived change in culture between these two time periods; when advertising on television was permitted and when, in the present, it is not. However even with this memory he goes on to claim that these factors never affected him, in particular because the taste was not enjoyable; he does not realise that this behaviour acts as a cue to smoking even if it, advertising, is not the precise one that applies to him. This has the effect

of minimising the influence of advertising on him and that his actions are all dependent on features of the product itself:

SP3 L397-399 "But they taste like crap to be fair! So it never affected me. I think, I can't really say really much on the impact of advertising other than I think that taste and the nature of the brand will end up having a much larger impact"

The question of health effects caused by different products is also commented upon; specific types of tobacco are seen as less toxic that others:

SP9 L68-69 "I find that there is a richer taste to the (rolling) tobacco and I find manufactured versions, I don't know, it just seems like there are too many impurities in them"

Not only is the health effect questioned there are also differences perceived in their effect on the smoking behaviour itself; some are seen as more addictive:

SP9 l 72-73 "Trying to stop smoking normal cigarettes after having a period smoking them, I find it more difficult (than rolling tobacco)"

The idea that rolling tobacco is purer than manufactured cigarettes is continued by:

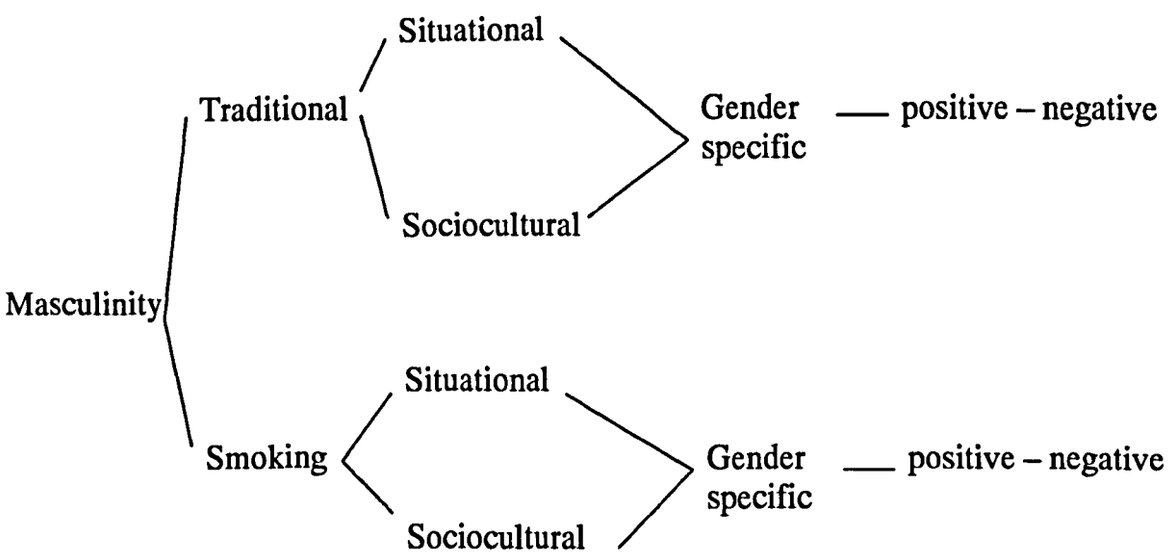
SP9 L95-97 "You know there's some pretty nasty stuff which goes into them which I don't think appears to go into rolling tobacco. I might be wrong I might be naïve and it might be part of my denial"

There is also a degree of insight expressed here that this smoker uses this strategy as a way of justifying his decision to smoke, whatever the product.

3.3.3 Masculinity

In the discussion relating to masculinity, traditional descriptors of being masculine were discussed before moving onto the effect of smoking on images of masculinity. The following diagram highlights the factors emerging from the data.

Diagram 3.3.3 Masculinity and its subcategories



1. Traditional masculinity

When discussing self in terms of imagery used for males, terms such as 'strong', 'unemotional', 'aggressive', 'competitive' and 'unconcerned with family life' (Lee & Owens, 2002) have been used to describe traits associated with the traditional male. However while some are considered as useful when building a sense of identity, e.g. strong, others are seen as negative, e.g. aggressive, and are rejected:

SP2 L409	*"Nah, not aggressive... that's bullshit, that's just macho crap... "*

In comparison, as well as 'strong', others, such as 'competitive', are seen as positive. For example, someone who plays sport could view competition as being positive, while someone who does not have strong family ties would see being 'unconcerned with family life' as not necessarily positive or negative; it just not relevant to their concept of self. To

illustrate, unconcern may be as a result of circumstances and situational; in many families distance is a separator of families and it may just not be possible to maintain relationships as you may like. Therefore, this approach may be a more realistic view of modern living:

SP1 L667-675 "... a lot of my friends, although you know they love their family they aren't emotional people. They're not overly 'oh I've got to be with my family' you know. I'm not from round here and neither are my friends and we don't see our families very often. It's not because we don't care it's just... I'm concerned but I'm not like, that concerned"

In a similar way it may be a case of not being able to express feelings (whether verbally or demonstrably) rather than not feeling them at all:

GP1 L680-681 "I don't go on about it, I'm not over the top. It's just you see your mum and I don't plan to giver her a big hug or anything like that"

As such, this fits into the image of being stoic, rather than unemotional.

Similarly there is a degree of self-awareness about ones actions:

SP4 L501-503 "... I strive not to be like this because it would be alienating for everyone else. Yes, I can be all of those things from time to time but it's not consistent"

Traits to describe oneself are situational and to apply all these traits listed earlier would be unrealistic and imply that they originated from a dated definition of what it means to be male. There is also a need to consider cultural sensitivities, especially around the concept of the family: in some cultures family is more important than it may be in other cultures:

SP3 L893-897 "I've come from a family of strong women... I have got a lot of English family and I've also got a lot of Nigerian family and family is very important to me. I don't agree with that and I don't agree... The competitive and aggressive, no. I recognise them as being male traits but they are not remotely applicable to me. I'm a very unaggressive person.

They are not perceived as negative, just not applicable to most in this sample.

2. Smoking

When parameters of masculinity are applied to smoking it has to be seen in the context that smoking was traditionally seen as positive for a man and negative for a woman. As such this has taken away a degree of impetus that is provided by social influence to stop for men. While this attitude may be expected as something that would be expected from older generations it is also evident in younger age groups as can be seen in the following extracts from participants aged 22 years and 24 years respectively:

SP3 L919-921 "It is more acceptable to spend every single evening in the pub having more than your recommended alcohol and going out for cigarettes every time you do. All of that is more acceptable if you are male without a doubt"

SP6 L568-570 "... my dad told my sister that he wouldn't mind if he found out that I smoked but he minded when he found out she did because she's a girl. And I suppose traditionally girls didn't smoke, you know it's unladylike"

These extracts illustrate that this behaviour that was seen as socially and culturally acceptable and unacceptable depending on gender. One participants views compared to his father's view expressed in the preceding extract further illustrate this generational difference:

SP6 L574 "I don't see it as a bloke thing now, I see it as equal smoking rights"

Smoking's link with a masculine domain is disputed from the experience of growing up:

GP1 L590-591 "... most of the people I knew who smoked were girls, girls smoked more than boys"

This sociocultural image has changed with time:

GP7 L567-569 'There was a time probably for the older generation when it was the socially thing for a man to do but now it's more personal choice"

Within this changing social context, other behaviours indicate masculinity for some:

SP6 L 579-583 "... something like a beer makes you feel like a man. A cigarette is a more generic thing now... Its like the black and white film thing... it was more of a man thing then"

Again, 'a beer' is used to create a sense of occasion, a statement. Despite not seeing smoking as a major part of someone's male identity it is noted that for some occupations it may not fit into the stereotype for that person:

SP4 L508-509 "I don't know if it would be part of my identity, in some ways I suppose, like if I'm a weathergirl who smokes it wouldn't be part of that dynamic... "

This illustrates that for women it would not be expected, adding weight to the idea that smoking implies something not associated with the image of this particular profession.

With changes in the sociocultural acceptance of smoking since its peak discussed earlier with relation to advertising and the media, the health effects of smoking are now used to disclaim any positive effect for an individual on their image of masculinity:

GP1 L593-594 "The publicity and everything tells the contrary, you'll have cancer, you'll have less sperm, you'll have erection problems blah blah blah... smoking will make you asexual... like, psychologically I don't think it has an effect on masculinity"

In this respect it is viewed that a person would exhibit more traditional ideas of masculinity, e.g. virility, by not smoking, although the need to do this is not important. As such, the reality of past advertising images as being hyper-masculine is counter intuitive to the real biological effects that are intrinsic rather than extrinsic.

Alternatively, and in comparison to this position, for the gay participants, it is also perceived that smoking helps portray a societal expectation of masculinity away from a stereotype of 'gay' and therefore a way to hide sexuality:

GP3 L558-565 "... because society doesn't really make the distinction between, well, gay people... I think it could be a way of establishing masculinity... "

GP3 L575 "... it could make you look normal perhaps"

GP4 L576-578 "because I wasn't 'out' when I started... it was helping to blend into the crowd more... easier to pretend... "

This shows a conflict between self-image and how society sees a person and smoking helps to 'pass' (Goffman, 1977) as a straight person, even though smoking is more socially unacceptable; this implies that socially it is better to smoke than be gay. This is reflected in the way smoking can break down perceived barriers between straight men and gay men and could potentially be a self-protective strategy:

GP4 L517-519 "... it's a lot easier for straight guys to talk to gay guys because somehow they don't see them as so much of a threat to them and so it creates an understanding on some level"

This is seen as being more pertinent to younger generations because gay people are seen by some as having socially isolated themselves, whether through intimidation or purposely separating themselves:

GP4 L526-529"... everything just seems to be gay gay gay... they almost don't even want to know about this other area... they don't want straight people in the gay bar but they also don't want to go to straight bars either"

It is seen that the balance has gone in socially mixing, it is more polarised along sexuality lines, led by increased legal liberalisation. For others, it is recognised that despite the image of smoking maybe being used by some to indicate a certain aspect of the male character, such as aggression, this is not the intention of the smoker himself:

SP5 L417-418 "It isn't done to make me look hard... that's not the way I perceive myself. And it doesn't affect my personality"

This person tries to distance himself from the action or behaviour to one of it helping him make a statement:

SP8 L399-400 "I wouldn't say that it makes me feel more masculine as such, it makes me feel that I am resisting to a certain extent the increasing oppressiveness... "

In a similar way it is one other way of exerting masculinity when he thinks that an aspect that he links to masculinity has been removed. In this context, masculinity is subsumed into an intellectual position of it being expressed in ones freedom of choice.

CHAPTER 4

DISCUSSION

The aim of this research was to focus on factors affecting the maintenance of smoking in the context of health, the constraints of material, social and cultural contexts and diversity among different sections of the male population.

The results indicate much similarity in the groups of men. Knowledge of smoking-related diseases between the two groups appeared to be comparable and for the majority of the men their reasons to smoke were very similar and not necessarily a function of their sexuality as has been reported in many studies (Meyer, 1995; O'Riordan, 2002; Sheahan & Garrity, 1992; Skinner, 1994). It is also clear that the meaning of smoking to these men is not derived in a vacuum. In addition, areas such as attitudes to illness, discussing their perception of susceptibility to illnesses as well as health-seeking behaviour and seeking support to stop smoking were mirrored by most of the participants.

Despite all the men in this study being generically classified as 'smokers', different social, material and contextual circumstances have embedded and supported their behaviour, whether they had been smokers for 3 years or 25 years. These positions include socially constructed relationships such as family structures, workplace links, medical institutions and cultural definitions of masculinity (Schofield, Connell, Walker, Wood, & Butland, 2000).

The sample in this study was chosen due to them being identified as belonging to a socio-economic group, defined by their routine and manual employment, that is found to have a higher smoking prevalence as described in the introduction. However, they do not conform to all of the complex interactions which are recognised as being a cause of health inequalities and that include the long term effects of a disadvantaged position, differences in access to information, services and resources, differences in exposure to risk, lack of control over one's own life circumstances or a health system that may reinforce social and economic

inequalities, (NICE, 2007). Despite this, they do all arrive at the same position, a desire to continue to smoke.

In addition to the external factors mentioned, in comparison to females for whom research has found that initiation and maintenance may be explainable by one single variable, e.g., having one parent that smokes, holding positive views on smoking or having an awareness of different cigarette brands (Charlton & Blair, 1989), for these participants a combination of factors contribute to their smoking. For example, it may be used as a coping mechanism to deal with negative affect such as stress and feelings of anger (Lambert, Hublet, Verduyckt, Maes , & Van den Broucke, 2002; Oakley, Brannen, & Dodd, 1992) as well as more pleasurable aspects such as the sensory effects and the 'rush' experienced due to the nicotine.

This study has illustrated this fluid combination of variables that are considered to be important for the participants, resulting in 'reducing the potential for cognitive dissonance, caused by the action of smoking by rationalising, normalising and minimising intrinsic and extrinsic factors'. This affects the response exhibited to the attempts by various agencies to achieve a reduction in smoking prevalence. These will now be discussed.

4.1 Maintenance

4.1.1 Sociodemographics

The wider reasons for initiation of smoking have not been reported in this study but it can be hypothesised that it is too simplistic a position to expect people not to start smoking. This may be illustrated by the finding that the large majority of the participants began smoking in childhood (below 16 years of age). This is similar to the general findings that approximately 65% of current and ex-smokers started smoking before age 18, with 39% starting before age 16 (NHS Information Centre, 2010). Despite the best efforts of schools to incorporate education against health destructive behaviours such as smoking, this appears to

be a systemic issue, of which schools are but one influence.

Most of the participants recognised that they continue to smoke due to its addictive nature and habit, with the numbers of cigarettes that they smoked having gradually increased. It is however difficult to make a direct link with this rate of smoking within these participants as being due to social inequalities as demographic data for their families was not gathered. However, it has been found that children from lower social classes and lower socio-economic status households initiate smoking from an earlier age (Robinson & Bugler, 2010). In addition, young people are more likely to smoke if their friends or family smoke (Fuller, 2009) but also have greater ambivalence about the dangers of tobacco and smoking to their health (Amos, Hastings, Angus, Bostock, & Fidler, 2009). This ambivalence was seen in this study;

"... I just wasn't going to achieve anything by not smoking. If that makes sense. I know I'm not achieving anything by smoking but, I don't know..." (SP1, L122).

4.1.2 Knowledge

A good overall level of knowledge of the main health concerns about smoking emerged from this study. One explanation for this could be the average age of the participants; 29 years (range 21-40) for the straight participants and 27 years (range 20-35) for the gay participants. Although not explicitly measured, it could be assumed that they would have been exposed to substantial health related messages and media discourse in the U.K. especially since the Smoking Kills White Paper (Department of Health, 1998). This knowledge has not had an immediate effect on the men's behaviour in this study as it has in other sections of the general population where smoking rates have reduced more markedly. A possible explanation could be that due to the information being promoted widely but not necessarily in a proactive manner, for example being passive recipients in healthcare interactions, it has not resonated with the groups of men in this study.

Taken in consideration with the fact that groups who have high rates of smoking may also indulge in other unhealthy behaviour there is a need to consider smoking cessation and the encouragement needed to think about stopping, in the wider context in order to reduce health inequalities (Jarvis & Wardle, 2006). In this study, such other 'unhealthy' behaviours, mainly reported as being alcohol or cannabis, were perceived as being in moderation.

4.1.3 Cost and availability

Cost and availability of tobacco was a factor in the discussions around encouraging maintenance. This has been recognised by policy makers in areas such as cheaper brand availability and an increase in rolling tobacco use (Department of Health, 2010). While some participants in the current study reported this to be the case it should be noted that cost was not always the reason cited for an increase in the use of rolling tobacco but also factors such as the sensory pleasure from the actual production of the cigarette and the aesthetic qualities of this type of cigarette, and the role of group norms on product selection.

Availability was also a determinant of consumption but was minimised due to different routes of accessing tobacco, such as family and friends, whether purchased or 'blagged', although for some this did have an effect on the numbers and regularity of their smoking habit. These routes were, however, also forms of social bonding, for example, sharing cigarettes was seen as a reciprocal act while also being seen as a way of controlling the numbers smoked.

4.2 Coping

There was great similarity in the results obtained in this study related to coping for both groups of men and these will be initially discussed, followed by a section addressing aspects that specifically emerged for the gay participants.

4.2.1 General coping

A number of the men in this study identified with smoking being a source of predictability and support to help them cope with daily struggles. In such cases long term benefits of stopping smoking have little relevance when they are focussed on coping with the present and the challenge this poses for them (Stewart et al., 1996). In this context it is important to be aware of the unique role that smoking may play in some peoples' lives.

Realities of life differ for everyone and risk is perceived on a spectrum that has a consequent impact on how behavioural effects are interpreted. An additional factor that emerged from the data is that even if they have decided to stop smoking in the past, often other factors become a barrier to stopping, including time pressures and stressful life events.

One response for the participants is to develop better coping mechanisms. Some men may have a limited repertoire of coping strategies, with smoking being, for some, the primary strategy;

"I can't really think of anything else, it's just smoking really" (SP7 L 382-383).

Any disclosure of this being an issue for them could be linked to what Schofield, Connell, Walker, Wood, and Butland (2000) have reported as compromising traditional masculine coping mechanisms, resulting in "cocooning' themselves in constructs of 'typical' male behaviour discussed earlier, such as 'stoicism' (Hibbard & Pope, 1986). This supports their notion that health research, rather than being based on 'oversimplified assumptions about men and masculinity' should instead adopt a gender-relations approach where health concerns are perceived in the context of men's (and women's) interactions with each other as well as their positions in the larger, multidimensional structure of gender relations (Schofield et al. 2000).

For those men in this study who may admit to themselves that they have to stop smoking, while simultaneously realising that they have a limited repertoire of coping strategies, this could constitute a sign of weakness in their bodies, and perhaps that their body

cannot cope with the potential impact of disease. This would also conflict with their assumptions of 'invincibility' afforded to their construction of their body that has also emerged from this data and is discussed in relation to illness risk perceptions later in this section. As such, it could be argued that for most men continuance of smoking could be seen as a defence mechanism to manage this lack of coping ability in order to remain positive about themselves.

4.2.2 Gay coping

As has been mentioned the results from this study indicate smoking as a coping strategy for both groups. However in relation to the perceived higher prevalence rate for gay men reported in the introduction, Offen et al. (2008b) have commented that understanding how alcohol and other drugs became seen as gay specific concerns would be helpful as social attitudes are seen as affecting how behaviours are normalised. This may also help to explain this process with regards to smoking. Challenging the idea that most gay people smoke, and so normalising non-smoking, could make it easier for an individual to become, and remain, smokefree.

In comparison to the straight men in this study who did not have to confronts issues associated with their sexuality, a greater understanding of the 'coming out' process of gay men, when a person's 'authentic self' challenges societal norms, could give young people the strength to resist the initiation of smoking if it is seen by them as a coping strategy of not being able to be overt about one' sexuality. This is more pronounced if there are additional barriers for them during this process, such as is illustrated in this present study by the conflict felt by a gay participant with religious parents. In this instance, being gay was another pressure to deal with while also trying to become independent. However, for most of the other gay participants this additional barrier was not met and so this questions the validity of previous findings (e.g. Lombardi, Silvestre, Janosky, Fisher, & Rinaldo, 2008) of the extent

of this effect.

4.3 Stopping

4.3.1 Health beliefs

As has been reported, smoking has a high morbidity and mortality rate (NHS Information Centre, 2010). A paradox is that older people are more likely to successfully stop smoking than younger people (Department of Health, 2011a). This could be related to older people being more aware of the implications of smoking as they are more likely to have noticed the effects in comparison to the sense of unrealistic optimism (Weinstein, 1987) and being indestructible illustrated by some of the men in this present study. Breaking the incongruence between knowledge of the health effects, the fact that stopping earlier in life can have a beneficial effect on health outcomes and that quitting when younger can be easier in terms of the level of addiction and habituation, is challenging.

What has emerged from this research is the reinforcement of the fact that knowledge of smoking related diseases and hazards does not result in a desire to cease in this behaviour immediately in younger men. Whether this is rational or irrational depends on the viewer; a number of men in this study would probably not view smoking as irrational but a choice. However, whatever term is applied to describe this situation it is difficult to counter these beliefs in terms of health education alone or merely offering interventions aimed at supporting people to stop once the decision has been made by the smoker to make an attempt to stop (Dennis & Miles, 2010).

What has become clear from this study is that the beliefs of some smokers in the general population differ from the more focussed beliefs of the health professionals. Furnham (1988) explains that individuals' beliefs are affected by their experiences and as such these beliefs will hold different functions. Such a cognitive social psychological approach allows individuals to make sense of their worlds, to increase their psychological comfort and

consequently reduce the level of cognitive dissonance. The aim is one of the following; to achieve control through understanding the world; to increase feelings of self esteem and to gain public approval; and finally, to avoid public embarrassment (Hewstone, 1983).

Of these it can be said that the second point, to increase feelings of self-esteem and to gain public approval, fits into what Weinstein (1999) recognised as smokers ignoring the belief that health risks associated with smoking do not apply to them while also, for some, conforming to social norms. Such a position reinforces the ideas put forward by Sensky (1997) that people act on their own illness beliefs rather than on objective evidence.

This may be further complicated due to the knowledge that a proportion of the harm done by smoking can be reversed in later life; this could actually be detrimental to the attempt to encourage men to stop at an earlier age. This situation is illustrated in this sample on a number of occasions where the belief is held that there is time in the future for the body to repair itself; the assumption is that they will be able to stop smoking in the future, without realising that the nicotine addiction is stronger and the behaviour is more entrenched after these additional years of smoking.

For some in this study this can be seen lead to a misinterpretation of official stop smoking service information which highlights these improvements over time, such as Stop Smoking, Start Living (Department of Health, 2011b). In this, instance health benefits of stopping smoking are seen in the context of between 20 minutes and up to 10 years; when viewed by someone aged between 20 years- 40years, as in this sample, this removes the immediacy of stopping and reinforces the idea of stopping as something to be done in the future;

"Since I was 18 I've assumed I wouldn't actually live much longer than the age I was then... it really does seem a general thing... it stops at about 30 you realise ... 'I'd better do something about it'"(SP6 L187-193).

This corroborates the findings noted earlier of Hodgetts and Chamberlain (2002) who proposed that concern over health matters for males is located in the future; health problems are constructed as not happening in earlier life, possibly linked to the different socialising of males and females, where females are 'gatekeepers' to the healthcare system (Camiletti & Marchuk, 1998; Mackereth & Milner, 2009) and where female concern for their own health is normalised (Seymour Smith, 2002). The consequence is that they do not see themselves as vulnerable and conclude that the emotional energy to engage in ceasing a potentially health-damaging behaviour is not justified. This was also the case for those who had already exhibited illnesses such as chest infections; despite considering their smoking status while ill, as soon as they recover the person soon forgets stopping.

This situation highlights that for some the need is to focus away from the health effects of smoking and on to the financial benefits of stopping as well as increasing the realisation that the process of stopping is likely to be more difficult later in life due to increased levels of nicotine addiction as well as the increased habituation. This could however increase their anxiety, reported elsewhere in this discussion, and lead to never attempting to stop unless a conversation is had with them in an attempt to discount these misconceptions.

4.3.2 Gay men and health

Health effects of gender have been summarised earlier as a tripartite relationship between biological, psychological and social differences; Keleher (2004) reported that the biological advantages which women experience when compared to men are counteracted by social disadvantages which may be manifested in areas such as social, economic, cultural and political inequalities (Krieger, 2000). In addition, men's social experiences, including health, have been allied to factors such as sexuality and ethnicity as well as disability and social class (Robertson, 2007). In terms of this study, using sexuality as a proxy for these findings, such

disparities did not appear to arise for the majority of the gay men and their health.

McKirnan et al. (2006) commented that health issues for gay men, or MSM, have concentrated on HIV/AIDS. As such smoking and other behaviours affecting health, such as alcohol and drug use, have been overshadowed in terms of public health. While HIV status was not asked of any participants in this sample, no one volunteered this information or discussed its impact if it was relevant to them when commenting on any aspect of their smoking career. For example, it was felt that had coping with this, or any other illness, been of relevance to the participants in this study it would have been brought up by the participant when discussing their future health concerns. However, the one item that this area did raise was the sense that the advances made in the treatment of this disease gave a sense that medical science would devise cures for smoking-related diseases;

"Well, I'm a real bugger for believing in medicine and science and I'm kind of relying on that to save the day...they cracked the genome so it's a matter of time"(GP5 L473).

This could be perceived as another example of unrealistic optimism.

4.3.3 Health messages

As men develop a sense of their self in childhood, the health messages about smoking that they may remember are not seen to be relevant to them as adults. In this respect, the messages need to be salient, while, as stated by some of the participants, the 'messengers' delivering these messages need to be perceived as valid. While it was commonly stated that role models are not applicable when they are adults to encourage them to stop smoking, it was acknowledged that they might be more valid for young people to encourage them not to start smoking. However, this may not always be successful, as young people may want to have different personas, or identities, depending on their audience; they will act differently whether they are with parents, peers, teachers etc. and so a repertoire of messages could be developed for different situations to counteract this pattern of complex identities used by

smokers to 'hide' their habit from specific audiences.

There is a sense that the men do not respond to the numerous exposures to health related messages that they are exposed to, whether it is verbal or written;

"I do actually think 'just shut up about it' because it's by rote... I'd rather we just took it as read that I smoke and carry on" (SP8 L114-116).

It is not clear whether the messages themselves conform to an effective format with a high threat message (perceived severity and vulnerability) accompanied by an equally strong recommendation about how that threat can be overcome, highlighting response efficacy and self efficacy messages (Rogers & Prentice-Dunn, 1997; Witte & Allen, 2000).

One suggestion for this could be that the men are so aware of the threat posed to them by smoking that a more novel approach is needed to engage them in the present. One suggestion could be to make this advice more tailored to them, following the Elaboration Likelihood Model (Petty & Cacioppo, 1981) where greater personal involvement can result in higher message-relevant thinking. The nuances that each individual attaches to their behaviour due to their personal circumstances need to be considered although the results in this study indicate that even with this approach the men may not be open to receiving such information, regardless of the format.

In addition, the aspect of compulsion and enforcement to encourage smoking cessation has, for some, made the possibility of changing behaviour more doubtful and could be said to be an unexpected contingency or side effect, reinforcing their continuing habit.

4.3.4 Life stages

In this present study, the age of potentially stopping appeared to be a factor for both groups, but in particular for the gay sample; those who gave any thought to stopping appeared to make this quitting time point at an older age than the straight participants. For example, SP3 who is aged 22 years uses someone aged 30 years as a comparator; GP 5 who

is aged 27 years uses someone aged 40 years as a comparator. This position indicates the main issue; stopping is always procrastinated. Sirois (2004) found that procrastinators might engage in fewer health behaviors because of weaker health-specific self-efficacy that reflects a sense of control over ones health. Not feeling capable of engaging in actions to look after their health results in not forming a strong intention to perform these behaviors. This in turn reduces the mediation effect of intentions on attitudes and beliefs within behaviour change models such as the theory of planned behaviour (Ajzen, 1991; 2008) and is recognised by some participants;

"...maybe that's just a psychological trick not to, you think you're going to but really you're not" (GP3 L411-412).

It should also be noted that social and material circumstances change over time, and although at one point individuals may believe they will behave in a certain way, this behaviour may not be acted upon and maintained. Such changes have been mentioned in the results, e.g. becoming a parent, experiencing a 'serious' illness and reaching a 'significant' age, and can be further influenced by socio-demographic factors such as income, employment opportunities and the impact of prejudice. These factors have a cumulative effect over the life course (Graham & Power, 2004). For example, in this sample, SP5 has been in employment and has the support of his partner and enjoys smoking, compared to SP10 who is casually employed, living in a squat and does not have a partner, and smokes to cope with life. Based on these findings it could be questioned what effect intervening or concentrating on such 'transition points' may be.

Similarly, there did not appear to be awareness that by stopping smoking earlier they may reduce their chances of contracting a smoking related disease, unless this is linked to a sense of inevitability of this happening. As such there appears to be a vicious circle developing between age, health and life changes, or transition points. This had led to a denial

of potential problems, especially for the younger participants. This is similar to the findings of O'Brien et al (2009) and supports the view that men identify an appropriate, 'commonsense' course of behaviour at different stages of life related to their social circumstances and obligations (Backett, Davison, &Mullen, 1994; Backett & Davison, 1995). This has been reported from the viewpoint of fatherhood and a committed partnership replacing the 'chaotic' nature of being single (Backett & Davison, 1995; Bartlett, 2004). Such findings have led to the belief that a life course approach could be appropriate and beneficial when considering men's health (Arber & Cooper, 2000; Lohan, 2007).

While health problems commonly associated with smoking are located in the future, so too is the idea of stopping, although for some there is the recognition that this point may never arrive; it is a constantly moving deadline. Therefore, to understand not just the uptake of knowledge regarding the risks and the effect of information-giving it is essential to consider other constraints to locate the person and therefore to contextualise their concerns and appreciate the boundaries of their lived experience.

When discussing factors in their life course that may encourage them to re-evaluate their health behaviour, the men from both groups cited the examples of ageing, employment opportunities and experiences of illness, and for the straight group, fatherhood. These factors all relate to major transition points rather than a desire to perform healthier behaviour for themselves in the present. This sense of stopping in the future could also be reinforced by research findings that if someone stops smoking by the age of 30 they are likely to live as long as someone who has been a life-long non-smoker (Doll et al., 2004). This could be seen as reinforcement to continue smoking until this age, and appears to coincide with the views for most of the men in this research who are aged under 30. However, it should be noted that this finding does not take into consideration the quality of life for some in later years and the effect of other lifestyle variables such as diet, alcohol consumption and physical activity that

also impact on overall life expectancy. In this context, despite an expected extended lifespan from quitting earlier, Doll et al. (2004) noted that a more appropriate conclusion is that 50% are likely to die from smoking related diseases.

The sense of 'future' was illustrated most clearly by having children. Although for the gay participants this was not such a common view, with a changing social environment perhaps this should not be totally discounted as adoption or having a surrogate pregnancy has become an option for gay people. However, only one of the participants, SP5, aged 40 years, had children and so the potential effect of having children was theoretical for a majority of the sample. As such it was not possible to say whether this factor would have the expected effect of changing their behaviour or whether they would follow the pattern of not stopping as reported in the introduction (Blackburn et al., 2005; Everett et al., 2005).

In comparison to these scenarios for a few of the men there is no sense of a future due to personal and financial circumstances and so do not see a reason to stop, making them a greater challenge.

4.3.5 Health protective behaviour

For some of the participants there was an active engagement in positive health behaviours in other areas, such as diet and physical activity; however, this did not result in them embracing health practices with relation to stopping smoking. In terms of health protective behaviours such as screening and self-examination, Ogden (2004) has noted that this course of action may indirectly negatively impact on an individual, with increasing anxiety resulting in avoidance behaviour and abstinence.

Applying this premise to smoking, it could be surmised that in a similar way potential anxiety relating to stopping smoking could be perceived by some as greater than the apparent benefits of stopping smoking, especially for those who may already be ambivalent. Many of the participants stated their ambivalence, especially if they perceived themselves to

not be at risk of disease. To overcome this, increasing the relevance of the potential disease and their estimation of their own risk levels could be as important as attitudes, social influence and feelings of self-efficacy to stop smoking that are recognised as influencing lifestyle changes.

Similarly, despite the sample indicating a mixed ability to recognise bodily symptoms, in a sense self-examination, that may indicate various levels of potential for an illness, which in itself could induce anxiety, the men appear to apply a 'common sense' approach, similar to the self-regulation model (Leventhal, Brisette, & Leventhal, 2003). However it is difficult to ascertain how effective this approach might be in the longer-term. In addition, some of the men confirm previous research and do not wish to be viewed as 'trivial' healthcare users (Cameron & Bernardes, 1998; Noone & Stephens, 2008).

In this respect, rather than conforming to a 'masculine' lack of concern for their health, the men in this study appear to be looking for a balance in their lives where other health protective behaviours are perceived to compensate for those behaviours which may be deemed as 'unhealthy' (O'Brien et al. 2009). The challenge appears to be to embrace health protective behaviour by identifying the reasons for engaging in it and then to extend this behaviour to other areas. Some see that they engage in exercise in their daily lives in the workplace whereas others may need more organised activity. This would address the finding by Amos and Bostock (2007) that that a unique concern for boys was the effect of smoking on their physical fitness. However, it is not clear whether sport is engaged in for the idea of competition (a traditional masculine trait) or for the health benefits it results in; anecdotally this can be seen in the Sunday football match which stereotypically ends in the pub; is this to achieve a life-balance identified earlier, where one activity (exercise) is perceived as cancelling out the other (alcohol)?

Similarly, in the case particularly of the participants who identified band culture, it

could be argued that this identity with band culture and smoking may be necessary in order to be 'acceptable' to peer groups, described by Connell (2005) as 'masculinity as collective practice'. This is similar to the sense that certain masculine practices are 'privileged' in different groups, where there is a need to negotiate an environment as 'male', i.e. find a group where certain practices are accepted and are seen as identifying themselves as masculine within that group. O'Brien et al. (2009) found that men who identified as working class, and labelled as routine and manual in this study, but who no longer work in traditional, primarily masculine occupations such as heavy industry, other activities have to be found in their social world to maintain this identity. It could be argued that for some this may be where the traditional view of smoking can be of use in defining themselves.

However, the data from this present study suggest otherwise; for the majority of the men this is not stated as the reason to smoke. These older constructions of masculinity are now seen to be outdated in terms of continuance of a specific behaviour; for those who remember images such as 'Marlboro man', an archetypal image of smoking, they are no longer relevant, especially now that it is known that smoking is detrimental to the ultimate sense of masculinity; virility. This could be due to the age of the data used in previous studies. For example, when investigating the smoking behaviour of gay and bisexual men, the results found by Stall et al. (1999) referred to data collected in 1992.

4.3.6 Risk perceptions

It could be viewed that despite the prevalence of smoking related diseases and the possibility of themselves contracting such diseases, most of the men appeared to discount their risk levels, especially those of the sample who knew survivors of these smoking related diseases who, whether male or female, take on the image of men adopting the role 'risk-taking superhero' (Lyons & Willott, 1999);

"she had a mouth cancer... but she got over that. She had an operation to sort it out.

Invincible" (SP6 L323-325).

A reason for the lack of immediate concern for health is given in an Offen et al. (2008a) study as the juxtaposition by one respondent that 'alcohol kills actively' (p148) through drinking irresponsibly and driving while drunk as opposed to tobacco killing 'passively' (p148). This highlights the need for information to be disseminated as tobacco kills more people than alcohol, AIDS, cocaine, heroin, car accidents, murder and suicide combined (Department of Health, 2011a; Warner, 1989).

For others it was made explicit that 'life was not a game', and that such an experience would be a reason to stop if a smoking related problem was identified. However, at the time of the study this sense of 'threat' to health was still not a strong enough motivator for them to stop.

4.3.7 Mortality

This research was conducted a number of years after the smoking legislation was introduced in England in 2007 and the higher profile this afforded to the dangers of smoking. In this context the question is one with which health psychology models grapple and endeavour to explain; why behaviours occur, even with the level of knowledge about the detrimental effects of that behaviour.

Another approach to explain this behaviour could be to consider the male sense of mortality. A number of the participants held a fatalistic attitude to their health; "Certainly I shall die one day and that will put paid to it. No, I think it's unlikely in the foreseeable future, I've got no plans to stop" (SP8 L125-126).

In addition, reframing smoking as a form of self harm may have more of an effect than being seen as a behaviour choice; of the main public health issues which are of concern, such as obesity, alcohol consumption and inactivity, smoking is one of the only activities that even in moderation is not advisable.

The participants suggested that they were viewing all of their behaviour as a balance between enjoying life and a realisation of their own mortality, where the perception of enjoying life as a smoker is more important than potential, but not guaranteed, additional years. As such, once any sense of threat leaves consciousness, for example a sick relative recovering or a chest infection improving, psychological defence mechanisms override this rational self in order to increase self -esteem and avoid the anxiety that thoughts of their own mortality may engender. As such it could be suggested that fear messages to encourage cessation may inadvertently promote continuance of risky behaviour, supporting a 'live for today' philosophy. This could be a narrative the men engage in to avoid cognitive dissonance; if smoking is considered an addiction, and therefore a behaviour they have impaired control over, they need to re-frame their beliefs about smoking, as it might be too emotionally difficult to recognise the implications of their behaviour while simultaneously not feeling empowered to change it which also links to coping strategies.

4.3.8 Perceived likelihood of success

In addition to smoking being used as a coping mechanism, the possibility of failing to stop smoking, and the anxiety this might engender, could be another reason to prevaricate and not follow the health protective behaviour of smoking cessation.

The construct of knowledge preceding behaviour (change) must also be seen in the context of the realities of the individuals. Jarvis and Wardle (2006) and Kotz and West (2009) have highlighted that poorer smokers are more likely to be more physically addicted to nicotine with a resulting lower ability to succeed in their quit attempts. In this study there was an understanding of nicotine addiction which had a mixed effect on the participants smoking behaviour; the analysis shows a range of past success with some being able to stop at will while for others the main problem was to keep the sense that maintenance of cessation as a priority for them, for long enough, to overcome this addiction and to change their

habituated behaviour. This may be based purely on the addictive explanation of quitting, based on 'willpower', or on a more cognitive approach. For others, having no social comparison for the process of stopping is a limiting factor, creating a vicious circle leading to a feeling of helplessness.

As well as reflecting their personal and material circumstances this could also be seen from a number of viewpoints for future attempts; they do not actually want to stop, or they want to reduce the expected anxiety of 'failure' to quit.

4.4 Cultural differences

Galdas et al. (2005) found that general health status of men needs to be more focused on sub-populations of men as the concept of traditional masculine behaviour, recognised as being tough and self-reliant, may be a culturally defined phenomenon and may not adequately explicate the influence of masculine beliefs among the wider male population per se. This raises the question of whether the dominant form of masculinity that is discussed in the literature as the 'western' perspective is always relevant. There is a need to recognise that when talking about masculine socialisation this is dependent on culture, beliefs and environment. This is especially evident when one investigates differences in morbidity and mortality across SES and ethnicities and the type of ill-health suffered as described in the introduction (Robinson & Bugler, 2010). In this present study there was mixed pattern of others' smoking around them; for some they may have been the only smoker while for others their whole social grouping was one comprised of smokers. Of those participants not originally from the U.K. and who may have been subject to different levels of media exposure and discourse, it could be surmised from their responses in the discussions that they were equally aware of the issues surrounding the health effects of smoking. However, there are implications for the cultural appropriateness of messages delivered and would suggest that there is a need to have a tiered approach in a multi-cultural society such as the U.K. as

not all non-U.K. men may be as aware as these participants.

4.5 Healthcare professionals

4.5.1 Communication

Most of the participants identified that healthcare professionals had, on at least one occasion, advised them that they should stop smoking. However, being given this advice is not necessarily the same as a 'lifestyle discussion' which Lehman and Krumholz (2009) have found doctors do not engage in.

It appears that there may be a need for health professionals to have a clearer understanding of the psychosocial factors that influence the decision making of men so that they may be approached in an appropriate, relevant way by healthcare professionals. Communication has long been a factor that is seen as impacting on the healthcare interaction so by enabling and training healthcare professionals to identify the reasons men continue to smoke so that they can then have an honest discussion with the person. This would help to make the intervention more relevant and enable them to tailor their approach.

Whatever model is used to explain health behaviour change in its theoretical form may not result in actual change due to the context of the advice giving or the delivery of that advice and support. For example, Vogt, McEwen, and Michie (2008) found this to be the case where GP's did not feel social pressure to deliver advice or feel able to deliver brief stop smoking interventions. It is necessary therefore to work with these professionals to understand their resistance to engage with such resources.

4.5.2 Biomedical approach

One reason for not being successful at engagement could be that when discussing health, Smith and Robertson (2008) have noted that many health professionals continue to approach men from a traditional biomedical approach, with a focus on issues of their physical health to the exclusion of the effect of the social and behavioural factors that help to maintain

their smoking once initiated, and which make it harder for them to quit when they arrive at that point. These factors could be influenced by issues such as self-esteem, confidence and a sense of resilience, as well as wider issues of social norms and social barriers (Department of Health, 2011a) that have been seen in this study with respect to maintenance factors and beliefs about ability to stop in the future.

4.5.3 Structural problems to communication

There are a number of questions related to the health professionals communication approach which a number of the participants have identified as a problem when confronted with the stop smoking message, e.g., the frequency and the delivery of the message perceived as being 'by rote' which is seen to reduce the strength of the message as it is repetitive and not contextualised to the persons circumstances.

Walsh, Swangard, Davis, and McPhee (1999) stated that GP's have a consistent relationship with their patients and as such are in an ideal position to facilitate behaviour change. Whether this is still the case with more fragmented practice relationships in that many patients no longer have a 'named' GP could be open to question. However, irrespective of this it has also been found that GP's are dubious as to the efficacy of the behaviour change message (Bruce & Burnett, 1991). Historically this could be due to the perceived additional workload and/or the belief that this possibly moves away from the biomedical approach and as such the belief that this approach should come second to the more traditional curative care.

There is also a suggestion that repeated changes to the health system have led to a more fragmented service by making professionals less motivated to address such issues due to reduced 'relational continuity, coordination of care and whole-person, patient-centred care' (Roland, Campbell, Bailey, Whalley, & Sibbald, 2006; Willis, 2009). An example of these changes could be the introduction of targets while the advent of Quality and Outcome Framework (QOF), aimed at incentivising discussion and recording of specific health related

behaviours such as smoking (Roland, 2004), has perhaps resulted in advice being given 'by rote' as reported in this study.

Chisholm (2010) found in a study of health care professionals that there is also often a lack of consistency in the manner in which GPs approach consultations with consequences on how effective behaviour change information and support is communicated. This was reflected in this present study by the different, sometimes conflicting, advice being given, including that the smoker had sufficient time to stop in the future.

4.5.4 Stereotypes

Smith and Robertson (2008) comment that where men are approached by health professionals from a sociological perspective of masculinity this can be homogenising and not explore the complex relationship between men, masculinity and health. A similar situation may exist with the construct of sexuality; in comparison to many previous studies e.g. Gruskin and Gordon (2006), the participants in this study identified as gay rather than as men who have sex with men (MSM) that relates to sexual rather than social identity (Greenwood et al., 2005; Pitts, Couch & Smith, 2006; Sell & Becker, 2001). Such 'labels' may impact on their view of their own masculinity and identifies an area for future training of healthcare professionals and/or the provision of more specialised practitioners, such as health psychologists, to offer support at a community level.

4.7 Smokefree legislation

This data was collected post-introduction of the smokefree legislation that came into force in 2007 (Smoke-free (Premises and Enforcement) Regulations, 2006). Platt et al. (2009) reported that there is a growing perception of the personal health and environmental benefits, after an initial sense of resentment. The data for the Platt et al. (2009) research was collected up to one year prior to the data collection for this current study and for some in this present study this resentment is still present.

One aspect that appears to dominate in the accounts of both groups of men is the effect of socialising. The introduction of the smokefree legislation in 2007 has reduced the influence of socialising on smoking, especially in bars and clubs, making maintenance of the behaviour harder. One might expect this to have an influence for gay men in particular in light of previous research (e.g. Lombardi et al., 2008) that commented on the lack of social space for LGBT populations other than bars and clubs. Whether this aspect has changed has not been explored in this research explicitly although some commented that more socialising was being done at people's homes in both groups, especially for the older participants, an that in these locations behaviour may have changed, depending on the views of the home-owner and those present. This supports Platt et al. (2009) who noted that there was an increase in the numbers socialising at home, especially in the lower socioeconomic groups, although this did not impact on cigarette consumption. However, it is difficult to say whether this was a function of the legislation or a function of their age.

Recognising the reasons for the introduction of this legislation while a few did mention the positive effect on socialisation, the majority of participants in this sample were not supportive of the imposed requirement to smoke outside for a number of reasons, which included, among others, comfort, a negative effect on their socialising and the sense that it made them feel like second class citizens. It did not emerge that anyone shifted their attention to other drugs, including alcohol, rather than being forced outside to smoke.

This finding supports those of Hargreaves et al. (2010) that after the smokefree legislation was introduced in 2007, tobacco consumption, including those cutting down as well as people quitting, reduced, especially in public settings. This was cited as being due to not only inconvenience of having to smoke outside but also the fear of public disapproval, indicating the power of social norms. For example, in the present study participants commented on some members of the public crossing the street to avoid them while they were

smoking. Bauld (2011) has highlighted that people from lower socioeconomic status groups have reduced access to comfortable outdoor spaces, while older smokers experience a sense of loss of pleasure of socialising in bars and other public places. This view also emerged from the current data set as well as the sense that having to smoke outside spoilt the whole socialising event; for some they did not want to socialise with people they were thrown together with outside. In this climate, some of the participants referred to themselves as 'survivors', giving themselves an heroic quality.

Prior to this legislation, as has been reported, the prevalence of smoking in the gay population was higher than in the general population, and it may be too early to say to what extent this has dropped, although it could be hypothesised that any drop may be a similar proportion to that seen in the general population. However, just like the general population and reflecting what has been found in this present study, tobacco control initiatives need to be grounded in the lives of gay men to be effective (Greenwood et al., 2005; Harding et al., 2004).

4.7 Legislation and equality

One aspect that has emerged from this data, and which runs contrary to previous research findings, is the effect that sexuality has on the increased use of tobacco products for gay men (e.g. Bontempo & D'Augelli, 2002; O'Riordan, 2002). Although not dealt with extensively in this report, when looking at the reasons for initiation it could be posited that, just as the timeline of smoking legislation has possibly affected the behaviour of those already initiated in smoking, there could also be a similar impact on the prevalence of smoking among gay men. This could be due to the increased social acceptability and wider legislative changes that have been introduced that affect gay men, such as the Civil Partnership Act in 2004 and the equalising of the age of consent in 2001 (Stonewall, 2011).

Previous research has occurred against what could be described as a more hostile

social environment: a social background where being gay and coming to terms with an alternate sexuality was enacted in an environment where three main of the main influences on social life (religion, law and health professions) ostracised the gay community by labelling being gay as a 'sin', a 'crime' and an 'illness' respectively. This resulted in the reported psychosocial issues such as stress, anxiety and depression that have been seen as one of the main reasons for a much higher smoking prevalence in the gay population than is seen in the general population (Greenwood et al., 2005; Gruskin et al., 2007; Harding et al., 2004; Ryan et al., 2001; Tang et al., 2004).

This could be the case especially in much of the American data reported where men may have been more concerned about disclosing their status and so the only men possibly accessible to these studies were the ones who were overt about their sexuality; it is possible that by being overt about it, they were more likely to be targeted by an antagonistic society, leading to further stress. For example, the data used in studies published recently e.g. Lombardi et al. (2008), used data gathered from men between 1984 – 1985, just 10 years after the American Psychiatric Association removed homosexuality from the Diagnostic and Statistical Manual of mental disorders (DSM) in 1975 (Herek, 2011) and just 5 years after the Supreme Court of the state where the data had been collected had repealed it's sodomy law.

In comparison, the U.K. could be described as more liberal than the United States, decriminalising homosexuality with the Sexual Offences Act (1967) when the age of consent set was set at 21 years before the Sexual Offences (Amendment) Act (2000) equalised the age of consent for gay men to 16 years (Stonewall, 2011). Although a positive step decriminalising being gay does not necessarily make it socially acceptable to all. However, the gay participants did not recount problems experienced in wider society; interestingly the discrimination reported by two participants came from inside the family rather than external homophobia.

Similarly, social and employment law surrounding homosexuality has been formalized and prompted by EU legislation. The European Union Article 13 Race & Employment Directives require EU member states to introduce legislation to outlaw unfair discrimination on the grounds of sexual orientation as well as race, sex, religion or belief, disability or age. In response to such directives the U.K. government introduced the Equality Act (Sexual Orientation) Regulations 2007 (Stonewall, 2011).

Taken cumulatively these could be a partial explanation for the differences seen between this and earlier studies, with most of the gay men having similar drivers as the straight participants, and with the exception of the two participants mentioned earlier, sexuality not being a primary factor for their smoking.

4.8 Smoking, gay men and external pressures

Offen et al. (2008a), in a study of tobacco industry funding for LGBT organisations carried out between 2002 and 2004, found that out of 74 leaders of LGBT organisations and publications in the USA 22% had received funding while just slightly more, 24%, identified tobacco as a priority issue for gay people. Most saw smoking as a personal choice rather than a health crisis, due to it being a 'legal' choice. As such it was recommended that LGBT tobacco-control advocates reframed the smoking debate as one of an unhealthy response to the stresses of homophobia in order to place tobacco control at the centre of LGBT health. This was one of the consistent findings for initiation and maintenance in earlier studies. On the whole, and as has been mentioned earlier, the current study did not find support for this.

As well as a more progressive social and political climate, for the majority there may also be an effect of looser family structures where a more relaxed view is taken of many lifestyle issues. It is possible that working to reduce any remaining stigma further is the more effective way to help reduce the smoking prevalence in the gay community.

4.9 Image and Identity

Whether the identity afforded by the product or by the quantity smoked, it seems possible for the men to rationalise their own sense of identity due to their smoking behaviour. For example, 'social' and 'heavy' does not appear to have a concrete number of cigarettes to be smoked, rather it is a product of comparing themselves with other smokers. In addition, smoking does not feature high on the list of descriptors for themselves. Similarly, terms such as 'light' and 'heavy' tar and the image attached to different cigarette brands, for example the cheaper brands through to the perceived upmarket, 'hardened' smoker brands, such as Marlboro Reds, is also used to denote difference in the participants' identity as smokers.

In spite of these findings, the majority of the men claim not to be influenced by marketing and imagery from external sources; for most of the participants the reasons to smoke particular products, and indeed to smoke at all, are for personal satisfaction and aesthetic reasons. These reasons include taste and the emotional effect rather than for any outward reflection of their self and their identity. For the majority the image created by historic imagery are presumably held as attachments in the collective memory due to the lack of recent advertising of tobacco products. For a few of the participants this may mediate their choice with social influences on product choice, for example the choice of rolling tobacco as opposed to branded cigarettes. This highlights the difficulty in establishing where one effect ends and another begins, and the narrative men attach to these processes.

A category that emerged more for the gay participants was around the idea that smoking is used more as a tool with socialising rather than as a coping mechanism. There was also a sense of a cigarette being a 'prop' to increase confidence levels in social situations. In addition, smoking was a tool gay men could use to judge others, especially when it came to partners, possibly because they may feel more judged by others than the majority straight population.

Despite masculinity research showing that traditionally smoking has been seen as masculine, this study indicated that masculinity is now enacted by other behaviour, with examples given being drinking beer. The data does not support the view that smoking helps the participants achieve a macho image which is often portrayed as being at the root of unhealthy behaviour (Department of Health, 2003).

Although a couple of the gay men engaged in smoking as an initial masculine credit/insurance when looked at in terms of hegemonic masculinity (De Visser et al., 2009) for the majority of the gay men smoking did not appear for the majority to be used as a tool to 'pass' as straight, or to merge into the background. It was, however, recognized as being a personal choice for gay and straight men and where the outdated negative views of female smoking have been removed for many. In fact, a couple of gay participants did think that with an increase in the confidence of the gay population and the polarisation of social venues due to sexuality, it was seen as a facilitator to conversation between the two groups as something they had in common, and so although not directly adding to either groups sense of masculinity it helps to reduce perceived social barriers;

"...it's a lot easier for straight guys to talk to gay guys because somehow they don't see them as so much of a threat to them and so it creates an understanding on some level" (GP4 L517-519).

In this research the social consequences of smoking appear to be mixed, especially in relation to the factors of social pressure, parental smoking and image. This may be a function of the age of the sample with most being over 21years and so more habituated to smoking and further away from the age when these processes may be more powerful;

"I think role models work for younger people, for me now it's like someone else being ill – you remove yourself from their effects. I mean my dad was a role model..."(SP6 L421-423).

This would support the findings of Gardner and Steinberg (2005) that peer pressure may

exert greater influence over risky behaviours in younger age groups. As such social factors may amplify the desire to smoke compared at an earlier age than later when it may be viewed more as a personal choice.

4.10 Legality of tobacco and choice

It cannot be disputed that at a population level the prevalence of smoking has reduced over time (Department of Health, 2010). However, as demonstrated in this study, there still remains a section of the population that states a lack of intention to quit in what may be described as a 'timely' or 'immediate' timescale. One problem with combating this situation, the essence of which was conveyed in this data around limitations put on the freedom to smoke in public, is that tobacco is legal; as long as this is the case a section of the population will still be willing and content to continue with the behaviour, irrespective of the perceived and real negative health outcomes. This is the paradox to this situation; the participants regard tobacco smoking as a legal activity and yet they see that restrictive legislation is in place to reduce consumption and to encourage cessation, resulting in a perceived illogical position of the messages around smoking for some of the participants;

"...cigarettes apparently kill more people than a lot of these other drugs that are banned" (GP3 L592-593).

It would be easy to ignore the fact that, despite a widely held awareness of the negative aspects of smoking on the individual as well as those around them, perhaps some men just do not want to stop with such an imperative as may be desired by professional and medical bodies. It appears from the data that rather than continuing to smoke out of a sense of rebelliousness that may have be cited as a reason to begin smoking (Easton, Jackson, Mowery, Comeau, & Sell, 2008; Ryan et al. 2001), continuing the behaviour is due to a number of others reasons. For example, some of the men in this study fuse, or confuse, the science of ill-health effects with political direction or political control and as such appear to

reject any individual or organisational effort to change their behaviour as they see it as a means of control over their free will.

Therefore, the process of encouraging men to quit may be a gradual process; as Rose (1985) commented, even small degrees of change can result in significant changes in population health and the process of encouraging men to stop smoking will require more time, if it is to happen at all.

4.11 Psychological determinants

A number of factors are required to facilitate behaviour change behaviour and their presence, or absence, can influence success. These include an individual possessing cognitive, emotional and behavioural skills such as a readiness to learn, coping skills, self-esteem, self-efficacy and social capital through friendships and family (Graham & Power, 2004; Morgan & Swann, 2004; Bandura, 1986) which collectively may be called personal capital (Graham & Power, 2004). In addition, Hargreaves et al. (2010) found that couples and groups of smokers were more likely to change their behaviour together.

A combination of these factors results in boosting resilience to protect against negative behaviours and therefore health outcomes and by adopting positive attitudes to health. Engendering such positive attitudes to health enhancing behaviour could therefore impact on increasing motivation before actually engaging in behaviour change. This challenge was seen with many of the men who took part in this study. In this context, by increasing the negative attitude to the effect of smoking on health and increasing the sense that stopping earlier can have a better outcome in the long term becomes more important, e.g. by saying 'although it will be good to stop at 40 years', for example, 'you would have x number additional life years of better quality' by stopping sooner. This would help to reinforce stopping before 30 years.

An influence on this could be the participants of locus of control, with differences

emerging in both groups of their reliance on others for taking care of their health or telling them that they should stop smoking. This would be mixed support for the view that men are not health conscious but irresponsible, having to be brought by their partner "...kicking and screaming" (Seymour-Smith et al., 2002, p257) to the surgery. This was also the case for those men who were single.

An aspect that is more difficult to estimate from this sample is whether the personality of the participants had any effect on the data. For example, Costa and McCrae (1992) found this to be the case with extroverts. Of those expressing negative beliefs about the health risks of smoking, do they hold stronger, more entrenched, negative views or are they just more likely to express their views, irrespective of the core strength of the views? This begs the question of whether some men are 'hard wired' to predicate their smoking behaviour despite the danger.

This situation raises the question of how then can this be addressed? If the man has more negative feelings towards the attitude object, smoking, could the answer be to just emphasise the pros of stopping and focus on their sense of personal responsibility to stop? If the man has limited negative feelings towards the potential outcomes of their behaviour how are they to be made to care about their health? This would however depend on a number of factors, including them having a conversation with someone with the right skills to spend the time to have that discussion.

4.11.1 Theory of planned behaviour

The theory of planned behaviour was the basis for this research. As a general rule, the more favorable the attitude and subjective norm, and the greater the perceived control, the stronger should be the person's intention to perform the behaviour in question. Given a sufficient degree of actual control over the behaviour people are expected to carry out their intentions when the opportunity arises.

When considering the sense of control felt by the participants in the present study, there is a difference in the levels of feelings of control over their behaviour. The majority enjoy the habit, a small number indicate that it is the only thing they are in control of in their lives while others feel frustrated that their sense of control has been taken away by others in terms of their freedom to smoke. This situation highlights how attuned any talk by health professionals of stopping must be to the individual to prevent adopting a generic sense of 'control'. This has to be done in the context of the meaning attached to this term for the particular individual (Willig & Mielewczyk, 2007) while also looking for factors such as procrastination, discussed earlier, as impacting on the theory of planned behaviour model.

4.11.2 Dissonance theory

As has been demonstrated in this study there is an overall sense that the men rationalise their decision-making, striving for balance in their beliefs in order to limit any effect of cognitive dissonance. Cognitive dissonance is a communication theory adopted from social psychology from Festinger and Carlsmith (1959) and is the psychological conflict from holding two or more incompatible beliefs simultaneously. The theory suggests that dissonance is psychologically uncomfortable enough to motivate people to achieve a cognitive state of consonance, and, in a state of dissonance, people will avoid information and situations that might increase the dissonance.

In this present study potential conflict can be reduced for most by the easier option of changing their beliefs rather than engaging in behaviour change, evidenced by strategies such as avoidance and denial of health impacts resulting in prevarication, whether over health-seeking behaviour or quitting. Another technique used is attributional bias, where people have an unrealistic optimism about their susceptibility to negative health outcomes that inhibits behaviour change (Weinstein, 1987). For example, developing separate 'selves' and comparing themselves to 'heavier' smokers reduce their perception of their health risk and

the perceived likelihood of developing a disease.

To reduce this dissonance and loss aversion, in the case here of enjoyment of smoking, the men apply mental shortcuts, or heuristics (Tversky & Kahneman, 1973). For example, in the case of smoking related disease, rather than processing the large amount of information available to them, some men decide on its relevance to them by the frequency with which they have personal experience in their immediate social network to the negative effects of this behaviour. This also helps them to underestimate the perceived risk to self (Weinstein, Marcus, & Moser, 2005).

4.12 Implications for clinical practice

4.12.1 General

Despite an awareness of media campaigns and services to obtain support to stop smoking, sections of the population, similar to the men in this study, are still unaffected or not spurred to action. There has been discussion about increasing men's ability to access services, for example by increasing the number of workplace clinics/groups, working in conjunction with the employers, especially of large organisations (Department of Health, 2010) there may also be a need to help increase the motivation of those who do access services at the moment so that their quit attempt is maximised. However, Connell (2005) reports that masculinity can be performed as collective practice. Therefore, in some workplaces that could be described as 'macho' environments, e.g. routine manual workplaces, this could moderate the effectiveness of this strategy. This would help identify whether there is actually a section of the population, particularly in the context of these research findings, that may never stop or for whom any message will not encourage them to action between the ages of 20 years and 40 years.

This data supported the findings of Robertson et al. (2008) who concluded that, while it is not clear whether targeting men produces better outcomes than delivering a general

service to all, the main problem for use of support services arise around the perception men have of these services, the efficacy of medications and the format of 'behavioural support'. In addition, for some the idea that quit groups may be attended by a range of ages was seen as a signal that for the younger smokers this could give the idea that they had a lot more time to smoke before they should stop, in a similar way to the health benefits advice seen earlier.

Despite millions being spent on fear-induction, raising awareness and education, many people continue to initiate, maintain and fail to quit smoking. It could be argued that this may be due to the content of these messages not matching the individual mechanisms that regulate behaviour. In the longer term, development of interventions should include not just academic research findings that are often difficult to replicate in full in a real-world situation but also information from the service user.

Once a smoker has made the decision to stop smoking, to encourage their engagement with support services it is essential that the services offered are acceptable to the service user. This has been highlighted as a flaw in designing effective intervention approaches due to a lack of power calculations for sample sizes (Dombrowski, 2009). The results from this research study show that most of the participants, whether straight or gay, expressed a reticence to engage with such services and may result in the disparity between the theory of behaviour change models and effective implementation in practice (Dombrowski, 2009).

4.12.2 Control

A common theme emerging from the study was one of being in control. Perhaps men have a sense of this when it comes to stopping smoking; they want to do what they want, when they want, and so do not think they will fit into organised support. This could be perceived as similarly didactic just like their experience of health advice delivery, which identified a training need for healthcare professionals around communication. However, it

should also be remembered that being drawn from a group of men who did not want to quit also makes them a 'hard to treat' group and therefore potentially challenging, irrespective of any of tailored approaches and changes suggested.

4.12.3 Gay men

In comparison to a number of previous studies, e.g. Schwappach (2009) who found that older gay people welcomed a culturally sensitive intervention, this sample was not recruited from gay venues and did not find this to be the case. Most of the gay men preferred an approach supporting a sense of 'normalcy' that may be desired in order to deal with their feelings of stigma associated with their sexuality rather than being identified just by their sexuality;

"I don't think it would be beneficial to be separated just because of one thing in my character. It's like quotas for things like race...positive discrimination does not help" (GP5 L394-396).

This was perceived as actually increasing social barriers. Taking this into account, although the findings of Harding et al. (2004) regarding quit rates in an all-gay group are encouraging they need further investigation before a 'gay only' smoking cessation group becomes the norm.

This should then focus attention upon the service itself, its access, delivery and content highlighting issues of validity, rather than individual variables such as sexuality as the primary variable to attract attendees.

4.13 Recommendations

Dealing with a 'hard to reach' population is a challenge and any recommendations should be made in the context that whatever is attempted may not be acceptable to the all of the target audience.

4.13.1 One difficulty in persuading men to stop smoking is that while smoking is seen to have potential negative consequences it is also perceived to provide positive psychological,

social and physical benefits for the individual in certain contexts, e.g. an escape from a given situation, for group and individual bonding and boredom, either in the workplace or socially. They may benefit from the addition of an anxiety and stress management element to any support offered. Therefore, it is necessary to recognise the different meanings and values people may attach to such behaviours (Willig & Mielewczyk, 2007). As such, the ability to address potential complex situations to engage men within the context of the current mainstream support should be questioned as should the effectiveness of a relatively short, proscribed intervention that is often target led. While this approach has been found to be successful in the general population (Department of Health, 2009a) such a universal approach may not be suitable for all. However, it is also recognised that this in itself raises its own problems in terms of health economics.

4.13.2 One of the perceived barriers for these men to stop smoking was not in terms of knowing where to go to gain access to support services but in the participant seeing the utility of this 'support' to them. This could identify a need for more preparation before engaging in a quit attempt to allay any fears or misconceptions they may have. The initial problem is one of encouraging the men to access these services at the stage they feel ready to embark on a cessation attempt. In this sample, for most there was at least ambivalence if not antipathy towards these services.

Making the approach more individualised and giving more specific benefits of changes based on their actual health status would make the information more concrete, although even with this approach any potential health benefits are not guaranteed but relies on a leap of faith by the smoker. However this may help them to make a more rational choice, so at least minimising the fallback position of denial of their own vulnerability or unrealistic optimism (Weinstein, 1987) that emerged from the data. This would of course still require the men to engage at this level; a dynamic, flexible approach would therefore be

needed.

4.13.3 For many in the general population long-term health concerns are seen as a priority. However, such a perspective may not be the case if there is more of a focus on short term, immediate needs and goals, such as relieving stress and counteracting peer pressure, which in adult life could be a result of clustering of unhealthy behaviours, illustrated in this present study by low incomes or living in a squat. As some of these concerns are not in the control of the individual or the health worker a more integrated approach may be required, including local authorities and social services, before the person is in a position to perceive any action by them as having an effective outcome. This could make it more of an aspiration to achieve a non-smoking status for the individual, as opposed to the more immediate desire by health agencies to reduce a perceived and actual health inequality.

4.13.4 This research has raised questions over the effect of changing social climates on the perception of men and their sexuality. In addition it has highlighted the issue of procrastination in changing behaviour. It would be useful to introduce a prospective element to future research to follow up the participants in, for example 10 years, to measure outcomes and to help inform models of behaviour change.

4.14 Strengths and limitations of study

Despite identifying as being employed in routine and manual jobs at present the participants had a range of backgrounds, including educational attainment and sociocultural influences. This raises questions about the efficacy of work role classification. If socioeconomic status is accepted to be a function of the level of education of a person it would be a fair assumption that employment classification, e.g. managerial, routine and manual. Ryan et al. (2001) commented on the effect of education and how lower educational achievement resulted in higher smoking prevalence. However, despite the majority holding routine and manual jobs at the time of interview, most of the participants were educated at

least to 'A' level grade, with many having a degree. Also it is not possible to assume that the job held relates to the level of knowledge about this, or any other, health behaviour. Such a situation is important to remember when discussing the question of the generalisability of the findings. It would therefore be useful for this study to be carried out with men working in different job classifications such as managerial and professional where smoking rates are lower than in this sample. This would help to identify factors that may be related to the job classification and factors which may be common to men irrespective of socioeconomic status.

This is one of the strengths of this research; it takes a commonly held belief about employment classification as a proxy for education but is found to be too general an approach when applied to health behaviour in this study. It ignores the fact that for some these jobs are taken out of choice rather than necessity, such as the postal worker in this study. This raises the possibility that informed choice may be ignored too frequently and that within all classification systems there are complex sub-systems to consider which can make employment a blunt measurement tool such as the effect of social upbringing resulting in reduced expectations regardless of educational attainment.

The gay participants were not explicitly asked about their experiences of 'coming out'. It is difficult to know whether the effect of investigating this in a more structured way would be positive or negative; data emerged regarding their experience as well as others' attitudes towards their homosexuality which it had been hypothesised could affect smoking behaviour. As such this approach could be argued for and against; if this information 'emerged' it could be inferred that it was an important factor for them and vice versa. Similarly, if they were asked directly this could have been construed as leading them into a researcher led bias.

Although the results of the qualitative analysis are instructive they have also been limited due to the use of grounded theory. Due to its methods, no further interpretation or

meaning could be drawn from the transcripts other than the descriptive labels applied to the data. This resulted in a number of observations not being drawn upon such as the humour with which a number of comments were made. Previous research has found that the use of humour in these situations is a strategy employed by men to not only relieve tension but also to manage feelings, hide embarrassment and increase a sense of solidarity with other males (Chapple and Ziebland, 2004).

This study was by no means exhaustive and the voluntary nature of the interviewees' participation may have introduced a degree of self-selection bias which as with any research procedure may impact the findings. It could be argued that these aspects may not necessarily make the findings generalisable but as has been commented on earlier this is to some extent a philosophical position; if it is assumed that experiences are partially socially constructed, each individual reality is a representation of the social world and is consequently potentially generalisable (Willig, 2001).

As well as this potential for self-selection bias it should also be noted that the categories emerging from the data are dependent upon the sample itself. For example, while categories around physical activity and health protective behaviour emerged as categories for both samples, categories such as 'body image' or 'weight control' that have been reported in other studies did not appear to be a factor for this sample. This could be a result of the method of sampling, for example the observation made previously in section 2.2 that no gay participants were recruited from what may be described as 'usual' gay or 'scene' locations such as bars or the gym which have tended to perpetuate the stereotype of gay men being more concerned about their physical image when compared to straight men.

Finally, none of the participants had experienced an illness directly related to smoking and so the responses to the idea of threats to their health were largely theoretical. This could be influenced by the age of the cohort as most illnesses become apparent after many years of

smoking (NHS Information Centre, 2010). Those who die from smoking related diseases also lose an average of 16 years of life (Peto et al., 1996). Therefore, these responses could be contingent on time and place, where the sample in this study were speaking from a 'what if' standpoint rather than actual experience.

4.15 Reflection on the participants and gathering data from men

The men participating in this research encompassed men who had no thought of stopping. For these men smoking was not seen as the worst behaviour they could engage in or for whom it was not their immediate priority. There were also those who wanted to feel that they were their 'own men'. For the younger men gathering information tended to be more difficult in terms of their experiences to date or their lack of thought for the future, for whom smoking was a distraction rather than an important part of their lives per se. This compares to those who gave an impression of being in control of their own lives and content in these lives.

As the data were collected in individual interviews it can be assumed that they reflect more closely the participants beliefs than had the data been collected using focus groups where they may have felt a need to conform to group think and enact masculinity in a particular way (Robertson, 2003). Such a view is cautioned against when analysing men's representations of their health through fear of ostracism even from a focus group, and O'Brien et al. (2009) quote Haywood and Mac an Ghaill (1996) to highlight the strength and power for men which may be attached to group membership;

"Male peer group networks are one of the most oppressive arenas for the production and regulation of masculinities" (p54).

Thus, an individual interview can be assumed to be less threatening for most, unless confronting one's own construction of masculinity in an interview with one researcher could be too confrontational to their sense of self?

4.16 Future research

Overall, it is felt that using the individual interview was more valid for this group, as has been discussed earlier with reference to the findings of Robertson (2003) and the men in this sample responded on the whole with clarity surrounding their experiences. However, retrospective reports could be inexact and so a prospective study would be recommended for future research projects. This 'real time' study would then also be able to take account more clearly of specific changes that might be affecting behaviour in a more accurate way.

Taking the recommendations into consideration, future research could also look at the level of skills, knowledge and competencies required by healthcare professionals to deliver the appropriate message. Some of the participants acknowledged the stop smoking message had been exhaustively covered; perhaps training in approaches to take could result in a wider conversation around the precursors to their smoking behaviour which supports continuance of the habit rather than automatically jumping in with 'you should stop' message, described by one participant as 'by rote'. There is thus a potential need for health psychology to be involved at practice level in order to move away from a didactic approach in order to improve education and training of other healthcare professionals.

Cultural breadth has been added to the findings by the different nationalities of the participants; this breadth of nationalities could be extended in future research, for example if it was to be done with men from other groups with high smoking prevalence such as the Bengali population.

A future study with men continuing to smoke who are also from a smoking-related disease clinical population could therefore address these points. This may also help to address more concrete ideas of mortality and their thoughts around this concept.

4.17 Conclusion

This study has supported the findings of the Wanless (2004) report that stated that in

order to improve the health of the population approaches to behaviour change require an appreciation of the social, economic and environmental contexts that create the lived reality of the person, in this case, men. It is clear that men are not homogenous and do not all live in the same structural position in society. Previous studies have identified the role of hegemonic masculinity as being one of the main barriers to improving male health as it discourages any flexibility in their subject position through a fear of marginalisation (Hodgetts & Chamberlain, 2002).

This study adds to this previous research in that it has identified a male group which has historically been marginalised on many levels because of their sexuality and has compared them with men who it could be claimed occupy, through their sexuality, a niche in the traditional 'hegemonic' model. Therefore with regard to the research question it is possible to say that contrary to previous research there does not appear to be a definitive difference between these men based on sexuality that encourages them to continue to smoke.

To be relevant to as many men as possible any development of health awareness campaigns should recognise the differences and similarities of men and harness existing knowledge. The challenge is to transfer the awareness of potential dangers to their own bodies and gender to make them more health conscious and to see any smoking behaviour as problematic and to affect their attitudes and beliefs to be more congruent with changing behaviour. This would help to prevent deflecting the occurrence of smoking-related illnesses onto the 'other' and improve a situation that has led to Cameron and Bernardes (1998) making the wry comment that:

"...the world is run by men but they don't listen to health messages", (p691).

This realisation would be helped not by reductionism, in this case between a binary Masculinity (Collier, 199), gay and straight, but by the acceptance of the concept of multiple masculinities. The aim is to facilitate men to react to their changing life courses and negotiate

and redefine their masculinity without fear of being marginalised (Charmaz, 2006) while remembering that biology and behavioural processes exist within a sociocultural context on an individual and a societal level.

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SECTION C

PROFESSIONAL PRACTICE

Competence 1: Generic Professional

Training as a Health Psychologist in the National Health Service

TRAINING AS A HEALTH PSYCHOLOGIST IN THE NATIONAL HEALTH SERVICE

To meet the requirements of a minimum two years relevant experience while undertaking the professional doctorate I have been employed by the National Health Service (NHS) as a Health Psychologist in training within a Primary Care Trust (PCT) Smokefree service.

Implement and maintain systems for legal, ethical and professional standards in applied psychology

As a Health Psychologist in training systems for legal, ethical and professional standards have been employed mainly within two domains; working with clients and working with other staff members, inside and outside the NHS. Being a member of the British Psychological Society (BPS) I was always conscious of the BPS Code of Ethics and Conduct (2006) which stresses the four main ethical concepts of respect, competence, responsibility and integrity and was mindful of these tenets when dealing with clients, colleagues and supervisees. I was also aware of the requirements placed on me within the context of my workplace contract.

Within both of these documents guidance has included requirements for client confidentiality in areas such as the storage of personal data as well as when discussing client case studies and presenting client case studies to supervisors, supervisees and peers. These standards for client and data confidentiality have also been observed when undertaking research projects. For example, when transcribing audio taped interviews, the data transcript has been identifiable only by the notation, SP1, SP2 etc.

Procedures to ensure confidentiality of client data and data protection are in place and focus on obtaining written client consent before beginning an intervention as well as recording their information on a secure password protected database. This database is accessible to all members of the team, all of whom have signed a confidentiality agreement in their contract of employment. Any hard copies of this client information are kept in locked

storage space in the team office and there is a protocol in place to ensure all client information faxed to a third party is received by the intended recipient. There is also a system in place for the confidential disposal of any unneeded paper-based client information.

Being part of a multidisciplinary team (MDT) all staff is subject to the requirements of client confidentiality stipulated in their workplace contracts. This requirement is reinforced at the beginning of employment by attendance at a structured PCT induction programme. With the growing use of databases and to comply with the Data Protection Act (1998) I was aware that security of data is a primary concern of organisations. All access is password protected limiting the possibility of unauthorised access and employees have their personal encrypted data stick for all work related items, including client data, for which they are responsible.

During my training there have been occasions when it has been necessary to liaise with external organisations to ensure the confidential transfer of client data. This has occurred primarily in relation to carrying out consultancy and delivering interventions and has been discussed in the case study for competence 3 (consultancy) and the case study for competence 5.1 (implement interventions to change health-related behaviour). For example, to conduct the consultancy case study it was necessary to complete a data sharing agreement between the PCT and the local authority organisation. Similarly, when planning research projects it was necessary to gain approval for the research from a number of committees, including the Central Office for Research Ethics Committees (COREC), renamed the National Research Ethics Service (NRES) in April 2007, the PCT local research ethics committee (LREC) and the City University ethics committee to protect the participants and to ensure the integrity of the study.

In addition to my primary workplace contract, in order to deliver interventions in acute settings it has been necessary to complete an honorary contract to ensure compliance

with their local policies and to gain access to the computer network. However, despite the local agreements, in all instances I was mindful of the primary requirement for explaining and obtaining informed consent and adhering to the professional obligations as a member of the BPS.

Potential conflict can also arise for health psychologists working within a large organisation. This can be illustrated by the need to work within a target-driven service following the 'gold standard' intervention as recommended by the Department of Health (DH; 2009). Such guidance documents are produced against an evidence base to ensure the best treatment outcomes for the majority of clients and to ensure that these treatments are operationalised and reproducible by all advisors (Dryden, Mearns & Thorne, 2000). Such a cost-benefit analysis is a prerequisite of health economics and essential when planning strategy and deciding on the provision and delivery of services.

However, within the local population there are some individuals who require additional support both before their quit date and beyond the four weeks post-quit date support recommended by the DH. Thus the reliability achieved for the majority by following the 'gold standard' would reduce its validity and efficacy for the few. Becoming a non-smoker is the best clinical outcome and yet these clients would not meet the DH criteria to be counted as a quitter for the department's target. Although practitioners are concerned with the well-being of their clients, this could possibly raise conflict in the practitioner when also balancing the needs of the organisation. For example, if targets are not met this can result in a negative impact on PCT ratings and eventually on funding.

To illustrate, one such group recognised as benefiting from a more intensive approach is the chronic obstructive pulmonary disease (COPD) client group. A systematic review (Wagena, van der Meer, Ostelo, Jacobs, & Schayck, 2004) has identified this group as having a more difficult time stopping smoking than the general population. Local services

have been developed to not only target and provide additional behavioural support sessions to this group but also to incorporate psychoeducation to encourage the client to understand the link between their smoking behaviour and conditions associated with COPD. Such conditions include breathlessness, increased levels of anxiety, an increased nicotine dependence and a distorted perception of smoking and their quality of life. However, this extended approach can result in a number of outcomes;

1. The client may eventually stop smoking but due to this happening beyond the four weeks post quit date set by the DH they will not contribute to targets
2. Unless these clients are referred into specialist services offering this additional support this client group may not receive sufficient support to stop smoking successfully. This would have the effect of widening health inequalities further. This also illustrates the balance needed between limited resources in order to meet externally set targets while also reducing local health inequalities across a range of client groups which a generic protocol may not recognise.

In comparison, a health psychologist practicing privately would not be constrained by the target–driven culture of statutory agencies. However, the introduction of payments could raise ethical considerations such as the appropriate number of sessions beyond which no additional benefit could be expected. If the NHS model was followed, it could be expected that the number of support sessions offered by the NHS would be the minimum although this could vary depending on the needs of the individual client. This would have to be negotiated between client and practitioner at the outset and reviewed depending on progress.

Just as clinical work has raised a number of issues in terms of ethical and professional standards another example has been the experience of attaining ethical approval when planning research. This has been primarily after the initial approval was attained when minor amendments were necessary to the protocol leading to delays in proceeding with the research.

Although this could be frustrating, upon reflection the purpose of the ethics board became clear in that the protection of the research participant is paramount over the aim of the individual researcher.

Both of these examples illustrate how applied health psychology does not exist in a vacuum but is constantly faced with issues arising from social, political and economic factors which Marks (2002) has stated results in the four themes of clinical, public, community and critical health psychology which have to be considered.

Reflection

Being involved with a broad range of organisations and situations, maintaining standards of legal, ethical and professional systems has been challenging in so far as balancing the standards of the BPS with the pragmatic needs of the organisations. I have found my personal reflection and formal workplace and academic supervision sessions on my experiences constructive in all of the differing requirements of my role, especially where there may be conflict between the differing requirements of my roles. Discussions around the scenarios described in this paper with supervisors have been important in terms of my future development as a health psychologist and I felt that my experience and confidence grew in my own development. Accordingly, as my identity developed supervision sessions became more balanced, being less advice-seeking to a more informed (on my part) joint discussion.

Contribute to the continuing development of self as a professional applied psychologist

Employed within a smokefree service my role has been much broader than merely delivering stop smoking interventions. These roles include working with colleagues in primary care, acute trusts and community organisations. They include regularly training new stop smoking advisors and being involved in a number of projects such as assisting with the development of new local enhanced service (LES) contracts aimed at increasing stop smoking intervention activity by advisors in general practices.

In addition I have been involved in the development of a more specific LES aimed at improving access and activity for people with COPD into stop smoking services. I have also participated in a new pulmonary rehabilitation group in the borough. The aim of this has been to raise awareness and facilitate discussion of the dangers of smoking and secondhand smoke with people diagnosed with COPD.

These roles, and a range of others, have resulted in a broad knowledge of partnership working within the NHS organisation in primary and acute care as well as gaining an insight into the political and organisational imperatives and demands of other agencies such as local authorities and community organisations. This has helped to develop the skills and competences that will be needed in more senior and specialist roles that will be available to me upon completion of my training. These roles include consultancy, where different approaches may need to be adopted depending on the organisation with whom I am engaged. Across these different organisational cultures I have been conscious of employing the qualities exemplified in the BPS guidelines that are transferable and constant to ensure best practice. These include areas such as respect, responsibility and integrity. In addition I have had the scope of different work experiences with the necessary support and supervision to increase my competence. These roles have also required the practice of more generalisable qualities such as good timekeeping, time management, prioritising duties, problem solving and multidisciplinary working.

From these experiences communication has emerged as one of the main areas that can facilitate successful outcomes. This communication has been on an individual and team basis, both of which have on occasion required a degree of tact and diplomacy. This is irrespective of whether communication has been in the written format (predominantly email), telephone or face to face meetings or in less formal environments. Through advice-seeking and feedback, especially in written communication, I have become more succinct and clear when

posing questions and stating requirements. This has been done with an awareness of the need to also maintain a positive and helpful relationship with colleagues and other health professionals. For example, when contacting GP's I have been aware of the need to maintain client confidentiality and gaining the clients consent as some may not want their GP to be aware of their smoking status or may not be aware of issues which have arisen in discussions.

Communication with other health professionals is normally made only when that health professional has referred the client or when there is an issue concerning medications, e.g. varenicline. In this instance, it has been necessary to discuss the health professional's reluctance to prescribe a new medication; while respecting their clinical expertise it was possible to have a discussion whereby their reservations were discussed and the desired outcome for the client was achieved.

Given the wide range of people with whom I have been involved, whether clients, team colleagues or within partnership working, I have been aware of tailoring my approach to the specific situation. For example, clients have come from various socio-demographic backgrounds, with a range of conditions and/or disabilities whereas work colleagues and contacts have been from a broad base of professions, ranging from routine manual workers to medical doctors. These differences raise a number of challenges.

Occasionally it has been necessary to defend and adapt the behaviour change approach taken. These challenges may arise from beliefs and attitudes about smoking from either the advisor or the client as well as through physical limitations of the client due to other medical conditions. Two examples can illustrate this; 1) some medical doctors may practice from a more biomedical perspective and prescribe nicotine replacement products without recognising the benefits afforded by the behavioural support component of stopping smoking; 2) to keep routine manual workers engaged it has been necessary to offer shorter sessions with more prompts to help them devise their own coping strategies.

These beliefs may be reinforced by cultural aspects that reinforce this behaviour, such as the higher prevalence of smoking in some black and minority ethnic populations compared to that seen in the general population (Camden Primary Care Trust, 2007). Other challenges have arisen due to other presenting difficulties and lifespan events such as being housebound which can limit available coping strategies. As such, a number of approaches have been required to ensure effective communication and so to promote validity, authority and credibility of the message content. Working within a culturally diverse MDT it has been possible to gain some insight into these differences although engaging with local community groups and leaders has resulted in the best outcomes for understanding these differences and promoting the services. This has resulted in the development of appropriate resources e.g. for routine manual workers and presentations for health teams e.g. the respiratory team of an acute trust. The aim of these has been to make the message audience-specific so that these specific groups are more likely to take action, whether referring patients or engaging in the desired behaviour change.

To aid this development, one of the main processes followed as a health psychologist in training has been the keeping of log books for each competence which have provided opportunities for reflection. Such reflective practices have encouraged self-development and self-awareness which has highlighted areas for improvement in my practice as well as an opportunity to evaluate ones own feelings and blind spots which may unconsciously impact on this practice. Regular supervision meetings with academic and workplace supervisors, discussions with fellow Stage 2 trainees as well as attending workshops relevant to each competence have enhanced this process. Such meetings have been arenas in which to increase learning and also to discuss concerns or dilemmas in a 'safe' environment.

I have also attended a number of national and European health psychology conferences as well as PCT run public health continuing professional development (CPD)

meetings. Such conferences have been ideal opportunities to keep abreast of developments in the wider health psychology community while the internal meetings offer opportunities to promote health psychology and its concepts to other public health workers in the immediate work environment.

Reflection

Developing an identity as a health psychologist has been challenging from a number of perspectives. Within the wider NHS workplace health psychology is still a relatively new discipline and as such psychological skills tend to be incorporated into competencies and skills as part of the job description. Accordingly jobs within smoking cessation are generally advertised as smoking cessation advisor instead of health psychologist or health psychologist in training. Although this was not the case in this instance, despite the job title of health psychologist in training there was sometimes incongruence over others' perception of my role, i.e. not being recognised as an applied psychologist who was training in a wide number of competencies with transferable skills; as someone working in a smokefree service I felt the perception was as a clinician with a specialism restricted to one area. As such it took a number of months for me to clarify my identity and to begin to use my health psychology knowledge in day-to-day practice.

It was also difficult to verbalise the difference between myself and other members of the MDT who were also advisors and to convey the added benefits that a health psychology perspective could add to the team. Some of the skills I developed as part of my training in health psychology include service development for specific populations based on psychological evidence rather than a one-size fits all approaches. I have also used psychological theory to improve training.

As a scientist-practitioner my role has also been one of conducting and disseminating research within the service to enable me to inform and improve clinical practice e.g. developing focussed approaches towards working with COPD clients. However,

incorporating health psychology into clinical practice has not always been seamless. For example, using a range of concepts from health psychology aimed at broadening the sessions in order to add value to the intervention could cause division with other members of the MDT. However, as well as highlighting the responsibility to disseminate psychological approaches with other members of the team in order to help extend their skill set, being part of an MDT also exposed me to different approaches and viewpoints which may be taken when dealing with clients which can create added value to the intervention provided.

Reflection

I believe this lack of an immediate identity as a health psychologist was added to by little prior experience of working in such a large organisation while simultaneously taking on the challenge of Stage 2. Reflecting upon this it may have been preferable to initially have an opportunity to settle into and find my place within the organisation before embarking on the training. However, while difficult to manage these demands at the beginning of the training the steep learning curve experienced has improved my confidence levels and as a result I started challenging my own practice by undertaking more challenging roles. One example of that is having observed others prior to doing the tasks myself, such as delivering interventions. I would then be observed delivering interventions and receive constructive feedback which would help me to improve my skills as a practitioner.

At a later stage, I acquired the appropriate experience enabling others to observe me and learn from it. This was at times quite stressful and possibly resulted in slower progress; however this method has resulted in boosting my confidence and reinforcing my identity from someone who is labelled as being 'in training' to being a productive team member. As such, differentiating between my role and that of others in the team was not immediate; however, with supervision, feedback from others and continual reflection, incorporating health psychology best practice into my work has become automatic.

Provide psychological advice and guidance to others

The main areas where I have provided psychological advice and guidance to others have been in the area of consultancy, teaching and training, delivering interventions and directing others' delivery of interventions. These have been discussed in greater detail in other case studies but as an example, interventions have been designed to increase positive behaviour change outcomes and have incorporated psychological aspects such as motivational interviewing, weighing up pros and cons before changing behaviours, assessing and building motivation to change as well as self-efficacy, action planning, self-monitoring via techniques such as diary-keeping, and developing coping strategies. These concepts have been discussed with clients to encourage their engagement and ownership of responsibility for their behaviour change with the aim of achieving a successful intervention.

Through this discussion and negotiation of acceptable and realistic goals the client can then recognise and accept that that they are integral to changing their behaviour rather than having behaviour change done to them. At the beginning of an intervention, clients have varying levels of engagement and motivation to change behaviour. This affects the client conceptualisation but through discussion and the feedback loop strategies can then be designed and acted upon to facilitate successful outcomes. This is done within the framework of evidence-based psychological models to identify the factors that are important and relevant for that specific client.

When conducting supervision of others, I have been aware of the need to maintain a partnership in order to build and promote trust and discussion. Whether this has been done individually or in a group the aim has been to not only provide psychological advice but also to evaluate their understanding and practice of the techniques employed, identify future learning needs and by their reflection on their practice to learn from their own experience. For example, the health trainer programme was developed following health psychology

principles (Michie et al., 2004) and supervision has included not only assessing adherence and application of this approach but also their understanding of their abilities and boundaries within which they practice. This has been carried out on an individual and a group basis and processes involved have included client presentations to encourage individual and group reflection, observation of interventions and regular reviews of the handbook on which the programme is based in order to evaluate how this approach is being applied.

Evaluating the advice given in all of these situations can be seen in terms of the supervision process and in the outcomes achieved in interventions delivered. Methods can include discussion with clients during quit attempts which has allowed for reflection on the way this advice has been received while on-going supervision has enabled identification of areas where additional support may be required. For other healthcare professionals who deliver interventions but are not formally supervised, evaluating advice given in teaching and training scenarios has been achieved through observation during training and by the completion of training evaluation forms which have been used to inform future training sessions, whether it has been with health professionals, community based family workers or health psychology students. For healthcare professionals this has also been achieved by evaluating their performance in terms of numbers of clients seen and the success they have achieved.

Reflection

Whereas the development of my identity as a professional applied psychologist was gradual, the need to provide psychological advice and guidance to clients was more immediate after a short period of observation of others. However, I found that after the initial interventions, whether with individuals or groups, the process became much less anxiety provoking. Despite my growing confidence in delivering interventions and an awareness of the need for boundaries some clients tested this knowledge in practice. For example, I found that some complex clients were more demanding of my time and initially it sometimes

became difficult to not become involved in their story, e.g. one housebound client would see my visits as a social occasion rather than as an intervention. I realised that while it was important to be aware of the issues facing the client that may impact on the success of the intervention I also had to remain professional and be aware of my levels of expertise. After taking advice from my supervisor I was then able to have an open discussion with the client about these issues and with their consent was able to refer them onto other agencies, including local befriending services.

The skills needed to provide clinical supervision of health trainers had to be gained quickly after beginning my training post. Previous workplace supervision experience had helped to develop my interpersonal skills but had been task oriented. In comparison I was aware of my responsibility to be able to provide appropriate psychological advice and guidance. Rather than employing a didactic style, in individual and group supervision sessions I focused on a collaborative approach to encourage the health trainers to discuss and reflect upon their experiences and reviewed outcomes in subsequent meetings.

Reflection

Despite having the theoretical psychological foundations I found the prospect of this initially daunting as it required the ability to translate this theory into practice while also developing an effective supervision style.

Provide feedback to clients

In its broadest definition, feedback is the process by which one person provides another person with important information that may be of benefit to that person. DiClemente, Marinilli, Singh and Lori (2001) state that the aim of feedback is to create a sense of a caring and helping relationship, to reach decisions, to increase engagement in the materials available, to increase motivation or to provide social comparison and norms.

As a health psychologist in training feedback could be provided for a range of reasons:

1) Intervention: it could be to address service enquiries or the effective support and guidance offered once a behaviour change attempt has been started.

2) Supervision: it could also be the process by which a supervisee/trainee is supported in their practice and learning.

I have provided feedback in the form of information to both a general population by the distribution of service related information with the aim of increasing awareness and referrals at community events, as part of national stop smoking campaigns as well as handing out flyers at public transport locations. As with many traditional health promotion events the effectiveness of such events is difficult to measure. However one positive outcome has been the increase in referrals to the service achieved following the event.

In comparison to these wider community events, more focussed feedback has been possible with a range of smaller group activities. These have included short presentations to acute sector medical teams on the benefits of stopping smoking before operations, induction days for PCT staff on the stop smoking service, level 2 stop smoking training to health professionals and people treating specific disease groups as well as clients with specific diseases. Such events require different approaches to ensure validity of information provided as well as recognising the level of information these different groups may already hold in order not to alienate them while respecting their own areas of expertise.

Finally, clients undergoing an intervention receive feedback in the initial assessment of their desire to change behaviour as well as during the intervention. This discussion encompasses discussion of their progress as well as problems they experience in this process.

In these various contexts, feedback has included one-to-one discussions, role-play and observation of practice. When preparing for any of these groups of people, I have been aware of the need to structure feedback so that it is communicated in a precise fashion and is relevant to the situation. This communication can follow either an informal path, such as

general observations of practice delivered during role-plays or in a more formal way such as that given to health trainers after supervision. Such feedback is bi-directional and includes written, verbal and non-verbal communication such as body language.

Other forms of feedback have included updates at meetings or in targeted newsletters. Such feedback has included information on the number of referrals received from a service provider, the number of clients seen by a specific advisor or updates on changes in service delivery. The reach of the feedback approach used is therefore dependent on whether the message being communicated is situation or individual specific or general in nature.

Reflection

With the wide range of scenarios of feedback I have tried to maintain a professional approach in order to be constructive, positive and non-judgemental. I have seen clients on a case-by-case basis with a positive outcome (abstinent from smoking) and a negative outcome (still smoking). I have striven to understand their reality when approaching behaviour change. When giving feedback to colleagues I have reflected on my own experiences of receiving regular feedback regarding my own performance. This has helped to model my feedback process as well as adding an empathetic understanding of how others may receive feedback. This is especially the case when giving negative feedback to ensure that the person feels supported and encouraged to improve rather than feeling undermined.

Overall Reflection

My period as a health psychologist in training has resulted in numerous challenges that have elicited a range of emotions and learning points for my professional practice within a large organisation but more importantly in my continuing development as a health psychologist. In addition to these generic professional developmental points, the reflective practice involved has also at times resulted in assessing my own values and belief structures.

Such reflection, especially when based on problematic situations, has provided what Jarvis (1992) termed potential learning situations allowing me to continue to learn, grow and develop in and through practice. This also highlights the importance of a safe environment in which to reflect as well as recognising that any self-criticism is not a weakness but a necessary process in my development. Such critical reflection was stated by Boyd and Fales (1983) as requiring the practitioner to locate himself or herself within the experience in order to explore theory and knowledge of that experience and so to gain an understanding of the experience. This was necessary in order not to just repeat the same experience and become proficient in one behaviour change but through reflection to become cognitively and affectively changed so that a number of behaviour practices could result. The wide range of roles and responsibilities involved in the position as well as regular supervision facilitated this learning process.

Through this whole experience, as knowledge and level of transferable skills increased, so too did my confidence in my identity as a health psychologist which will be of immense benefit for my future role as a health psychologist.

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Competence 3: Consultancy

Evaluating the effectiveness of a campaign to reduce children's exposure to secondhand smoke

EVALUATING THE EFFECTIVENESS OF A CAMPAIGN TO REDUCE CHILDREN'S EXPOSURE TO SECONDHAND SMOKE

Assessment of requests for consultancy

The request for this consultancy arose out of collaborative work being undertaken between two organizations; a smokefree service operated by a National Health Service Primary Care Trust (PCT) and a local authority funded agency, Sure Start (SS). Since the launch of the White Paper 'Saving Lives: Our Healthier Nation' (Department of Health, 1999) there has been a government priority of reducing a variety of health inequalities resulting in a range of local initiatives in order to address such inequalities. As such the main aim of SS is to "...act as a focal point for families, providing a range of integrated services such as access to health and parenting support services, advice and information about healthy lifestyles," (Department of Health, 2007, p5).

One work stream for this collaboration includes reducing the exposure of children to secondhand smoke (SHS) in the home, prompting the introduction of a Smoke Free Homes (SFH) programme for the borough, based on a campaign originally devised in the north of England (Hodgson, 2004). Organisation and control of this was contracted to SS with the support of the PCT. This was piloted in 2 out of 4 localities in the borough and after evaluation it was decided to roll this out across the remaining 2 localities.

Despite this evaluation being favourable as measured in number of households signing up to the scheme, following discussions with my line manager, a Consultant Health Psychologist, it was felt that from a health psychology perspective it was not clear what, if any, were the measurable benefits to the families in terms of implementing the required behaviour change to become 'smokefree' as well as the extent of actual harm reduction to children in those homes. The efficacy of this could also impact the organization in terms of

appropriate use of SS resources as well as facilitate organizational development, learning and change.

It was decided to present these thoughts and suggestions for further investigation to the steering group meeting for discussion and to establish levels of interest from SS in developing this further.

Having become involved in the earlier pilot I had attended steering group meetings previously and as such I was not an unknown person coming into the organization and to some degree could have been viewed as a member of the team already which could help the dyadic interaction with the wider team. Similarly I was already aware of the norms and goals of the organization, which could affect my approach with them.

Having explained the possible benefits which could ensue from the application of a health psychology approach it was suggested that a piece of research could be developed to be carried out by the smokefree service on behalf of SS. This was received favourably and being co-chaired by the manager of the SS programme as well as my line manager there was involvement from the outset of the highest level in the prospective client organization.

The aim at this stage was to encourage a feeling of joint ownership of the project. As an example of a technical expertise model (Schein, 1987) during this process it was important to ensure that the client felt empowered and to see this as a shared task. As well as building their self-esteem the aim was also to lessen feelings of dependency on the consultant by valuing their input to the process and ensuring commitment to the project.

Reflection

By offering technical expertise this process illustrates the promotion of health psychology to a wider audience who may have been unaware of the potential benefits to be gained to the organization and its on-going service development. This also provides skills which may not have been available within the organization.

This project was proposed by the consultant and although not being approached from a problem-centred perspective its aim was to measure the efficacy of a service provided by the client to its target population. Following an initial overview, the potential benefits to the organization in terms of service improvement and how this could positively impact future funding of this programme were recognized. It was generally felt that as well as the interest in showing the effectiveness of their work, while a number of the steering group members were familiar with the research approach and the rigour this would add to their work. Given the level of verbal feedback and questions this appeared to increase their enthusiasm to take part. In addition, this was seen as being an important outcome for the client especially as there are so many demands on their finite resources.

Reflection

I perceived this level of engagement as indicating inclusion and support for the project that I was keen to build upon. At this point both future contact, primary and intermediate clients were all present, and although it was not necessarily clear at this stage who would be the primary client, this added to this perceived engagement.

The outcome for the consultant would be the successful completion of this piece of work in order to improve implementation of smokefree homes as well as the contribution it would make towards professional development.

The process for this evaluation was initially explored and agreed at a SS steering group meeting to ensure the project followed the SMART template and also to promote a shared understanding of the overall goal (minutes can be seen in Appendix 1). A literature search was also completed to determine the approach that would be taken. The resulting research proposal and minutes extract of this meeting can be seen in Appendix 2.

It was determined that a feasible timescale for completion would be 18 months which also corresponded with the consultant's employment contract.

Plan consultancy

The implementation process evolved at succeeding steering group meetings. The research proposal (Appendix 2) incorporates the aims, objectives, theoretical framework and scope of the project. Factors were recognized and discussed through joint diagnosis (Schein 1999), including the objectives for the client and the consultant, inclusion and empowerment of the client, the timescale of the project, contact with the client and the cost involved. The aim was to agree parameters for the work and to develop a contract for the agreed work.

It was agreed that there would be a six month lead period to the roll out of this programme into the two localities which had not taken part in the original pilot. This was understood to be a realistic timeframe that would allow for various tasks to be completed, including gaining ethical approval for the research project, the redesign of the SFH campaign information leaflet and sign-up form as well as training of the SS family support workers (FSW) who would be promoting this initiative. An added benefit was recognized in that this launch would also coincide with the national No Smoking Day campaign and so help to increase the opportunity to raise awareness of the negative consequences of smoking and SHS not only in the general population but also in the target group.

Reflection

I had not experienced the National Health Service (NHS) ethics system and this was my main concern at this point but having discussed this in supervision and with colleagues it was felt this was a realistic timescale and that even with unforeseen events this would allow one year for data collection.

As the consultancy progressed, the following action points were highlighted to improve the progress of the consultancy:

- Identifying one person from each locality as the main point of contact for the SFH project to:

-improve communication between the client and the consultant

-provide additional information, problem solve barriers and ensure sustainability of the project.

- The steering group meetings would be the main point for communication and feedback on progress. The consultant would also attend locality team meetings on an ad hoc basis.
- Training, on-going support, and refresher follow-up sessions would be provided by members of the PCT. Organisation of attendance at these sessions would be the responsibility of the client.
- Roles were also decided. SFH was contracted to the client and the main emphasis for promoting this campaign would fall to the client's employees. As can be seen in Appendix 2, once clients agreed to sign up to SFH they would be contacted by the consultant to recruit into the research aspect of the project.

These points were then included in a client contract (Appendix 3).

Local NHS ethical approval was obtained two months prior to the roll-out. To ensure an optimum effect, training was planned and delivered by the PCT just prior to the proposed launch date. This resulted in a total of 37 employees, (20 from one locality and 17 from the other locality), being trained in 'Smokefree Homes Campaign: Helping to reduce children's exposure to secondhand smoke in the home' (Camden Primary Care Trust, 2006; resources can be seen in Competence 4, Appendices 2, 3 and 4). The aim was two- fold; to increase knowledge of the effects of smoking and SHS and to provide techniques and role play experience in order to approach clients based on the spirit of motivational interviewing.

This was also an opportunity to introduce the research intervention in order to improve engagement and encourage ownership of the project equally between the consultant and the

client. This discussion resulted in the SS health lead in each of the two new localities to be identified as the lead for the rollout of SFH.

Reflection

There appeared to be a slight reticence in the health leads taking on this role manifesting mainly in an expectation that the PCT staff would carry out much of the implementation of the campaign. This resulted in having to constantly remind them that their organization was responsible for this campaign and often led to frustration and time delays in planning and implementation a number of aspects of the roll-out. This could have reflected the culture of an organization that was either over-stretched or possibly not able to cope with such a project. In future consultancies I will be more aware of this and also prepared to raise such perceptions with the client.

Despite the client being the budget holder for this programme, a small grant was sought and awarded to the consultant for the purchase of the test kits that were integral to the study for the measurement of the children's exposure to secondhand smoke (Appendix 4). The outstanding funding for these kits was agreed with the client at a meeting close to the planned roll out date. It was agreed that the client would liaise with the body awarding the grant regarding the ordering and payment for this resource.

Reflection

As the consultant was employed by the PCT that was also a partner in this campaign no direct cost was levied for the consultant to conduct this project. Due to the research project being agreed after the budget had been settled for the financial year, financing of the cotinine test kits was not confirmed by the client until the end of this financial cycle, when a surplus in the budget of the client was identified. I am not sure how much this could have reflected their motivation to take part. However, as a consequence of the lateness of this commitment, the administration process for this to be completed before the end of the financial year was

quite hectic. While this is often a reality in modern organizations it would have been better had this funding requirement been made more explicit to the client from the outset of the proposal and arrangements made accordingly.

Administration of the project, including the return of the signed SFH leaflets and entry of these onto the client's database, was agreed to be carried out at one central location by a member of the clients' staff. To improve time management it was also agreed and arranged for the researcher to be granted permissions and trained to access this database remotely at locations that would meet the governance requirements of the client organisation.

The cost of printing of the SFH forms and other aspects of the campaign implementation had been agreed to be met by the client. However, their redesign was not completed until 2 months after the original roll out date.

Reflection

Although much of this was formulated into a consultancy contract (Appendix 3) signed by a locality lead and with overall responsibilities clearly delineated, there was no penalty protocol specified if either party did not adhere to their agreed role in an appropriate manner.

Establish, develop and maintain working relationships with clients

The research was made a steering group agenda item where feedback was also given. Outside of these meetings feedback was also given via email or telephone. Such a feedback loop could then be used to reformulate the approach at implementing the campaign if necessary.

Reflection

This level of feedback indicates an awareness of the process and active involvement of the team leads, especially as one was the project sponsor. However, on more than one occasion the consultant was requested to conduct community outreach work to promote the

scheme that I had to refuse due to my own work commitments. In line with process consultancy I was aware of maintaining the boundaries of responsibilities in order not to take on the contracted responsibilities of the client despite the fact that I also had an investment in the successful outcome of this project. This illustrates how it could be easy to become involved in organisational problems.

It was observed in an earlier meeting that it would be preferable to establish one lead person for the consultant to liaise with. However, as stated earlier, due to the structure in SS it was felt by them for it to be more appropriate for each of the locality leads involved in the roll-out to be responsible for the organization of the campaign in their localities with the overall lead for SS being responsible for its strategic direction.

Reflection

Although not necessarily precluding the maintenance of the relationships over the course of the consultancy this was not the most effective way of liaising. It resulted in the consultant not only having to attend the main steering group meetings that the two leads also attended but also having to attend locality meetings with these same leads individually to address local issues which arose. This raised a number of issues that impacted on the later progress of the consultancy. In retrospect it would have been more effective to insist that one person took overall responsibility. This situation may have indicated a reticence to take ownership of the campaign.

The impact of this was more pronounced when the strategic lead of the client organization left the service for approximately 5 months with no replacement being made. As such, no one senior person was in charge from the client side of the collaboration and made progression of the project more difficult.

Reflection

As mentioned earlier it was not clear whether this slow progress was due to lack of engagement, the workload of those involved or the culture of the organisation. Although the inter-personal relationships developed well it is not clear how effective they were. Due to the power dynamic of the consultant also attempting to reach a beneficial outcome from this project in terms of the research I found it difficult to be firm with the client over their level of contribution to its outcome.

Conduct consultancy

Despite agreements having been made a number of challenges arose in implementing the consultancy. An interim report was also delivered to the client as agreed in the consultancy contract and addressed a number of these points. This, and the client response, can be seen in Appendix 5.

Of these, the greatest challenge was maintaining communication. This was due to no one person being in overall charge of the SFH campaign within the client organisation. A project manager role would have been an ideal solution, however as described earlier there was not any scope for this within the organization. This position was later exacerbated by the strategic lead leaving the organization and no replacement being appointed.

The main impact of this was two-fold.

1) There was a delay in the redesign of the SFH leaflet with the consequence of a 3 month delay in rollout. This also resulted in the planned training being completed without the leaflets available at least 2 months prior to this date which may have impacted its efficacy. In an attempt to overcome this time delay, update training sessions were given at team meetings to refresh knowledge and to discuss problems. At these sessions, the main problem identified by the FSW trained in delivering the smokefree homes campaign was that in terms of their role; they often tended to be in a role of crisis management, i.e. whenever they visited families there were always other more immediate concerns or issues arising which took

priority over the longer-term effect of SHS or smoking for the family. The consequence of this was that although they recognized the importance of SFH, when viewed in terms of their clients' reality they did not have sufficient time or opportunity to discuss the topic.

Reflection

This highlights how difficult it is to foresee difficulties and to transfer research into practice. This could indicate the commitment of the management to making it successful not being communicated and facilitated to the FSW. It was later agreed to include targets for the FSW to sign families up to SFH's and while this did increase the number signing up to the programme very few FSW met them. Further, despite being contracted to recruit participants, the consultant did not expect the impact their 'crisis management' role would have; neither of these points had been volunteered by the client at in the assessment stage. Again this would be probed in future consultancies. Unfortunately it would appear that improving the SFH project itself was not enough of a driver for the client in its current structure and highlighted their different priorities when compared to those attending these more natural team meetings. This could indicate more consultation with these workers at the outset may have highlighted potential problems.

2) No promotional materials were agreed on or produced by the client to promote the SFH campaign widely in the borough. There were a number of delays in design and by the close of this consultancy this has still not been resolved. This resulted in a small uptake level and consequently negatively impacted the progress of the research.

Due to these problems the consultancy was closed not having met its objectives of evaluating how effective smokefree homes are at reducing exposure to SHS. However, despite the unsuccessful outcome, a report was presented to the client, (Appendix 6) after which feedback ended. Within the consultancy framework this would indicate a shift from process model to the expert model. A report was also submitted to the local NHS National

Research Ethics Service to report the premature end of the research project (Appendix 7).

Reflection

Although these problems were fed back to the steering group on a number of occasions it was not felt by the consultant that renegotiating the end-point for the consultancy would have resulted in a more positive outcome for either the client or the consultant.

Monitor the implementation of consultancy

When reviewing the consultancy, feedback and partnership building was one of the main elements of this process. Feedback was given monthly in a concrete manner both directly to locality leads and at steering group meetings i.e. actual numbers given and the impact this would have on the outcome, very few referrals had been made after 4 months. The challenge this presented to successful completion was communicated to the steering group.

Further attempts were also made to improve partnership building outside of these formalized meetings by meeting individually with each locality health lead in an attempt to find solutions to the participant recruitment problems. The research area was also amended to include the original two pilot localities and so increase the numbers of potential participants.

Reflection

In future consultancies it would be useful to do this earlier in the contract in an attempt to improve outcomes before such a 'crisis' arose. However, it was difficult and sometimes frustrating to interpret what was happening with the campaign as the feedback was often congruent to that expected but in reality was not implemented.

Despite this, after a further 2 months, very few families had signed up to SFH. Concerns were again communicated at the steering group over the viability of the timescale and the client was reminded of their role without which successful completion was not possible.

In an effort to improve this situation, the consultant recruited a Masters level student to a voluntary part-time position in order to offer support to the SS workers in recruiting to the SFH campaign at local events as well as following referrals up for potential participants for the research. This role for the Masters student was aimed at overcoming time pressures that the FSW reported having. This extra support was in addition to booster training sessions that were offered by the consultant in order to refresh knowledge of the campaign due to the time delay between initial training and implementation of the campaign. However, the responsibility for ensuring that the workers were discussing SFH with new and existing clients remained with the local health lead.

Reflection

The changes in personnel and the organizational culture made it difficult to progress quickly. These internal organizational factors required tact in order not to alienate them from engaging further. At this point I was aware of not falling into either a doctor-patient model of highlighting problems and telling them what to do to solve the problem as by imposing a 'solution' to a particular problem I was aware that the organization may resist that suggestion. Instead through active enquiry I attempted to improve the situation of low referrals. However, this did help to implicitly identify problems within the client organization which were addressed, albeit slowly. This could possibly indicate that the organization had not clearly thought through the commitment they were making by agreeing to the research.

Finally, there were a number of administrative staff resource challenges affecting the SFH campaign that resulted in a concern that due to delays in processing the referrals, the period of time between families being referred and receiving the intervention was becoming unacceptable to the researcher. It had initially been agreed that the SS teams would complete all administration of the scheme and that the researcher would have access to this data online via their database. However due to database problems which resulted in delayed data entry it

was agreed that new client details would be forwarded to the researcher via an email spreadsheet for follow-up and potential enrolment into the research programme.

Reflection

Boulton, (2003), recommends that the consultant has a clear description of what will be done and by whom, therefore setting boundaries for the completion of the consultancy. Therefore although this proactive approach was meant to assist the client in the completion of what was their responsibility and overcome a number of barriers it led to a blurring of these boundaries. This may also suggest that successful completion was more important to the consultant than it was to the client.

Evaluate the impact of consultancy

This programme roll out was just one in a wide range of tasks required of the client organization. As such, it was expected that finding the time required to develop and sustain the project from its pilot status to one being rolled-out borough-wide would be challenging. Despite attempts to work collaboratively, a number of issues have been outlined which delayed the project and ultimately contributed to its close. There have been a number of learning points that may be used as recommendations for future activities carried out by the client organization:

- One person should have been responsible for the roll out of the SFH campaign. This would have made communication lines clearer and ensured adherence to timescales and actions. This would have allowed a better degree of accountability.
- The responsibilities of the consultant were actioned in a timely manner, including research design and ethical approval. However the material resources for the campaign were not finalized until 2 months after the original roll out date. Similarly no advertising resource was developed by the client as had been agreed at previous steering group meetings.

- Problems with providing a central administration person delayed the referral process for the small numbers recruited making maintenance of the project more difficult and delayed the initial follow-up of those referred.
- This experience has highlighted to inefficiencies in the client's organisation that were communicated in the end of consultancy report. This will hopefully lead to improvement in their structures and have a positive effect on not just this project but future projects that are undertaken.

Overall Reflection

It would be easy to see this consultancy as a failure. However in terms of a learning experience it has been immense. With the changing structure of working practices in the NHS, this consultancy gave invaluable experience of the skills required to operate in this specific job role when taking into account management and financial considerations, the skills available and the facilitators and barriers present when working within a collaborative structure. This was especially pertinent in terms of working with limited funding which can impact on what is perceived as not just ethical in terms of research procedures but also financially viable.

The process of consultancy defined by Earll and Bath (2004) as 'a formal relationship where one party seeks help from another... to facilitate the process whereby both the consultant and client arrive at a mutually acceptable solution' (p230-231) was followed. This has also raised the profile of health psychology in an organisation to which they may not otherwise have been exposed.

Working with a multidisciplinary team was a continual learning experience that identified a number of agendas and cultures that impacted on what was assumed would be a shared goal. Despite having one contract client, by moving informally between different people within the organization and more formally with the steering group I was able to work

with a fluid approach and with different personalities, some of whom were more independent than others. Similarly, such flexibility was found in the non-linear way the consultancy stages described above progressed (Dryden, 2004).

It could possibly have been useful to have discussions not only with the management but also with a number of the FSW who were expected to implement this campaign to establish the feasibility of this approach from their perspective. This would have allowed potential issues, such as workloads, to have been recognized and possibly the realization would have been reached that, while beneficial to the organization it was not feasible without a change in work priorities or increased resources. Schein (1999) has observed that the consultant can only be in one mode at a time and has to be aware of which role they may be from one moment to the next. This shows the dynamic process of the consultancy contract and process. As such, being willing and able to switch roles depending on the situation was essential, for example changing from what was planned to be a predominantly process model to one of moving into an 'expert' role.

Despite the problems which arose, the main concern at all times was to maintain and develop the helping relationship and although some of these problems may have been avoided had more inquiry been made at the beginning of the relationship, these could not all have been planned for. As such, the 'emerging realities' (Schein, 1999) were dealt with as effectively as possible in the overall intervention, helping to develop skills to be used in future consultancies.

Finally this experience has demonstrated my ability to work within the professional limits set out in the British Psychological Society's Code of Conduct, Ethical Principles and Guidelines (2006), evidenced by my conduct throughout the consultancy and designing the research in terms of observing client consent and confidentiality.

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Appendix 1

Consultancy Meeting Minutes 15th June 2006

Present:

[redacted]

Gareth Absalom, Smokefree [redacted]

Area	Topic	Actions
Opportunity for consultancy identified	An evaluation of a smokefree homes initiative being rolled out across the borough.	
Proposed consultancy aims and evaluation	Tasks discussed: • To evaluate the impact of the initiative, a research project would investigate the health benefits for children in homes signing up to the scheme • The process for enabling this evaluation was discussed	• All would consider the implications this would have on the service • GA would review health psychology research and previous evaluations of the scheme.
Next meeting	Once the process had been developed by the consultant this would be discussed at the next meeting.	• A steering group meeting to be held

Appendix 2

Consultancy Meeting 2nd October 2006

Present:

[redacted]

Gareth Absalom

Area	Topic	Actions
Consultancy proposal	The proposal for the consultancy was presented to the steering group.	• Agreement was reached on the proposal.
Time frame	To ensure adequate time it was estimated that the consultancy would last for 18 months.	• GA would complete ethical approval • Sure Start would identify a lead to act as client • Sure Start to review their processes of promoting the smokefree homes campaign
Meetings held between the client and the consultant	Regular contact was to be maintained via steering group meetings and when required directly with the named client by e-mail and telephone contact.	
Consultancy contract	A consultancy contract to be agreed outlining the terms of the agreement, including an estimate of cost.	• GA to design a consultancy contract by the end of November 2006

Proposal for Sure Start consultancy

The purpose of this study is to investigate the effectiveness of the Smoke Free Homes intervention in terms of smoking behaviour change, uptake of the four levels of the scheme as well as the effects on childrens' exposure to secondhand smoke and its potential for health risk reduction. This process will also uncover knowledge, beliefs and potential barriers to its uptake for future development.

Method

The initial stage is to gain ethical clearance from the PCT.

A mixed methods approach will be followed using a waiting list control design. Prior to any data being collected, informed consent will also be obtained at the initial stage of the research. This will include details about the timing of the intervention (receiving the pack), and an assurance given that the participant may withdraw from the study at any time.

Collection of data will be done using a questionnaire pre and post the Smoke Free Homes intervention to measure its efficacy. A questionnaire regarding the implementation of the Smoke Free Homes intervention will also be completed in the treatment group one month after the intervention. At these time-points, cotinine measurements of the children in the household will also be taken to provide an objective measure of exposure to ETS.

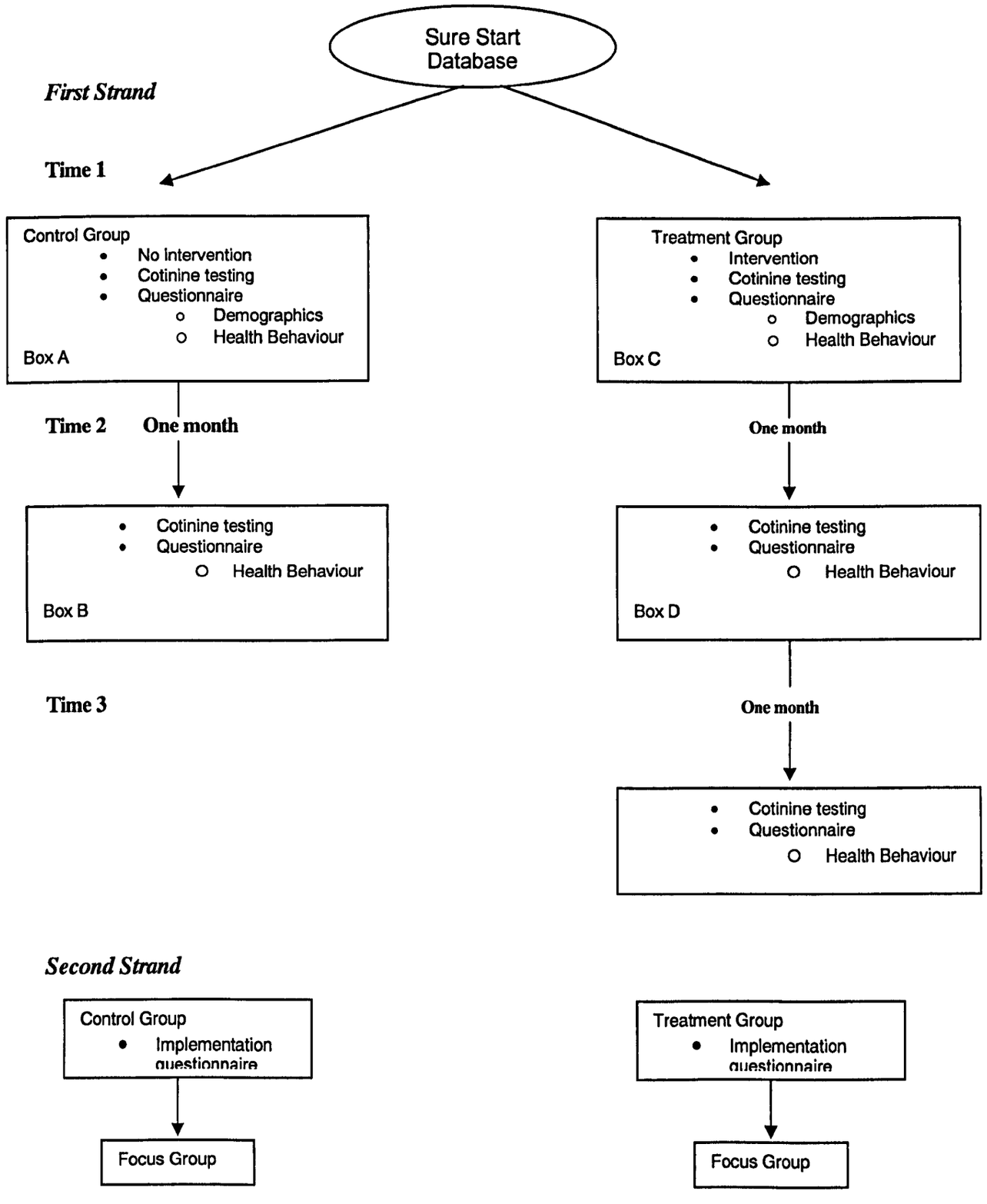
The participants will be recruited from the Sure Start database in those localities in [redacted] which have not been affected by the pilot study.

1. All Sure Start registered families will be mailed about the Smoke Free Homes initiative, with a self-referral form. Also included will be a letter regarding the research being undertaken, with the option of volunteering to take part in the study or a notice that they are willing to be contacted by the researcher.

2. From these returns, a self-selected sample will be randomly allocated into two groups;

- Control group (Group 1)
- Treatment group (Group 2)

The following diagram shows the design of the study.



3. First Strand

3a. **Time 1**: The control group will be advised that they will receive their intervention pack in one month. They will also be asked to complete a questionnaire measuring demographics and current

smoking behaviour. Any children in the household will also have a cotinine measurement completed. This will require a visit by a member of the research team.

3b. **Time 1:** The treatment group will be given their intervention pack immediately. They will also be asked to complete a questionnaire measuring demographics and current smoking behaviour. Any children in the household will also have a cotinine measurement completed. This will require a visit by a member of the research team.

4. **Time 2:** Both the control group and the treatment group will be advised that they will be visited again in one month when a further questionnaire assessing their smoking behaviour will be completed and further cotinine measurements taken for the children in the household.

Differences between results at T1 and T2 for each group will show the effectiveness of the intervention, with the main effect being the difference between Box B and Box D.

5. **Time 3**: The treatment group will be followed up again to establish the on-going effect of the intervention, (the control group will not be followed up at this time point as the purpose of this group was only to investigate any effect due to the intervention delay).

6. **Second Strand**

The control group and the treatment group will be asked to complete a semi-quantitative questionnaire regarding the implementation process itself. This will also give an opportunity to address any barriers faced by the participants to uptake, whether they were overcome and what could be changed to the process to facilitate it in the future. Concerns about the child's health or the child becoming a smoker, and attempts to identify the level of exposure outside the home will also be investigated. These will be enabled by the use of open-ended questions allowing free-text answers.

This will be after Time 2 for the control group and after Time 3 for the treatment group.

To allow for a more detailed evaluation of the implementation, the participants of each group will also be invited to take part in a focus group to allow more detailed data to be gathered regarding the whole intervention. This may also uncover aspects to the successful and unsuccessful implementation attempts which may have been missed from the more-standardised questionnaires and which the participants may not have been able to communicate in their written responses.

7. **The Questionnaires**. They will incorporate demographic questions to identify the population accessed. This may be facilitated by postcode analysis of participants. Participants will be asked to complete a structured demographic questionnaire assessing social and material aspects of their lives including marital status, housing tenure, employment status,

occupation, ethnicity and education. The level of cigarette use will also be established, including any quit attempts to estimate their commitment to smoking.

The quantitative data will then be analysed using SPSS while the qualitative data will be investigated using content analysis. This analysis will identify successes and failures of the implementation and address issues for future improvements.

Research defined objectives

The main outcome measures are;

- Total numbers who sign up to the SFH initiative. These can be sub-divided into four groups
    - Level 1 – Bronze – commitment not to smoke in front of the children
    - Level 2 – Silver – commitment to smoke in one room only
    - Level 3 – Gold – commitment to make the whole home smoke-free
    - Level 4 – Gold Plus – those progressing to quit smoking with the SSS

Movement across these levels from the initial level to which the participant signed up will also be monitored and add value to the initiative

- Risk reduction will be quantifiable by the cotinine levels taken
- Ideas for service development will be gained

Appendix 3

Client Contract

TITLE OF WORK : How effective is the Smoke Free Homes initiative at reducing health risks

Contracting Client: Sure Start [redacted]

Consultant: Gareth Absalom, Health Psychologist in Training

BACKGROUND

The consultant is undertaking a doctorate level course in Health Psychology at City University, London while employed at [redacted] Stop Smoking Service, London as a Health Psychologist in Training.

The contracting client is a local authority organization designed to deliver the best start in life for every child by bringing together early education, childcare, health and family support.

OBJECTIVES

The aim of this consultancy is to evaluate a smokefree homes initiative aimed at encouraging households with children under 5 years to become partially or fully smokefree

The objectives are to measure the uptake of the smokefree homes initiative, client knowledge of the effects of smoking on themselves and their families, measure childrens' exposure to secondhand smoke, investigate adult beliefs and attitudes towards smoking and smoking in the home and understand participant barriers to implementation of the intervention. This will be done within a health psychology framework.

The following will be completed to achieve these aims and objectives:

Conducting research in two parts:

Part one – This will involve recruiting participants who sign up to the smokefree homes initiative and allocating them to one of two groups. Each will receive the intervention, the difference between the two groups being one group receiving the intervention immediately and the other group one month later. There will be three contact points with the researcher when the client will be asked to complete questionnaires investigating demographics, health behaviour and their experience of implementing the behaviour change including successes and barriers encountered.

A urine sample from a child under 5 years of age in the household will also be taken and tested for cotinine, which as a metabolite of nicotine will measure any change in exposure to secondhand smoke.

Part two – This will involve inviting participants to take part in a focus group discussion to add more detail to their experiences which may have been lost in the questionnaires.

The quantitative and qualitative data will be analysed and the findings will inform the effectiveness of the current structure of the initiative and its future development and improvement.

The consultant will also ensure the organizations ethical procedures and permissions are gained and funding for the requisite testing kits is found.

A more detailed description can be seen in appendix 1.

Outcome of Consultancy

Due to the length of the consultancy period, the consultant will provide a written interim report at one year and a final report to the contracting client on the outcomes. This will include successes and failures of the current initiative and recommendations for future improvements

CONSULTANT REQUIREMENTS

- An identified link person, [redacted], from Sure Start [redacted] will be the main point of contact for the duration of this consultancy.
- [redacted] will act as a liaison to aid communication, provide requested information, help problem solve barriers and ensure sustainability at the end of the project.
- Regular contact will be maintained with the contracting client.
- The contracting client will be responsible for liaising with relevant associated groups to secure and fund resources for the implementation of the initiative.
- The contracting client will provide permissions and access to client details at suitable locations.
- [redacted] PCT will act as sponsor of the researcher.
- [redacted] PCT will provide training and support to Sure Start [redacted] workers in approaching clients regarding smoking and smokefree homes. This will include follow-up sessions, the times and organisation of which will be the responsibility of Sure Start [redacted] in collaboration with [redacted] PCT.
- Sure Start [redacted] workers will promote the research to clients.
- Sure Start [redacted] will assist in the provision of rooms suitable for the hosting of focus groups.

TIMEFRAME

The total duration is 2 years.

Start of consultancy - December 2006

End of consultancy - December 2008

CODE OF CONDUCT

The consultant, a health psychologist in training, will carry out the service in accordance with the British Psychological Society guidelines.

INTELLECTUAL PROPERTY

The consultant, a health psychologist in training, shall be named on any publications arising from his work. This has been discussed and agreed.

CONFIDENTIALITY

During the course of the services the consultant, a health psychologist in training, may have access to, gain knowledge of or be entrusted with information of a confidential nature. In signing this contract, the principal investigator agrees, unless expressly authorized by a senior authorized person to so, will not disclose to any unauthorized person or organization any such confidential information. The consultant, (health psychologist in training), agrees to store and process information in accordance with the Data Protection Act 1998.

COST

This piece of consultancy forms part of the consultant's job description and as such no extra fees will be requested. If a payment was required, the estimated fee for this work would be budgeted at a total cost of £26,000 (£100 per day)

Breakdown of cost

Planning and carrying out research	49 weeks
Analysing research data	1 week
Transcribing and analysing data	1 week
Writing up interim report	2 days
Writing up final consultancy	3 days

Signature... ... ... **DATE** ... ...

Gareth Absalom

Health Psychologist in Training

Smokefree [redacted], City University, London

Signature... ... ... **DATE** ... ...

[redacted]

Sure Start [redacted]

Appendix 4

Grant Application

Early Years and Sure Start Service
Application for small grant from Sure Start [redacted] Children's Centre Locality Services Parents' Forum
For a copy of this form on disc or by e-mail, ([redacted]@[redacted].gov.uk)

1. Name of applying organisation

The applicant is undertaking a Doctorate in Health Psychology at City University and working at [redacted] Stop Smoking Service

2. Contact person and contact details

Contact name	Gareth Absalom
Organisation name	[redacted] Stop Smoking Service
Address	[redacted]
Tel no	[redacted]
Fax no	
E-mail address	[redacted]@[redacted]pct.nhs.uk

3. Status of organisation – e.g. council service, health trust or voluntary organisation. If you are a voluntary organisation, give your registration numbers as a charity and/or limited company.

City University and [redacted] Primary Care Trust

4. What are the outcomes for children 0 - 4 that you hope to achieve using this Grant?

- ☑ To be healthy
- ☐ To stay safe
- ☐ To enjoy and achieve
- ☐ To make a positive contribution
- ☐ To achieve economic well-being

5. Which of the following Children's Centre Core Offer activities does your grant address?

- ☐ Early Education Integrated with Day Care
- ☐ Family Support and Outreach to Children and families
- ☑ Child and Family Health Services
- ☐ Enabling parents to access advice and information
- ☐ Developing pathways to employment through training and development opportunities

6. How will your project / activity benefit children and families who are at risk of poor outcomes or who may find it difficult to access services in the past, these include:
   - Teenage parents
   - Lone parents
   - Families living in poverty
   - Workless households
   - Parents with mental health, drug or alcohol problem's
   - Families with a parent in prison or known to be engaged in criminal activity
   - Families from minority ethnic communities
   - Families of asylum seekers
   - Parents with disabled children; and
   - Parents with learning disabilities

A major target area for Sure Start [redacted] and [redacted] PCT is to address health inequalities, one of which is smoking. A Sure Start Smokefree Homes project is to be rolled-out across [redacted] and is aimed at reducing the effects of smoking in homes with young children as well as being a positive role model for those children. Although well received, there is little evidence to date to demonstrate the effectiveness of this scheme on health outcomes for the child.

The health of the family will be improved by encouraging households to become partially or fully smokefree. The research attached to this roll-out will also benefit families in the longer term as investigation into the effectiveness of Smokefree homes will inform us in terms of knowledge, beliefs and attitudes towards smoking in the home as well as highlighting barriers and will be used to improve future schemes. Importantly, tracking changes in the childrens' exposure to secondhand smoke by measuring the levels of cotinine (a metabolite of nicotine) in their urine will add an objective measure and strengthen the findings.

This research aims to include parents/primary care givers who are involved with Sure Start. People from deprived communities are more likely to be smokers and these could fall into any of the above categories.

7. Your proposal. Describe briefly what your organisation proposes to buy or do with a Children's Centre Locality Services Parent's Forum grant. Use more space or sheets of paper if you need to.

The applicant plans to use the grant to purchase cotinine testing kits which will be used at three time points during the above research to measure the exposure of one child in the home to secondhand smoke. These measurements will act as a proxy for the general exposure to secondhand smoke for the whole family

8. Finish date. When will the grant be fully spent and/or the project comes to an end?

The research will start in April 2007. This grant will part-finance the total number of test kits. The grant will be used immediately to purchase the test kits for use by the researcher. An estimated 100 participants are required for the research – it is not possible to give an exact completion date but it

is hoped to be by December 2007.

9. How will your proposal benefit children aged 0- 4 and/or their parents/carers who live in the Sure Start [redacted] Children's Centre locality?

Refer to the guidance as detailed above:

- You should refer to the Every Child Matters outcomes as mentioned on above
- Please indicate if your proposal reflects suggestions or requests made by families.

Use more sheets of paper if you need to.

This proposal relates to the 'to be healthy' outcome as it promotes healthy behaviours in adults. Smoking negatively affects children in the health and well-being of themselves and their parents; changing these behaviours will have a positive impact for the adults by hopefully moving them to stop smoking. It will benefit the children by reducing their exposure to secondhand smoke as well as giving them a positive role model.

When trying to stop smoking, service users often report that they want to quit for their children but many have difficulty doing this because of others smoking in the home and other social locations. With the smoking ban introduced in July, the home will become one of few indoor locations where smoking will be allowed. This project will help to reinforce and support those who may want to change these behaviours but who may need a little more support.

As well as the Sure Start [redacted] locality this research is also being carried out in the Sure Start [redacted] locality and they are also being approached for support

9. Please give numbers of children 0 - 4 and families who will benefit

The research aims to have a total of 100 households participating in the research.

In the wider context, this research will help to inform future campaigns to reduce smoking in the home in all families, including from the above groups, across Sure Start locations.

10. Please briefly explain how the proposed activity or event would be additional to, or enhance existing services and activities

This specific proposal relates to a piece of research and consultancy which is not within the usual remit of the stop smoking service or Sure Start. It is complementary to an initiative being supported and rolled-out by Sure Start Stop Smoking Steering Group. The research uses a systematic and evidence-based methodology, the results of which will be used to enhance and improve existing programmes.

11. Grant request

Evaluating the effectiveness of a campaign

How much money will your organisation need to carry out your proposal? Please give a breakdown to show what makes up the total figure.

Item	Cost in £
300 (100 x 3 timepoints) cotinine test kits @ £3.00	£900
Colorimeter (to accurately measure exposure)	£400
Total grant request	**£1000**

12. Declaration by manager or member of management committee.

I confirm that the information included in this application is complete and accurate, and that the named organisation accepts Children's Centre Locality Services and [redacted] Standard Conditions of Grant Aid conditions of funding

I confirm that the organisation which receives this grant has the following **policies and procedures** in place (Please tick beside each).

- ☐ **Child Protection**
- ☐ **Equal Opportunities**
- ☐ **Public Liability Insurance**
- ☐ **Complaints Procedure**
- ☐ **Up to date CRB check, evidence to be provided – if the grant involves workers or volunteers working directly with children or families**

Signature: ………………………………………………………….

Date: ……………………………………………………………

Name: ………………………………………………………………

Position in organisation:……………………………………………

Appendix 5

Interim Report on the Project: "How effective is the Smoke Free Homes initiative at reducing health risks. "

Prepared by Gareth Absalom, Health Psychologist in Training, Smokefree [redacted]
for [redacted], Deputy Manager Family Support, Sure Start [redacted]

BACKGROUND

The consultant is undertaking a doctorate level course in Health Psychology at City University, London while employed at [redacted] Stop Smoking Service, London as a Health Psychologist in Training.
The contracting client is a local authority organization designed to deliver the best start in life for every child by bringing together early education, childcare, health and family support.

OBJECTIVES

The aim of this consultancy is to evaluate a smokefree homes initiative aimed at encouraging households with children under 5 years to become partially or fully smokefree
The objectives are to measure the uptake of the smokefree homes initiative, client knowledge of the effects of smoking on themselves and their families, measure childrens' exposure to secondhand smoke, investigate adult beliefs and attitudes towards smoking and smoking in the home and understand participant barriers to implementation of the intervention. This will be done within a health psychology framework.

PROCESS

The process for this evaluation was initially discussed and agreed at a Sure Start Children's Centre, (SSCC), steering group meeting in July 2006. The original timescale would be completion by March 2008, (the end of the researchers employment). The research process then evolved over succeeding steering group meetings. An overview can be seen in appendix 1.

The timescale of the project was agreed as beginning with a rollout in March 2007 into two localities which did not take part in the original pilot. This was viewed by both partners as a realistic timeframe that would allow for ethical approval to be granted for the research, the redesign of the SFH campaign information leaflet and sign-up form as well as training of the

Sure Start staff members who would be promoting this initiative. Furthermore, as this date would also coincide with the national No Smoking Day campaign which is held annually in March, it was perceived that this would have a value added effect of helping to increase the opportunity to raise awareness of the negative consequences of smoking not only in the general population but also in the target group.

From succeeding discussions in group meetings, the following action points were addressed:

- Identifying one person from each locality as the main point of contact for the SFH project. This would improve communication between Sure Start and Smokefree [redacted], provide any requested information, help problem solve barriers and ensure sustainability of the project.
- The SSCC steering group meetings would be the main point of communication on the overall progress of the project as well as intermittent attendance at locality team meetings.
- Training, support, and refresher follow up sessions would be provided to Sure Start [redacted] workers by members of Smokefree [redacted]. The dates would be agreed with Smokefree [redacted] while the organisation of attendance at these sessions would be the responsibility of Sure Start [redacted]
- As SFH was part of the Sure Start contract, the main emphasis for promoting this campaign would fall to Sure Start [redacted] workers. Once clients agreed to sign up to SFH, they would then be contacted by the researcher to recruit into the research aspect.

PROGRESS

Having submitted the research proposal for the December 2006 meeting, ethical approval was gained from the National Research Ethics Service (NRES) (formerly known as the Central Office for Research Ethics Committees (COREC)), [redacted] Community Local Research Ethics Committee in January 2007. The North Central London Research Consortium, Research and Development (R & D) department at [redacted] PCT provided approval of the research in February 2007.

Mirroring the two pilot areas, the Sure Start health lead in each of the two new localities was identified as the lead for SFH. The initial task was to organize the planning and roll out of SFH and to liaise with Smokefree [redacted] to arrange necessary training.
Training for Sure Start workers was planned and delivered by Smokefree [redacted] in March 2007. This resulted in a total of 37 employees, (20 from one locality and 17 from another locality), being trained in 'Smokefree Homes Campaign: Helping to reduce children's exposure to secondhand smoke in the home'.
A small grant was sought and awarded to the researcher by Parents Forum, (Parents Voice) to partially fund the cotinine test kits which would allow measurement of the childrens' exposure to secondhand smoke. The remaining funding for these kits was agreed with Sure Start [redacted] at a deputy managers meeting in March 2007. It was agreed that Sure Start [redacted] would liaise with Parents Forum regarding the ordering and payment of the cotinine test kits.

Administration of the project, including the return of the signed SFH leaflets and the database entry of these families onto the JNA system used by Sure Start, was agreed to be carried out at one central location. It was also agreed and arranged for the researcher to be granted permisiins to access this database remotely, at suitable locations, and training in the use of this database was received.

The printing of the SFH forms and other aspects of the campaign implementation were agreed to be funded by Sure Start, and the redesign of the SFH leaflet was completed by June 2007.

CHALLENGES

The rollout started in June 2007. This was a few months after the original, March, date. This was due to a number of reasons.

The greatest challenge was communication, possibly due to no one person being in overall charge of the SFH campaign within Sure Start. The main impact of this was two-fold.

1. There was a delay in the redesign of the SFH leaflet with the consequence of a later rollout date, from spring, (March), to summer, (June/July). This also resulted in the

training being completed at least 3 months prior to this date which may have impacted its efficacy. This also impacted on the timescale for the research.

2. No main publicity materials were agreed on or produced to promote the campaign. The lack of a promotional poster made it difficult to publicise the campaign. There have been a number of delays in its design, in particular the appropriate text, strapline and contact details, and to date, this has still not been resolved. This difficulty to publicise this campaign widely has resulted in a small uptake level and consequently negatively impacted the progress of the research.

UPTAKE

Up to mid-December, 12 families had signed up to SFH with the majority being from one of the pilot Sure Start localities. Of these 12 families, 1 has so far been recruited to take part in the research. As has been the experience of Sure Start other families have been difficult to contact or so far have not been available. Follow-up of these families will continue although it may be necessary to send goody packs out to them if no contact is made to ensure that too much time does not elapse between signing up to the SFH campaign and receiving their packs.

FUTURE PROGRESS

Signing up families has been the overall responsibility of Sure Start. Without these it has not been possible to recruit to the research. It is hoped that this role will be improved by the addition of the requirement to sign up 2 families per quarter to the workplan of each family support worker.

However, due to the delays in the roll-out and the lack of referrals between July and November there may be a problem in completing the research into this campaign. Due to the design of the research and a data collection deadline of June 2008, and the problems in contacting families described earlier, recruiting 100 families, (50 to each group), to the research by April 2008 will be a great challenge.

This challenge has been communicated to all concerned in the SSCC steering group as well as by attempting to meet with each individual health lead to attempt to find solutions to the recruitment issue. However, after discussion with individual Sure Start health leads, it appears that incentivising staff would not be a successful strategy to increasing uptake. The research has also been extended from the original two new localities to all four localities, which includes those that were involved in the pilot of this campaign.

Smokefree [redacted] has also recruited a Masters level student to a voluntary position. It is intended that this person will be able to support Sure Start workers and recruit to both the SFH campaign and the research simultaneously. It has also been communicated to all localities that booster sessions are available to staff if it is felt that knowledge needs refreshing. However, this is not intended to replace the organization ensuring that their workers are discussing SFH with new and existing clients.

Finally, there have been a number of staffing issues around the administration of the SFH campaign. To help with this it has been agreed that in the short-term all goody packs will be sent by the researcher. This is to include all families, including those not taking part in the research. The aim of this is to reduce the waiting times families face before receiving their packs. Also, due to problems with JNA access for initial data entry, until this is resolved, new clients details will be forwarded to the researcher via an email spreadsheet.

OVERALL

This project has been just one in a wide range of tasks required of the staff members of both Smokefree [redacted] and Sure Start [redacted]. As such, it could be expected that finding the time required to develop and sustain the project from its pilot status to one being rolled-out borough-wide was always going to be challenging. However, a number of issues have been outlined in this report that have delayed the project and have negatively impacted the uptake, the effectiveness of the campaign and consequently the progress of the research. It would appear that these delays could have been minimized if one person had been made responsible for this new SFH campaign. As such, this would be the main recommendation for any future project to ease communication and ensure adherence to timescales and actions to provide the optimum environment for success.

Dear Gareth

Many thanks for sending the interim report. I agree that progress has been slow to date and I will discuss this with the other deputy directors to try and improve the situation. I will be in touch soon to arrange a meeting.

With many thanks

[redacted]
Deputy Manager Family Support
Sure Start [redacted]
[redacted]
London
[redacted]
Tel: [redacted]

-----Original Message-----
From: Absalom, Gareth
Sent: 10 Jan 2008 09:36
To: [redacted]
Subject: Consultancy

Hi [redacted]

I have attached a consultancy interim report. As you know, progress has been slow and I hope that we can meet soon to discuss this.

Please let me know if you want any more information.

Thanks,
Gareth

Gareth Absalom
Health Psychologist in Training
[redacted]

Appendix 6

Final Report on the Project: "How effective is the Smoke Free Homes initiative at reducing health risks. "

Prepared by Gareth Absalom, Health Psychologist in Training, Smokefree [redacted]
for [redacted], Deputy Manager Family Support, Sure Start [redacted]

BACKGROUND

The consultant is undertaking a doctorate level course in Health Psychology at City University, London while employed at [redacted] Stop Smoking Service, London as a Health Psychologist in Training.
The contracting client is a local authority organization designed to deliver the best start in life for every child by bringing together early education, childcare, health and family support.

OBJECTIVES

The aim of this consultancy was to evaluate a smokefree homes initiative aimed at encouraging households with children under 5 years to become partially or fully smokefree
The objectives were to measure the uptake of the smokefree homes initiative, client knowledge of the effects of smoking on themselves and their families, measure childrens' exposure to secondhand smoke, investigate adult beliefs and attitudes towards smoking and smoking in the home and understand participant barriers to implementation of the intervention. This was organized and conducted within a health psychology framework.

PROCESS

The process for this evaluation was initially discussed and agreed at a Sure Start Children's Centre, (SSCC), steering group meeting in July 2006, with an original timescale being completion by March 2008. The research process evolved over succeeding steering group meetings. An overview can be seen in appendix 1.

The timescale of the project was agreed as beginning with a rollout in March 2007 into two localities that did not take part in the original pilot. This was viewed by both partners as a realistic timeframe that would allow for ethical approval to be granted for the research, the redesign of the SFH campaign information leaflet and sign-up form as well as training of the Sure Start staff members who would be promoting this initiative. Furthermore, as this date

would also coincide with the national No Smoking Day campaign which is held annually in March, it was perceived that this would have a value added effect of helping to increase the opportunity to raise awareness of the negative consequences of smoking not only in the general population but also in the target group.

An outline of the agreed action points for the set up and implementation of the initiative the following action points were addressed:

- Identifying one person from each locality as the main point of contact for the SFH project. This would improve communication between Sure Start and Smokefree [redacted], provide any requested information, help problem solve barriers and ensure sustainability of the project.
- The SSCC steering group meetings would be the main point of communication on the overall progress of the project as well as intermittent attendance at locality team meetings.
- Training, support, and refresher follow up sessions would be provided to Sure Start [redacted] workers by members of Smokefree [redacted]. The dates would be agreed with Smokefree [redacted] while the organisation of attendance at these sessions would be the responsibility of Sure Start [redacted]
- As SFH was part of the Sure Start contract, the main emphasis for promoting this campaign would fall to Sure Start [redacted] workers. Once clients agreed to sign up to SFH, they would then be contacted by the researcher to recruit into the research aspect.

PROGRESS

The research proposal was submitted by the consultant for the December 2006 meeting, ethical approval was gained from the National Research Ethics Service (NRES) (formerly known as the Central Office for Research Ethics Committees (COREC)), [redacted] Community Local Research Ethics Committee in January 2007. The North Central London Research Consortium, Research and Development (R & D) department at [redacted] PCT provided approval of the research in February 2007.

As with the two pilot areas, the Sure Start health lead in each of the two new localities was identified as the lead for SFH. The initial task was to organize the planning and roll out of SFH and to liaise with Smokefree [redacted] to arrange necessary training.
Training for Sure Start workers was planned and delivered by Smokefree [redacted] in March 2007. This resulted in a total of 37 employees, (20 from one locality and 17 from another locality), being trained in 'Smokefree Homes Campaign: Helping to reduce children's exposure to secondhand smoke in the home'.

A small grant was sought and awarded to the researcher by Parents Forum, (Parents Voice) to partially fund the cotinine test kits which would allow measurement of the childrens' exposure to secondhand smoke. The remaining funding for these kits was agreed with Sure Start [redacted] at a deputy managers meeting in March 2007. It was agreed that Sure Start [redacted] would liaise with Parents Forum regarding the ordering and payment of the cotinine test kits.

Administration of the project, including the return of the signed SFH leaflets and the database entry of these families onto the JNA system used by Sure Start, was agreed to be carried out at one central location. It was also agreed and arranged for the researcher to be granted permissions to access this database remotely, at suitable locations, and training in the use of this database was received.

The printing of the SFH forms and other aspects of the campaign implementation were agreed to be funded by Sure Start, and the redesign of the SFH leaflet was completed by June 2007.

CHALLENGES

The rollout started in June 2007. This was a few months after the original, March, date. This was due to a number of reasons.

The greatest challenge was communication, possibly due to no one person being in overall charge of the SFH campaign within Sure Start. The main impact of this was two-fold.

3. There was a delay in the redesign of the SFH leaflet with the consequence of a later rollout date, from spring, (March), to summer, (June/July). This also resulted in the

training being completed at least 3 months prior to this date which may have impacted its efficacy. This also impacted on the timescale for the research.

4. No main publicity materials were agreed on or produced to promote the campaign. The lack of a promotional poster made it difficult to publicise the campaign. There have been a number of delays in its design, in particular the appropriate text, strapline and contact details, and to date, this has still not been resolved. This difficulty to publicise this campaign widely has resulted in a small uptake level and consequently negatively impacted the progress of the research.
5. Signing up families was the overall responsibility of Sure Start. A number of barriers were identified in team meetings, the greatest of which was time and smoking not being seen as an immediate priority for their families when they meet them. To help address this a requirement to sign up 2 families per quarter to the workplan of each family support worker was introduced. However, this still made the target number challenging.
6. Due to the delays in the roll-out and the lack of referrals the data collection period was extended to June 2008 in an attempt to recruit 100 families, (50 to each group).
7. The challenges were communicated to all concerned in the SSCC steering group as well as by attempting to meet with each individual health lead to attempt to find solutions to the recruitment issue. However, although discussion with individual Sure Start health leads suggested incentivising staff this was not agreed.
8. The research was extended from the original two new localities to all four localities, which includes those that were involved in the pilot of this campaign.
9. Smokefree [redacted] recruited a Masters level student to a voluntary position to provide additional support to Sure Start workers. They were also to recruit to both the SFH campaign and the research simultaneously.
10. 'Booster' training sessions were also provided by the consultant during staff meetings.
11. Despite these last two points it was made clear that these actions were not intended to replace the organization ensuring that their workers discussed SFH with new and existing clients.
12. Administration issues were also a challenge including staffing issues at Sure Start around the administration of the SFH campaign throughout the timescale of the initative and as well as problems with the JNA database. To reduce waiting times for the families receiving their Smokefree homes pack the researcher took responsibility

for the dispatch of goody packs receiving their packs. Also, due to problems with JNA access for initial data entry new clients details were forwarded to the researcher via an email spreadsheet.

OUTCOMES

By the end of the project just 20 families had signed up to SFH with the majority being from one of the pilot Sure Start localities. Of these, 4 agreed to take part in the in the research but, as has been the wider experience of Sure Start the families were subsequently difficult to contact. Follow-up of these families continued but it was necessary to send goody packs out to them with no contact being made to ensure that too much time does not elapse between signing up to the SFH campaign and receiving their packs.

Unfortunately, due to the lack of uptake the research had to close without success.

OVERALL

This Smokefree Homes project has been just one in a wide range of tasks required of the staff members of both Smokefree [redacted] and Sure Start [redacted]. As such, it was expected that finding the time required to develop and sustain the project from its pilot status to one being rolled-out borough-wide was always going to be challenging.

However, a number of issues have been outlined in this report which have delayed the roll-out of the Smokefree Homes project as well as the research project that negatively impacted the uptake, the effectiveness of the campaign and consequently the progress of the research.

Despite this, there are a number of recommendations for future activities carried out by the client organization:

- One person should have been nominated 'project manager' and responsible for the roll out of the SFH campaign. This would make communication lines clearer and ensure adherence to timescales and actions. This would also have allowed a better degree of accountability.

- The responsibilities of the consultant were actioned in a timely manner, including research design and ethical approval. However internal issues resulted in the material resources for the campaign not being finalized until 2 months after the original roll out date. Similarly no advertising resource was developed by the client as agreed. This could be alleviated by the previous recommendation.
- More consultation by managers with the family support workers at the beginning of the project would have identified that workloads were felt to be too great to make such a programme viable on the scale required to carry out the research.
- Problems with providing a central administration person delayed the referral process for the small numbers recruited making maintenance of the project more difficult and delayed the initial follow-up of those referred. More robust systems are required in future campaigns.

Dear Gareth

Many thanks for sending the final report.
As we have discussed, I am very sorry that this has not progressed and had the outcome that we had all hoped. However, as you have noted we have experienced a number of problems since we first discussed this project in 2006. I agree with your recommendations for future engagement and I hope that we can learn form this experience. However, I do think that your engagement with us has benefited the family support workers and would like to thank you for all your hard work on this project.

With very best wishes

[redacted]
Deputy Manager Family Support
Sure Start [redacted]
[redacted]
London
[redacted]
Tel: [redacted]

-----Original Message-----
From: Absalom, Gareth
Sent: 08 Aug 2008 11:45
To: [redacted]
Subject: Consultancy

Hi [redacted]

I have attached a copy of the consultancy final report. I am sorry that it was not successful but I hope that there are a number of points arising from it that will be of benefit despite this.
Please let me know if you want any more information.

Thanks,
Gareth

Gareth Absalom
Health Psychologist in Training
[redacted]

Appendix 7

DECLARATION OF THE END OF A STUDY
(For all studies except clinical trials of investigational medicinal products)

To be completed in typescript by the Chief Investigator and submitted to the Research Ethics Committee that gave a favourable opinion of the research ("the main REC") within 90 days of the conclusion of the study or within 15 days of early termination. For questions with Yes/No options please indicate answer in bold type.

1. Details of Chief Investigator

Name:	Gareth Absalom
Address:	Smokefree [redacted]
Telephone:	0207 445 8532
Email:	Gareth.Absalom@[redacted]pct.nhs.uk
Fax:	0207 445 8556

2. Details of study

Full title of study:	Smokefree Homes Initiative; An investigation of effectiveness at reducing health risks
Research sponsor:	[redacted] Primary Care Trust City University
Name of main REC:	[redacted] Community Local Research Ethics Committee
Main REC reference number:	06/Q0511/104

3. Study duration

Date study commenced:	06/07/07
Date study ended:	24/03/08
Did this study terminate prematurely?	*Yes* *If yes please complete sections 4, 5 & 6, if no please go direct to section 7.*

4. Circumstances of early termination

What is the justification for this early termination?	Due to delays with the roll out of the scheme and problems recruiting into the smokefree homes campaign it is not expected that it will be possible to recruit sufficient participants into the research in the planned timescale for data collection.

5. Temporary halt

Is this a temporary halt to the study?	*No*
If yes, what is the justification for temporarily halting the study? When do you expect the study to re-start?	*e.g. Safety, difficulties recruiting participants, trial has not commenced, other reasons.*

6. Potential implications for research participants

Are there any potential implications for research participants as a result of terminating/halting the study prematurely? Please describe the steps taken to address them.	Not applicable - no participants were recruited

7. Final report on the research

Is a summary of the final report on the research enclosed with this form?	*No* *If no, please forward within 12 months of the end of the study.*

8. Declaration

Signature of Chief Investigator:	
Print name:	Gareth Absalom
Date of submission:	25th March 2008

Running Head: DELIVERING TEACHING AND TRAINING

Competence 4: Teaching and Training

Delivering Teaching and Training to Two Audiences

DELIVERING TEACHING AND TRAINING TO TWO AUDIENCES

Training was delivered with a colleague to family support workers on a new smokefree homes campaign as part of collaborative working and teaching was delivered to Masters health psychology students.

Audience 1: Delivering Smokefree Homes Training to Family Support Workers

Plan and design training programmes that enable students to learn about psychological knowledge, skills and practices

This training was to be delivered to a range of job roles, none of whom had been trained in specific smoking cessation interventions. Therefore, the sessions were planned with the assumption that those attending had no knowledge about the specifics of smoking and secondhand smoke (SHS). Similarly, due to the mix of roles, I had to be aware of making the psychological content accessible, using lay terminology. I was especially conscious of this when discussing the psychological theory of behaviour change and techniques in motivational interviewing. It was hoped that the practical session would illustrate how theory and practice are interdependent (Foley, 1995).

Reflection. It was assumed that the attendees to this session would be motivated as this vocational training was aimed at improving their work performance, add to their general skill base and consequently contribute towards their continuing professional development. However, I was conscious that this training was also going to involve an added duty to their role and could have a negative impact on their level of motivation, despite the beneficial outcome for their client group. As the training progressed I was mindful of resistance in terms of negative comments, body language and lack of engagement.

Description of activities

After meeting with a colleague who would be working on this training session

with me, a needs assessment, session plan and agenda for the training session was decided. These can be seen in Appendix 1. The training aim was extensive; to increase knowledge about the effects of smoking and in particular SHS as well as an overview of a research project associated with the campaign that their work would contribute to in terms of participant recruitment, a brief introduction to the Stages of Change model (Prochaska and DiClemente, 1983) due to it being one of the more intuitive and accessible models which is commonly used in public health, followed by the basic techniques encompassed by motivational interviewing (Rollnick and Miller, 1995) and finally a practical session rehearsing possible scenarios.

This final section of the training was designed to give the attendees added skills to increase their interpersonal skills helps, raise confidence and develop strategies to overcome difficult situations and/or clients. Kaufmann (2003) posits that that teaching and training should contribute to solving real life problems and take into account current knowledge and experience. To increase its salience, wherever possible I also gave examples from my personal experience as well as showing that this training could be generalised to other roles they may have.

Reflection. The aim of illustrating this link between theory and practice was intended to make the training more concrete for the attendees and by contributing examples of my personal experiences I hoped to convey an emotional involvement in the training. I believe that helped to increase their interest and motivation in the training, evidenced by the level of interaction.

The training materials used for this session can be seen in Appendix 2 and included a handbook that was given to the attendees. This was done so that they would have more time to listen and process the information given and participate in the session and so aid understanding of the material. The powerpoint presentation slides were made as clear as

possible and not too complicated or animated as this has been found been found to make them difficult to understand be a distraction for the audience (Murray, 2002). These were also given as a handout (Appendix 2).

Reflection. I felt that having a powerpoint 'prop' not only illustrated the learning points but also acted as a support, making me feel less 'on stage' and reducing feelings of self-consciousness. Anecdotally this has been a similar comment from a number of colleagues. From attending many lectures and presentations, I feel that audiovisual aids have also become the norm. While I am aware that this is not a replacement for the quality of the content of the presentation, I would be concerned that a lack of any visual presentation could leave an impression of a lack of preparedness. This could result in lowering the attendees' perception of me, the trainer, as the 'expert', which could impact the reception of the training.

Delivering the training programme

From experience, I arrived at the room in advance to ensure that the audiovisual equipment was in working order and that I felt comfortable using it. However, access to the room was not possible as it was in use. This put a time pressure on me with the session starting later than expected. However, I tried to normalise the delay by engaging in polite conversation with those attendees seated closest to me.

To ensure the training progressed well, at the beginning of the session introductions and any specific learning points from the session were requested. The aim of this was to identify the roles in the audience as well as to allow me to address any additional expectations of the training that may not have been included in the prepared programme. However, none arose, with most stating learning about smokefree homes as their goal.

Reflection. This lack of any prior expectation of what to expect or specific learning outcomes made me feel in charge of the material from the beginning of the session. However, I was aware that this could also have indicated a degree of passivity in their learning role,

especially as they are expected to go to a number of different training sessions. As such, despite the lack of feedback to their expectations I hoped that by at least giving them the opportunity to input into the day their engagement might be positively affected. In the future, this could be improved by requesting information of their expectations for the day in advance of the training, although this could result in requests for inappropriate learning requests that would then have to be addressed to avoid feelings of their requests being ignored.

The session continued with an outline of the importance of the topic to gain their initial attention, which was maintained by making the approach problem-directed, student-centred and as interactive as possible. This was achieved by encouraging questions, often prompted by me, at regular intervals and by the use of role-play with practical scenarios.

To encourage interaction with the attendees, the knowledge session was designed around a quiz (Appendix 3). As no advance knowledge was assumed, all questions were made either multiple choice or 'true' or 'false' responses. These were then answered and expanded upon by means of a presentation (Appendix 2). McDonough and Marks (2002) have commented that this approach helps the audience identify its current knowledge and help with engagement, although it can also be time-consuming.

Reflection. The quiz was received well and gave an opportunity for often animated engagement which I feel justified the time taken. It also helped to develop an early rapport between the audience and myself.

Questions were encouraged throughout the presentation for a number of reasons. Winefield (2004) proposes that question-asking should be at 20 minute intervals as they help reduce passivity of the audience, which can make retention of information more difficult, and it also allows clarification of points which may not have been understood. Also, by requesting all questions at the end, although enabling better time-planning by the facilitator, lack of clarity during the session could impact on the understanding of succeeding points or

the attendee simply forgetting to ask a pertinent question. Engagement was also facilitated by making eye contact whenever possible and scanning the whole room to help personalise the training.

Plan and implement assessment procedures for such training programmes

The quiz was used at the beginning of the training to assess each individual's current level of knowledge. Learning during the training was assessed by monitoring the number and types of questions asked throughout the session, for example whether the questions were for further explanation of the subject to aid understanding or whether they added to the breadth of knowledge. Further opportunities arose when split into pairs for the practical session (scenarios in Appendix 4). The responses of each pair gave an opportunity to gain an idea of the level of understanding that had been achieved and an opportunity to correct any misunderstandings. This could have taken the form of role-play, helping with assessment of understanding. However, assessment through such behavioural demonstrations is difficult as there may not be one clear defined criterion for successful skill performance (Winefield, 2004).

Reflection. A drawback of monitoring questions as a type of assessment is that a lack of questions could also be due to non-engagement rather than indicating understanding, although this could be indicated and inferred, for example by body language. While aware of this, I found that there was an understanding of the subject with questions around its further application rather than the principles themselves indicating a desire to apply the facts being explained. However, in a future session alternative types of assessment could be used such as asking review questions during the training or a formal assessment at the end, although this latter option could impact on the length of the training.

As with many workplace training sessions, the only record of progress and outcome was an attendance sheet. In the longer term, one indicator of progress and outcome will be the

number of families signing up to the scheme, although this prospective assessment will be difficult due to a number of confounding variables, e.g. whether the worker is full or part time, their role or the number and complexity of clients they have.

Reflection. A possible solution to this would be the addition of targets for the support workers to sign up a set number of families per quarter to the smokefree homes initiative.

Evaluate training programme outcomes

A short evaluation form was distributed at the end of the session (Appendix 5). To avoid what Race (1999) described as 'death by questionnaire', this included a number of questions to be answered by a scale measure as well as a few open questions allowing a response by free text. By using this approach it was hoped that some thought on the part of the attendees would reduce any bias in the questions asked. They were also asked how confident they felt at implementing this campaign. A summary of the evaluation forms can be seen in Appendix 6 and indicate an overall positive response to the training.

Reflection. This design was used to ensure that I did not predefine which areas may have needed improvement as it is possible to be over-critical of presentations delivered. The initial factor that I believe contributed to the successful outcome of the programme was the level of preparation in terms of having enough resources such as handouts as well as clarity of the presentation materials. I drew on past experiences of giving presentations such as things being missing e.g. basic equipment, illustrated here by an electrical extension cable being too short; fortunately I had brought a spare which prevented a last-minute panic! I felt in charge of the room, achieved through posture and maintaining eye contact with the audience and believe that regularly breaking up the presentation with opportunities to ask questions allowed for a short respite from concentration on the presentation itself.

Feeding back ideas on each specific question allowed a broader perspective on the subject area, capitalising on the knowledge and thoughts within the whole group; such problem-solving has also been found to benefit 'deep learning' (Kaufman, 2003).

Overall reflection on this audience

This teaching and training session was a good learning experience as part of my personal development as a health psychologist in training. Its successful outcome was helped by the fact that this was not the first time that I had delivered this training and, in comparison to other less-often delivered presentations, I felt very comfortable and confident both with the material and its presentation. Due to the mixed audience of health care professionals, it also helped to bring the role of health psychology to a wider multi-disciplinary community-based audience, raising its profile.

Audience 2: MSc Health Psychology Students

I was approached by a lecturer at City University to lead a session for the MSc Health Psychology students on the topic of Diabetes. As part of the Behavioural Medicine module this incorporated supplying information on the biological determinants of diabetes, its psychosocial impact and approaches to its management.

Plan and design training programmes that enable students to learn about psychological knowledge, skills and practices

Preparing for this session, I assumed that as postgraduate students they would be a motivated group with their shared background in psychology negating explanation of many terms commonly used in psychology.

Reflection. Having recently completed this course myself I reflected that I had found the illustration of practical implications more useful than being lectured to in pure facts and theory of behavioural medicine. Due to this I decided to illustrate the interdependence of theory and practice (Foley, 1995) by linking the facts of diabetes to its management in practice. I felt that this would make it more interesting for the students as at this stage a practical insight into the application of health psychology in practice is of more value.

After clarifying the needs of the audience with the module lead lecturer I then completed a needs assessment and session plan (Appendix 7). This shows a transition from knowledge-giving to a practical approach to the disease, beginning with an overview of the biomedical aetiology of the disease itself before progressing to the psychosocial implications and its management. This also included a short discussion of motivational interviewing to facilitate conversations with diabetic clients followed by a description of a project I had been involved in which was aimed at improving the care of this client group.

This not only gave an illustration of the translation of theory into practice but also a background in transferable skills which could be used for a range of client groups attempting

behaviour change. This met the recommendation that teaching and training should contribute to solving real life problems and take into account current knowledge and experience, (Kaufman, 2003), while relaying my personal experience conveyed an emotional involvement in the teaching.

In comparison to a traditional lecture, this was a relatively small group (20 students) making it possible to make the approach less formal and didactic. It was problem-directed, student-centred and where possible as interactive as possible, achieved by encouraging questions, often prompted by me, at regular intervals.

Reflection. I believe that regularly breaking up the presentation with opportunities to ask questions allowed for a short respite from concentration on the presentation itself, especially as it can be quite somnolent for an audience to listen to one speaker.

Training materials used for this session included a powerpoint presentation which was also developed into a handout for the attendees to follow and make extra notes where necessary (Appendix 8). This was designed to allow them more time to listen, process information and participate in the session rather than being concerned with more extensive note writing without necessarily understanding what was being covered. The slides were made as clear as possible. To help ensure this I asked a colleague to read through them at different stages of preparation.

Other handouts included a journal article I used to précis the various approaches taken to diabetes management. A list of references and links for those interested in further reading was also supplied (Appendix 9).

Reflection. As well as aiding their learning, handouts also help to meet their perception of themselves as consumers. A discussion with a lecturer on this course had highlighted that MSc students tend to think in terms of value for money when

assessing their satisfaction. Receiving handouts was an expectation from this group of students. As this was my first delivery of an academic session I was also anxious to keep them happy and present an image of myself as 'competent', reducing any chance of negative feedback. This was important for my own self-confidence as well as the success of the session.

I also investigated facilities in place for a student with special needs (visual impairment). It was not possible to arrange for the written materials in time for the session. As such the only option would have been to read the powerpoint slides out loud. However, despite this preparation this student did not attend.

Deliver such training programmes

I outlined the session and the learning objectives of the module. These had already been set and the material prepared with these objectives in mind. I also asked everyone if there was any other objective that they would have liked to be covered. Only a few ventured their learning goals and these included learning about diabetes and the usefulness of health psychology to its management.

Reflection. Advance knowledge of any additional objectives would have allowed for adequate preparation of these additional needs or expectations. This could have been gained by asking the course administrator to email a message prior to the session. Practical realities normally dictate that this question is asked in person at the start of the session. However, by raising this at the beginning of the session could have resulted in not having the information readily available or a lack of time in the session to cover it. Had this been the case I could have offered to inform them after the session. I was relieved that the learning objectives mentioned had already been built in to the prepared session. I wondered whether this congruence was a result of my having recently completed the MSc and so having a better understanding of what was expected.

The session then continued, beginning with outlining why this topic is important to gain their initial attention. At the end of each section the audience was prompted to ask questions.

Reflection. As well as aiding understanding, this technique also helps tackle the appearance of a bored, confused or irritated attendee; while scanning the faces and making eye contact with the audience it is sometimes difficult to differentiate these factors and can be disconcerting for the facilitator.

Assessment procedure

The formal assessment method for this session was an optional essay question set by the module coordinator; if this question is answered the host organisation has arranged for a fair appreciation of its assessment methods with their marking and moderating criteria.

As a non-compulsory question, this could result in no formal assessment of this session. I was also aware that some students may have done additional reading prior to the session to prepare for writing the essay or due to a pre-existing interest in the subject. With this in mind it was difficult to select an appropriate assessment regime for this session except monitoring the types of questions being asked of me as a guide to their understanding. I was also conscious that a lack of questions could also be due to non-engagement rather than indicating understanding. Thus, assessment in situ was minimal.

Reflection. Future formal assessment of the session in terms of application of knowledge attained by the students would be possible by being involved in planning and marking of the module assignments, or at least to request to view the papers relevant to the particular session. However, this may not be practical given the time constraints in marking assignments but is possibly a useful conversation to have with the institution in order to gain some feedback regarding the material taught.

Evaluation of the teaching

Evaluation of the session was enabled by the distribution of a short evaluation form at the end of the session (Appendix 10). This evaluation form comprised scale measures as well as a few open questions allowing a response by free text, prompting suggestions for improvement of the session; it was hoped that some thought on the part of the attendees would be required so that I did not presuppose the areas which may need improvement or may indicate which parts I thought may be seen as weak. A summary of these forms can be seen in Appendix 11).

Reflection. The students were positive about the training and interested in the topic with a short discussion being initiated at the end of the session, including thoughts on treatment and the pros and cons of automatic screening for diabetes. However, I realise that it could have been more proactive and improved in the future by discussion or role- play in smaller groups around different questions or problem-solving scenarios.

Overall reflection on this audience

Although diabetes is not my current area of work, I felt that by taking myself out of my 'comfort zone', this teaching and training session was a good learning experience as part of my personal development as a Health Psychologist in training. This was made more pertinent as the audience were training in health psychology and from my own recent training I entered this session with preconceived ideas over the potential standard of academic questions which may have arisen.

Overall Reflection of Teaching and Training Competence

The process of teaching and training has allowed me to design a realistic plan of a teaching session, implement this plan, observe intentional and unintentional effects, reflect on this process and raise discussion with colleagues over the experiences. All of these procedures are effective for improving my approach to teaching and training of two different topics to two different populations, one community-based workers and the other academic,

resulting in slightly different approaches taken. What has become clear however is the challenge to devise an effective assessment method in these sessions, especially in a workplace situation where there are pressures on the time allowed for training and realistic expectations that can be demanded of workers.

These experiences will influence my future style, building into an iterative process to gaining confidence in this competence. In light of the varied roles for health psychologists, it also helped to develop skills which may be required in future job roles.

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Appendix 1

Needs Analysis

Module: Competence 4: Teaching and Training

Subject: Smokefree Homes

Presenter: Gareth Absalom

Date: 21st March 2007 **Time:** 10.00 – 1.00pm

Venue: Sure Start [redacted]

Topic/Aim(s) of Session: To prepare a range of community and healthcare workers to promote a smokefree homes campaign to their clients.
The needs analysis for this training session were considered from three perspectives: 1. **The client – Sure Start** 2. **The provider – Stage 2 trainee** 3. **Stage 2 requirements** **The client was interested in rolling out the Smokefree Homes scheme to its outstanding localities. To this end, they required that the level of training was aimed at their workers assuming no psychological knowledge. Therefore lay language was essential. However, while acting within the remit of the structure of the smokefree homes process it was left to the discretion of the provider in how to convey this information.** **The provider wanted to use this session as an opportunity to convey information about smoking and secondhand smoke. It was necessary to take this approach to validate the importance of the new campaign so that the clients employees would see its importance in their day to day jobs. However, it was not only necessary to convey the information it was also felt that some of the workers may need guidance in how to approach clients and engage them.** **The Stage 2 requirements dictated the areas which had to be covered in the training. These were to be built into the structure of the day within the above parameters.**

Session Plan

Module: Competence 4: Teaching and Training

Subject: Smokefree Homes

Presenter: Gareth Absalom

Date: 21st March 2007 **Time:** 10.00 – 1.00pm

Venue: Sure Start [redacted]

Topic/Aim(s) of Session: To prepare a range of community and healthcare workers to promote a smokefree homes campaign to their clients
Learning Outcomes: By the end of the session participants will : **Have increased knowledge of the effect of secondhand smoke on children** **Be able to explain the features of the smokefree homes campaign** **Have an awareness of a piece of research into the effectiveness of this initiative** **Have a basic understanding of the principles of motivational interviewing**

Agenda

Module: **Competence 4: Teaching and Training**

Subject: **Smokefree Homes**

Presenter: **Gareth Absalom**

Date: **21st March 2007** **Time: 10.00 – 1.00pm**

Venue: **Sure Start** [redacted]

Time:	Outline Plan:	Participant activity
10.00	Introductions	Identify roles and their learning requirements
10.10	Quiz	Complete a quiz – feedback answers as a group
10.40	What is secondhand smoke	
11.10	The smokefree homes campaign	
11.30	Tea/coffee	
11.45	Local services available	
12.00	How to facilitate behaviour change	
12.30	Presenting the campaign to clients	
12.50	Session overview & evaluation Hand-outs – training booklet, smokefree homes leaflet	Individual feedback from audience and fill in evaluation form

Appendix 2

Handbook for training

Smokefree Homes Campaign

Helping to reduce children's exposure to secondhand smoke in the home

March 2007

INTRODUCTION

What is secondhand smoke?

The terms 'secondhand smoke', (SHS), 'passive smoking' and 'environmental tobacco smoke', (ETS), are all terms to describe the breathing of other people's tobacco smoke.
Tobacco smoke contains over 4000 chemicals in both a particle and gas form which affect both smokers and non-smokers around them, and which are too small for the eye to see.
People are exposed to both mainstream and sidestream smoke from other people's cigarettes. Mainstream smoke refers to the smoke that has been breathed in and out by the smoker. Sidestream smoke is breathed in from the burning tip of the cigarette, and is the source of 85% of all breathed in tobacco smoke. This sidestream smoke often contains higher concentrations of the toxic chemicals in cigarettes than the smoker inhales, for example, ammonia, carbon monoxide, nitrogen dioxide and hydrogen cyanide.
To establish a person's exposure to SHS, it is possible to measure cotinine, (a metabolite of nicotine), in non-smokers by taking a urine sample.

Why should we be concerned about secondhand smoke?

- ***The evidence on the negative health effects of SHS has been increasing*** over the last two decades, since Harlap first highlighted the link between exposure to SHS and child health in 1974.

- ***Children are particularly susceptible to the effects of SHS,*** especially in the pre-school years. Their bronchial tubes are smaller and their immune systems are less developed, making them more likely to develop respiratory and ear infections when exposed to SHS. Because they have smaller airways, children breathe faster than adults and consequently breathe in more harmful chemicals per kilo of their weight than an adult would in the same amount of time. They are also less able to choose to leave a smoke-filled room than an adult.

- ***Cigarette smoke interferes with normal development*** as it causes mutations, or genetic changes, in living cells.

- ***It is estimated that 42% of British children (52% in London-Smoke Free London 2001) live in a household where at least one person smokes*** and the percentage is higher among lower income groups, where smoking rates are higher.

- ***Awareness amongst parents of the link between parental smoking and particular conditions is low,*** such as Sudden Infant Death Syndrome (SIDS) and glue ear, although increasing (1). As awareness increases more parents should be encouraged to take action to reduce their children's exposure to smoke.

What are the health effects of Secondhand Smoke?

The following section lists the health effects that have been linked with SHS and children.

Specific effects on a foetus exposed to tobacco smoke include increased risk of low birth weight (LBW), intrauterine growth retardation (IUGR), and being born with reduced lung function.

Possible links may exist to increase risk of miscarriage and long-term effects on cognitive development.

In adulthood, non-smokers exposed to secondhand smoke have an increased risk of lung cancer and heart disease (2). It may also lead to increased risk of other cancers, asthma attacks, and exacerbation of cystic fibrosis (3).

Eye irritation, headaches, coughs, dizziness and nausea can also be immediate effects of secondhand smoke.

Risks with strong evidence of a link with secondhand smoke

Respiratory Health: Asthma

Asthma is the most common chronic disease of childhood.
Strong evidence suggests that exposure to secondhand smoke is linked to both the frequency and severity of asthma attacks in children with established asthma.

Asthma and respiratory symptoms (wheeze, cough, breathlessness and phlegm) are increased among children whose parents smoke (this information is based on 60 studies of school-aged children). The pooled relative risk from either parent smoking ranges from 1.2 to 1.4 (i.e a 20-40% increased risk) and symptoms seem to get worse with increased exposure (4).

Evidence supporting a causal role for SHS exposure comes from the small but significant effects of paternal smoking when the mother does not smoke.

It is also estimated that between 1,600 and 5,400 new cases of asthma may occur every year in the UK as a result of parental smoking (5).

Lower respiratory tract illnesses : Bronchitis, Bronchiolitis, Croup and Pneumonia

Parental smoking is a significant cause of lower respiratory illness in young children. 39 out of 40 studies have reported increased risks of these illnesses in children

whose parents smoke. Overall, the risk has been estimated to be 70% (1.7 fold) higher for children whose mothers smoke than for those of non-smoking mothers.

For children who live in households where the father alone smokes the increased risk is smaller but still 30% (or 1.3 fold) higher than in non-smoking households. This is strong evidence that SHS exposure does cause lower respiratory illness.

This risk of illness also increases with higher exposure to smoke (4).

Lung function

Maternal smoking during pregnancy has been found to adversely affect the growth of children's lungs. It has also been found to be associated with small deficits in lung function in school-aged children.

It is uncertain, however, how much of the effect on lung capacity is due to maternal smoking in pregnancy and how much to exposure to tobacco smoke after birth (4).

Low birth weight

Maternal smoking during pregnancy is a cause of low birth weight (3). The main effect seems to be in the second and third trimester of pregnancy; if a woman stops smoking once she knows she is pregnant she reduces her risk of having a low birth weight baby (see 7).

Consistent findings from over 30 studies show that pregnant women who do not smoke themselves but are exposed to SHS during pregnancy may also have lower birth weight babies than expected (3,4).

The mean reduction in birth weight across studies ranges from 25 to 40 grams, and higher exposure to SHS is linked to a higher birth weight reduction (4). Babies who are born with low birth weight are most vulnerable to health problems in early infancy, and possibly into childhood as well (7)

Middle ear disease (Glue Ear)

There is evidence that children's exposure to secondhand smoke increases their risk of having acute and chronic middle ear disease, which can cause deafness.
Over 40 studies have investigated the link and found a statistically significant increase of between 1.2 to 1.4 (20%-40%) increased risk of the disease compared to children not exposed to secondhand smoke (3).
However, due to a lack of research, it is not clear how much is due to maternal smoking compared to paternal smoking or whether the effects are due to prenatal or postnatal exposure (4).

The good news is that children show improvement from middle-ear disease when they have a smokefree environment.

Sudden Infant Death Syndrome (SIDS) or cot death

Parental smoking significantly increases the risk for SIDS regardless of which parent is the smoker (4). 50 studies into the relationship between SIDS and maternal smoking have all found an increased risk (4); infants whose mothers smoke are five times more likely to die from SIDS than infants whose mothers do not smoke, (4,6). However, it is difficult to distinguish between the effects of the mother smoking during pregnancy to the infants postnatal SHS exposure, although the main effect is believed to be from maternal smoking during pregnancy.

There is clear evidence that exposure to SHS is a cause of SIDS from studies which show an increased risk in infants who are exposed to paternal smoking even if their mother does not smoke.

Overall, parental smoking, especially by the mother, seems to be responsible for between a third and a half of all cases of SIDS (4).

Risks with moderate evidence of a link with secondhand smoke

Autism

Foetal exposure to tobacco smoke and the development of autism has been found (6), although this link has not been confirmed yet by other research.

Cancer

The evidence suggests that there may be a link between SHS and cancer in childhood. The pooled estimate from 11 studies that have investigated this link is a relative risk of 1.11 (or an additional 11% risk) of any childhood neoplasm (cancer) from exposure to maternal smoking. The increased relative risk for leukaemia is 1.14 (increase of 14%), based on 8 studies.

Less is known about risk from paternal smoking but it has been suggested that it may contribute to increased risk of brain tumours and lymphomas.
In all cases it is difficult to distinguish between risk from different periods of exposure (e.g. preconceptional, in utero and postnatal). Small increases in risk may also be due to unidentified confounding variables. Further research is therefore needed to clarify any link between exposure to SHS and childhood cancers (4).

Cardiovascular effects

There have been few studies done to date on a potential link between childhood exposure to SHS and cardiovascular disease. However there is a suggestion from available evidence that exposure to SHS may accelerate the development of cardiovascular disease, for example, atherosclerosis. This may be due to the negative effects tobacco smoke on oxygen transport around the body, high-density

lipoprotein (HDL) cholesterol, and possibly endothelial function, which affects the ability of a blood vessel to contract and dilate, and thus move blood around the body.

In adults both secondhand smoke and active smoking cause cardiovascular disease. These effects may credibly be extended to children (4).

Colic

Maternal smoking both during and after pregnancy may cause increased risk of colic in infants. One study has linked exposure to SHS to elevated blood motilin levels in infants, which is linked in turn with gastro-intestinal problems, including colic (8).

Meningitis

An association has been found between parental smoking and children's increased risk of serious bacterial infections such as meningitis (6). Further research however is needed to confirm these findings.

Mental (or cognitive) impairment

A study has found a possible association between mental impairment and exposure to even low levels of SHS (6). Lower academic achievement in young adults (including in reading, maths, logic and reasoning tests) has been linked to the mother smoking during pregnancy even when other factors such as socio-economic status have been taken into account.

Children who are exposed to SHS tend to have more days off sick from school and may also fall behind at school because of this. Problems with schoolwork may lead to lower self-esteem and behavioural problems in children who feel that they are doing badly (7).

Levels of serum vitamin C

Children exposed to SHS have been found to have lower levels of serum vitamin C, (an antioxidant which can protect the child from other illnesses), than children living in non-smoking households (6). It is believed that exposure to SHS affects the body's ability to absorb vitamin C.

Smell (or odour) discrimination

Exposure to SHS smoke can reduce children's ability to identify a number of different odours compared to children in relatively smokefree environments.

Wound healing

Exposure to secondhand smoke may also delay the healing of wounds. It is thought that the smoke affects cells in the body by making them less able to move to the site of a wound (see 9).

Other problems smoking may cause in the home:

Fire and injury

Cigarettes, lighters and matches are the biggest killers in accidental fires in the home. They cause up to half of all fatal house fires in London and are the second biggest cause of injury (see www.london-fire.gov.uk for more information on fire safety).

Childrens' play with matches and lighters is a major cause of these house fires so recommendations that parents keep smoking materials out of reach of children may reduce this risk. An alternative is to buy child-resistant lighters and child-resistant containers for match-boxes.

Imitation

Children who grow up in smoking households are more likely to become smokers themselves.

CHANGING PARENTAL SMOKING BEHAVIOUR

Options for smoking behaviour change

Nobody reacts very well to being told what to do, especially if it is to stop doing something they enjoy or feel they need to do. Likewise people who are contented smokers may become very resistant if they are advised to give up. Telling someone what to do can make them feel challenged and provoke them to continue with the behaviour you wish to change in an even more determined manner.

Smokers tend to react better to being asked if they could find ways to keep their children's breathing space smokefree (10).

It is recommended that the main aim should be to reduce children's exposure to secondhand smoke.

Some parents may express a wish to stop smoking themselves, either at your initial discussion with them or later, and there is information you can give them about stop smoking support in [redacted] at the end of this booklet.

The Smokefree Homes campaign, following the initial project designed by West Yorkshire Smoking and Health, (WYSH), has put options into place which you can discuss with parents about smoking in the home. These options enable parents to make a choice about what is possible for them.

The Four Promises

- ***Gold Plus Promise: to make the house totally smoke free at all times AND to quit smoking***
- ***Gold Promise: to make the house totally smoke free at all times***
- ***Silver Promise: to allow smoking only in one well ventilated room AND never to smoke in the presence of children***
- ***Bronze Promise: to never smoke in the presence of children***

Working with parents to reduce children's exposure to SHS

Interventions that have been evaluated to reduce children's exposure to SHS have been successful in raising knowledge about the effects of SHS. However, increasing parental knowledge alone does not always translate into action to reduce their children's exposure in and beyond the home.

> ***The most successful interventions to date have been ones that focus on changing participants' attitudes and behaviour rather than knowledge*** (11, 12).

Facilitating behaviour change

A technique that seems to have some success in promoting behaviour change in several interventions is **'Motivational Interviewing'** (MI). This is more effective than providing written information alone. This approach is different to the expert-advising role you may normally play in your post.

The goals behind MI are to build motivation to change in the client and to give the choice and responsibility for change to them. It is a client-centred approach but the advisor does direct the discussion towards factors which increase motivation for change, using a variety of strategies and techniques.

Important basic techniques of MI are(13):

1. ***Use open-ended questions***

   Examples include:
   'What have you heard about SHS and children?'
   'What would it be possible for you to do to protect your children from smoke?'
   'As people in the family smoke, have you thought how you might keep smoke away from your baby?'
   'What about smoking in the car or when you go out?'
   (see 13 for more ideas).

   The aim is for clients to express ideas about what could work for them and for you to reinforce them, or offer tips for them to consider if they are unable to come up with any (e.g. smoke before setting off on a car journey or asking friends not to smoke inside the house).

2. ***Listen reflectively to what they are saying.***
3. ***Affirm what they have said***
4. ***Summarize***
5. ***Elicit self-motivational statements***

These techniques will help you to work within the the five general principles of MI:

1. ***Express empathy*** - show respect for the client's opinion, even if you do not agree with it. Accept ambivalence as a normal part of the behaviour change process.

2. ***Develop discrepancy*** - help the client clarify their goals (eg health of a child) and explore the consequences or potential consequences of continuing with his or her present behaviour on these goals. The client should present the reasons for change, not the advisor.

3. ***Avoid argumentation*** - instead repeat what the parent has said and ask them why have those views. When you encounter resistance switch strategies.

4. ***Roll with resistance*** - turn the clients' statement or question back to them. As above, it can be reframed slightly to create a new momentum for change.

5. ***Support self-efficacy*** - self-efficacy refers to a person's belief in his or her ability to carry out and succeed with a specific task. Support from an advisor and positive feedback for client-expressed ideas for change are powerful factors in change.

Aids for the house, such as 'no smoking' signs and booklets on SHS can help if the client is concerned about asking people not to smoke in the house.

Follow up the initial session with a telephone call or query on next visit as to how the plans they came up with are going. Help address any barriers to change and encourage further.

- *MI is particularly useful with people who are reluctant to change or ambivalent about changing a behaviour. Ambivalence is recognised as normal.*

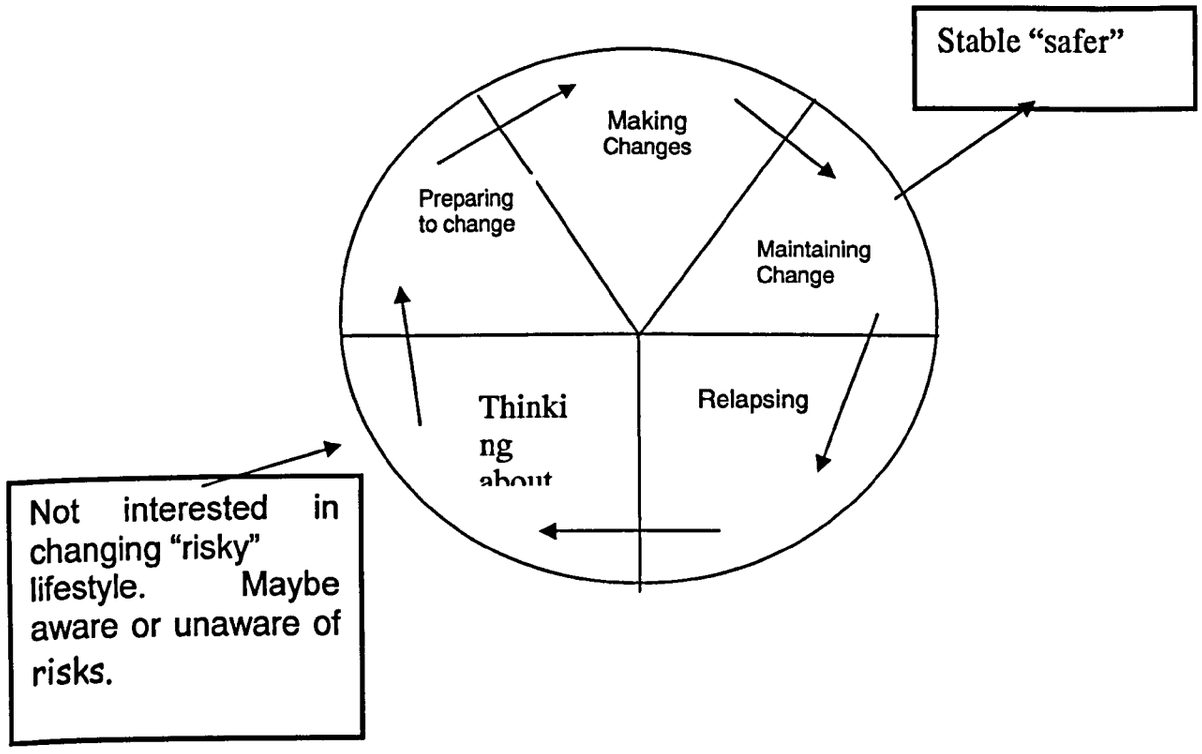
- ***The MI intervention that you provide to someone works better if it is tailored to a person's 'stage of change'.***

The **Stages of Change model** was developed by Prochaska and DiClemente (1983) to explain the process of behaviour change. It is one of a range of models of behaviour change and is not without limitations, however it does provide a good working tool for one-to-one interventions with clients around changing a behaviour.

It recognises that behaviour change is a process that goes through several stages before it is accomplished. Relapse is also recognised as part of the normal process in achieving lasting change.

As the following chart shows, people go through a number of stages when making any behaviour change in their lives. The amount of time they spend in each stage varies but most people go through all stages before they do achieve behaviour change. People may also go backwards and forwards around the cycle of change.

The Transtheoretical Model (Stages of Change Model)
Adapted from Prochaska and DiClemente 1983



People in a precontemplation **stage tend to be not interested in change.** They are either not aware of the risks involved in continuing with their current behaviour or resistant to doing so, perhaps because they have had a previous failed attempt to change in the past and feel they cannot do it. An intervention at this stage could raise awareness of the risks or possibility of change.

People who are contemplators and are thinking about change. They are aware of the risks of their behaviour but are ambivalent about change. Ambivalence is normal. They are aware of both benefits and costs of changing their behaviour. An intervention at this stage could focus on increasing the perceived benefits of change over the costs.

In the preparation stage of change, benefits now seem to outweigh the costs of change and change is seen as worthwhile and possible. People start to make plans for change and may need extra knowledge, skills and support to move into the action stage. This may include sharing ideas of what has worked for other people, and reinforcing positive ideas, although the focus should be on eliciting ideas from the client themselves.

People in the action stage have started making changes, although change takes effort and positive decisions to do so. This may require changing small

aspects of their lifestyle to help break habits associated with the behaviour. People need encouragement, support and reward as well as a clear plan of action.

In the maintenance stage of change people have become more accustomed to the change in their behaviour, however the novelty of it may wear off and relapse occur. To prevent this, on-going support and encouragement is needed, as well as the client remaining aware of potential relapse situations.

Relapse is recognised as a normal part of behaviour change which many people go through on the route to more permanent change and if it occurs should be treated as a learning experience of risky situations to plan for on a future behaviour change attempt.

Putting MI and the Stages of Change theory into practice

This can take practice but will improve the more you do it.

The following pages have a very good guide from the WYSH smokefree homes campaign (14) of how to put the principles of MI and a person's stage of change into practice to reduce children's exposure to SHS.

Additional points to remember include:

- Make it relevant-discuss in relation to an issue the parent can see is relevant to them and their child.
- Help increase their expectations that stopping smoking around their children will make a positive difference
- Help increase their perceived ability to change their smoking behaviour, either to stop smoking around the children or to stop completely. This can include helping the client to overcome perceived barriers to change (eg fear of upsetting friends or partner by asking them not to smoke near the children) by exploring with them how they think they could manage these situations. Information of how other people you know have managed these situations can also help as well as use of visual aids asking people not to smoke in the house and leaflets about SHS.
- Provide the client with positive feedback and encouragement for changes they propose, however small. Follow-up the session with telephone calls or queries as to how the changes proposed are going on the next visit.

Motivational Interviewing

Motivational interviewing is a tool you can use to encourage people to make their homes smokefree.

It will help you to have a productive discussion about secondhand smoke, to encourage people to come up with their own views about benefits of restricting smoking in their home and to identify their

own solutions for reducing exposure.

What the interviewer should not do is to assume responsibility for making people change their attitudes and behaviours or to feel guilty if they do not!

There are five principles in motivational interviewing:

1. Respect other people's view, even if you do not share them.

2. Clarify discrepancies in their knowledge

3. Avoid arguments

4. Help people identify their own solutions

5. Boost confidence

Stages of Change

1. Precontemplation

The person is contented with allowing smoking throughout the house; denies the risk of tobacco smoke to the family's health. May think that the amount of smoke their family is exposed to is not significant.

Your aim: plant doubts in their mind that tobacco smoke is not dangerous to others in the house

Intervention

- Show empathy and respect for the person's views, even if you do not share them. Do not argue; instead go along with the resistance.
- Ask: *Is there any way **at all** in which your family would be better off if they were not exposed to tobacco smoke?*
- Discuss the benefits of reducing secondhand smoke in their home.
- If they cannot identify any reasons, review the information in the bookmark, *Benefits to your family's health when you make your home smoke-free.* Because smokers tend to ignore general messages about the dangers of secondhand smoke, personalise the message by linking secondhand smoke to a recent illness or a family heath problem.
- Despite appearing entrenched in their attitude toward secondhand smoke, people may be receptive to friendly, non-judgemental advice. Develop a positive supportive relationship. Say: *If you change your mind at any time about limiting tobacco smoke in your home, please feel free to contact me.*

2. Contemplation

The person is aware of the dangers of secondhand smoke and intends to implement smoking restrictions albeit sometime *in the future.*

Your aim: Assure that the benefits of a smokefree home outweigh the costs, e.g. smokers having to go

outside to smoke; potential impact on relationships. Strengthen resolve to act; boost confidence in ability to make effective changes without risking important relationships.

People on the whole are 'contemplators' when it comes to changing behaviour of any sort. In regard to tobacco smoke, they may realise the dangers it poses and genuinely intend to make their home smokefree but more immediate needs prevent them from getting around to it. It will stay on their wish list until it becomes a major priority and they have a feeling of self-efficacy that they can do something about it without affecting value relationships.

Intervention

- Show empathy: *I realise it may be difficult to do so, but in what ways would your family be better off if your home was smokefree?*

- Feedback their response to them to emphasise the benefits of limiting smoking in the home.

- To reduce ambivalence towards making change, review the immediate benefits of reducing secondhand smoke.

- Boost confidence in their ability to impose smoking restrictions. Ask: *What changes have you been able to make in other parts of your life which involved your partners/friends needing to make changes as well?* Praise changes, no matter how small.

- Say: *You have been able to make changes in other parts of your life. I am sure that you will be able to do something about secondhand smoke in your home.*

- Don't pressurise the person to move into action; it will only increase resistance. Say: *When you decide to do something about where smoking occurs in your home, I can help you to do so.*

3. Preparation for change

The person is aware of benefits of limiting smoking in their home and is planning to do so.

Your Aim: Assist in maintaining a positive attitude and a plan of action. If people feel that making their home smokefree is something that has to be done, they will feel trapped and so tend to find excuses to escape from their decision.

Intervention:

- Assist in identifying and implementing an action plan. Discuss options. If the parent is hesitant about what to do, ask: *What are the benefits and barriers of each option? Which do you think is best for you?*
- Role-play various scenarios, e.g. Show a pamphlet describing the impact of smoking on children's health friends to friends and family who smoke, explain that you are not being judgemental about their smoking habit but that you're making your home

smokefree for the sake of your children's health.

- Suggest that they 'glamourise' the smoking area outside the house.

- Offer praise for whatever the person decides to do to increase their self-esteem and self-confidence.

4. Implementing change

The person has made their home smokefree, however, in the first six months relapse is likely.

Your aim: Reinforce determination to maintain smoking restrictions. Encouragement and praise from a credible person, such as a health worker, can prevent relapse.

Intervention:

- To strengthen resolve, help remind them why they did it, e.g. Why *did you want to have a smokefree home? In what ways are your family better off?*

- Discuss problems that may have occurred and how they were resolved.

- Praise efforts, no matter how small, in maintaining smoking restriction e.g. *I can see that you're trying really hard to keep your home as free of smoke as possible. That's brilliant. Keep up the good work. You are doing the best thing for your family's health.*

5. Maintaining Change

The person has maintained changes for over six months, but still may be vulnerable to relapse.

Your aim: Reinforce commitment to maintaining smoking restrictions; if they have had any setbacks describe them learning experiences and not as a failure.

Intervention:

- As with Implementing Change, strengthen resolve to maintain smoking restrictions. Help them remember why they imposed smoking restrictions: Ask: *Why did you make your home smokefree? In what ways are your family better off?*

- Praise efforts, no matter how small. *You're trying really hard to keep your home as free of smoke as possible. That's brilliant.*

- If their home is still not totally smokefree, ask: *Is there anything else you can do to further protect your family?* Let people come up with their own solutions so they feel ownership of their decision.

- If it is not possible to make further restrictions, don't make them feel guilty. Instead show empathy and respect for the decision that has been made, and praise current efforts, e.g. *I realise it is difficult to put greater restrictions in place in your home. Keep up the good work. If you ever do feel that you would like to make your home even more smokefree than it already is, please feel free to contact me.*

Summary: Show respect for different views. The overall goal is to help people have a positive attitude towards making their home smokefree as much as possible. Help them come up with their own solutions and feel they can implement them successfully without affecting valued relationships.

Reproduced from Smoke Free Homes Campaign. Interium Report (draft). July 2004, WYSH

SMOKING CESSATION

This session provides more information for people who are thinking about stopping smoking.

Why do people smoke?

Smoking behaviour is determined by a complex mix of pharmacological (drug), psychological (individual) and social (situational) factors which make it difficult for many smokers to stop smoking or consider doing so. Some reasons are listed below, although not all reasons apply to all smokers.

Why people smoke:	***Why people find it hard to give up:***
Nicotine addiction	Nicotine addiction
Habit	Withdrawal symptoms
Boredom	Fear of failure
As a reward	Guilt
To deal with stress	Don't want to
To help them concentrate	Not convinced about the harm
To feel better	Fear of weight gain
Peer pressure	Peer pressure
Weight control	Bad experience of quitting before
Comfort	Lack confidence
Enjoyment	
To cope	
For a break	
To look cool	
To relax	
Ritual	

Smoking is also heavily linked to situations in which people smoke, such as with coffee, on the phone, waiting for a bus, in the pub, with a meal, with certain friends, etc.

What help is available for people who wish to stop smoking?

A smoker who wishes to quit will have to deal with the withdrawal symptoms and also find alternatives to the functions that smoking performs for them and alternative activities.

Using Nicotine Replacement Therapy or Zyban helps to take the edge off withdrawal symptoms, allowing the person to concentrate on breaking the behavioural or habit side of smoking. Information on NRT and Zyban is provided on the following pages for those who wish to know more about it. It can double a person's chances of quitting successfully.

Accessing support from Stop Smoking Services increases a person's chances of stopping successfully to approximately four times that of someone who attempts to stop 'cold turkey', without using any help.

In [redacted] there is group and individual stop smoking support available to choose from:

Stop Smoking Groups

With the help of specialist advisors, a group of smokers will meet for one – one and a half hours once a week for seven weeks.
The first two weeks are spent preparing for stopping smoking. Members are also given detailed information on Nicotine Replacement Therapy (NRT) and Zyban (bupropion) so that they can chose which product(s) to use.
The third week is the week everyone stops smoking. Members will have their last cigarette outside the building.
The remaining sessions are to support members whilst they are adapting to their new healthy life without cigarettes.
Usually by the end of one of the groups 60-70% of the members will have given up smoking.
Groups are particularly suitable for the heavily dependent smoker. For example, someone who smokes as soon as they wake up or feels it will be very difficult for them to stop.

Individual Advice

Within [redacted] there are a number of GPs, practice nurses, pharmacists and other health professionals who are trained to give what is called Level II smoking cessation advice. It is run along similar lines to the clinic but is on an individual basis; is in the health centre or pharmacy and consists of five sessions of about 20 minutes each.

This may benefit some smokers, as they may be seen by someone they know i.e. their pharmacist or practice nurse, and is suitable for people who do not like the idea of a group or who are lighter smokers.

Referral Process

1. Give the smoker the Stop Smoking freephone number 0800 10 70 401.
2. Smoker calls the Stop Smoking freephone number. They will then be referred to either a one to one advisor or their nearest stop smoking group
3. The smoker will be sent a letter by the stop smoking service giving details (dates and venue) of the group chosen plus sheet about groups or details of local advisors
4. The smoker can then join a group or visit an advisor for help and ongoing support

NICOTINE REPLACEMENT THERAPY

Rationale for using NRT

- NRT provides sufficient nicotine to reduce withdrawal symptoms
- Main reason for relapse= withdrawal symptoms
- All NRT products are a course of 12 weeks

The benefits of NRT: three main messages

- 'Using NRT will double your chances of quitting'
- 'Nicotine is not the harmful part of the cigarette'
- 'Using NRT will help take the edge off the cravings while you work on breaking the habit side of smoking'

Obtaining NRT

- Obtain beforehand to start on the quit date
- Available on NHS prescription
- Health Education Authority guidelines: combining the patch with other forms of NRT may be more effective than the patch alone and appears to be safe. (West et al, 2000)

NRT can be used during pregnancy and whilst breast-feeding if the person is unable to give up without it.

It is unlikely that smokers trying to give up will become addicted to NRT because:

- NRT provides a low, steady dose of nicotine with no highs and lows
- Separated from cues to smoke
- No long-term use with patches. Occasional long-term (1-year) use with gum and nasal spray (rare).
- Even if NRT is used for a very long time, getting pure nicotine from NRT is safer than getting nicotine plus tar plus carbon monoxide from smoking cigarettes.

ZYBAN (BUPROPION)

- Only on prescription

Limits of NRT and Bupropion

- Not a Magic Pill or Wonder Drug
- Can make giving up easier by REDUCING, though NOT eliminating craving and withdrawal

Stopping smoking and staying stopped will still be challenging and will still require high levels of motivation.

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Other useful references:

Lloyd, K. Protecting children from exposure to environmental tobacco smoke. *Nursing Times*, 8 June 2004, Vol. 100(23).

Nursing Times articles can be good for more information on the mechanisms for example of how smoking affects the body. Online a search can be done for 'passive smoking' articles.

Other articles by Jennifer Percival, for example:
Protecting children from secondhand smoke. *Nursing in Practice*, Mar/Apr 2004, pp.51
The art of helping people to stop smoking. *Airways Journal*, 2004, Vol, 2(1), pp. 18-21.

Prochaska, J., Norcross, J. and DiClement, C. (1994) *Changing for Good*, pp. 13-49. 1st edition, New York, William Morrow and Company.

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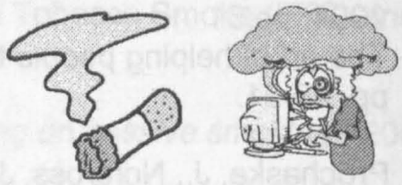
Handout

Smokefree Homes Training

Presented by : Gareth Absalom
Camden Stop Smoking Service



What is secondhand smoke?



What are some of the 4,000 chemicals in tobacco smoke?

- carbon monoxide
- tar
- nicotine
- cyanide
- arsenic
- Methane
- ammonia
- acetone



How does tobacco smoke affect health?

- it gets into every cell of the body
- irritates eyes, throat, nose & lungs
- can trigger allergies & asthma
- can cause heart and lung diseases later in life



Why is secondhand tobacco smoke (SHS) especially harmful to children?

- children's bodies are immature, their lungs are small and very sensitive to harmful chemicals
- children breathe faster than adults
- they may not be able to leave a smoky room



What health problems can SHS cause?

- chest infections
- coughing, wheezing
- asthma
- ear infections (glue ear)
- meningitis
- cot death
- learning and behaviour problems
- increase hospitalisation
- time off school



1

17,000 children go to hospital each year because of secondhand smoke

- car crashes
- drowning
- fire
- choking
- falls
- poisoning



Is smoke still harmful once the cigarette has been put out?

- yes, cigarette smoke stays in the room for a long time afterwards
- the chemicals stick to clothes, furniture, carpets, curtains long after a cigarette has been stubbed out.



What does it take to get rid of the smoke?

it would take the same force as a tornado going through your home to get rid of tobacco smoke.



Why should we promote smokefree homes?

- to protect young people from secondhand smoke
- enable them to breathe cleaner air



Why else?

- estimated that SHS in the home kills 2,700/year
- supports ex-smokers to stay stopped
- encourages smokers to quit
- people are more likely to accept restrictions in public and work places
- encourages young people not to start
- encourages young people to quit
- healthier pets

Campaign aim

To make it as easy as possible for families to restrict smoking in their homes without upsetting others by

- increasing awareness of dangers of SHS
- asking families to sign up to restrictions
- providing options – letting people decide what is best for them
- promoting smoke-free homes as the norm, especially in areas of high deprivation

Campaign principles

- negotiated goals
- signing a contract
- positive messages about the immediate benefits of smoking restrictions
- reinforcement from SS/health workers and goodie bag resources

Helping parents make a promise

[illegible] I/we promise to make our home totally smokefree and join a stop smoking programme.

- Gold Promise – I/we promise to make our home totally smokefree

I/we promise to limit smoking to one room in the house and never smoke in the presence of children

- Bronze Promise – I/we promise never to smoke in the presence of children

Resources

Application form/leaflet
Goody bag
- certificate
- door hanger
- window/door sticker
- tip sheet
- DH SHS leaflet
- Camden Stop Smoking Service card

Evaluation

- Family details will be recorded on database by Sure Start
- Families will be followed up by Sure Start at 3 months

Research Study

- Families will be asked to take part in a research study into the effectiveness of the Smokefree Homes campaign
- How will this happen?
  - When families sign up to their Smokefree homes promise they will also be given a participant information leaflet outlining the study

Research Study (cont'd)

What can you do?

When the family sign up please
- give them a participant information leaflet which outlines the study
- tell them that a member of the research team will call them after their details are processed at Sure Start Kentish Town to see if they are interested in taking part

3

Community-based Support

- Provided by around 180 community-based health professionals across Camden
- We should be able to find a convenient location for all
- Programme: 5 sessions 20-30mins
  - Week 1 - Preparation
  - Week 2 - Quit date
  - Weeks 3-5 Support
- Services available in different languages and at convenient times i.e. days, evenings & weekends

Specialist Service

- Groups provided across Camden (day & evening)
- 7 sessions 1 - 1½ hours
  - Week 1 - Information
  - Week 2 - Preparation
  - Week 3 - Quit date
  - Weeks 4-7 - Support
- Particularly good for people who want to quit with others and more highly dependent smokers
- Individual support for complex clients, including home visits

BREAK!



Basic techniques of MI

- Use open ended questions
- Listen reflectively to what they are saying
- Affirm what they have said
- Summarise
- Elicit self-motivational statements

Five principles of MI

- Express empathy - show respect for their opinion
- Develop discrepancy - help them clarify their goals
- Don't argue - ask them why they hold certain views
- Roll with resistance - repeat statements back to the client
- Support self-efficacy - increase their belief that they can change and be successful - offer support

MI is useful with people who are reluctant to change or ambivalent about changing behaviour. Ambivalence is seen as normal.

The MI intervention works better if tailored to the person's 'stage of change'

4

Brief tour of Stages of Change

- Precontemplation - - not interested in change
- Contemplation - thinking about change
- Preparation - change seen as worthwhile and possible
- Action - started to make changes
- Maintenance - become used to the change
- Relapse - normal part of behaviour change - use as a learning experience

Helpful hints!

- Make it relevant - to parent and child
- Increase expectation of positive effects of stopping smoking around child
- Talk through the percieved barriers to making the change.
- Give positive feedback - no matter how small the change may be.

Useful phrases to use

- What are the good things about what happens at the moment?
- What would be good about changing where people smoke?
- How does smoking in the home affect you/ your family?

Useful phrases to use (con'd)

- Is there anyway at all your family would be better off if nobody smoked in the house (pre)
- I realise it may be difficult to act but in what ways would your family be better off if your home was smokefree? (con)
- What other behaviour have you been able to change – maybe you could do the same with secondhand smoke? (con)

Useful phrases to use (con'd)

- What are the benefits of changing? (prep)
- What problems might there be? (prep)
- Which promise do you think you can manage to do? (prep)

Useful phrases to use (con'd)

- Why did you want to have a smokefree home? (main)
- How has this been a good move for your family? (main)
- What else can you do to help your family (main)

5

Take home messages

Your home is
- cleaner
- fresher
- healthier
- safer



Thank you for listening!



6

Appendix 3

Smokefree Homes Training

QUIZ - FACTS AND FIGURES

1. **What percentage of adults in the UK are regular smokers?**

   14% 24% 34% 44%

2. **What percentage of smokers want to give up?**

   50% 60% 70% 80%

3. **What percentage of children in a) UK and b) London live in a household with a person who smokes?**

a) 22% 32% 42% 52%

b) 22% 32% 42% 52%

4. **How many people die of a smoking-related disease each year?**

   12,000 54,000 114, 000 185,000

5. **Nicotine is the substance in a cigarette that causes cancer?**

   True False.

6. **Smoking relieves stress?**

   True False.

7. **How much money could someone save who smokes 20 cigarettes a day for one year?**

   £500 £1,200 £1,800 £2,100

8. **Secondhand smoke, (SHS), also known as Environmental tobacco smoke (ETS) or Passive smoking, is made up of two types of smoke. One is mainstream smoke, which is breathed in and out by the smoker. What is the other type called?**

9. **How many chemicals are there in tobacco smoke?**

40 400 2000 4000

10. **The number of children under 5 admitted to hospital every year in the UK with an illness resulting from SHS is:**

1,000 5,000 11,000 17,000

11. **Smoking by an open window is effective at protecting children from the effects of SHS?**

True False.

12. **How hot is the tip of a cigarette?**

30°C 70°C 300°C 700°C

13. **Fires started by smoking materials kill more people than any other kind of fire?**

True False

14. **In a poll in London in 2001 the percentage of parents who were aware that SHS caused Sudden Infant Death Syndrome (SIDS) was:**

3% 11% 25% 40%

Appendix 4

Putting Smokefree Homes into practice

1) You are a mother trying to persuade your partner not to smoke in the home. He is willing/not wiling to restrict his smoking. How would you have a discussion with him about it?

2) You are a Bangladeshi woman and your father-in-law always smokes when he comes around to your house. You want to make your house smokefree. How would you discuss not smoking in the home with him?

3) You are visiting a client at home. The client's baby has recently been discharged from hospital with bronchitis. How could you raise a discussion about secondhand smoke and keeping the baby safe?

4) You are visiting a client at home and see smoking materials on a table. How could you raise a discussion about secondhand smoke and/or child safety?

5) You want to make your home smokefree but your teenage daughter smokes in her room and is not interested in stopping. How would you discuss the issue with her?

6) You have a good friend who is used to smoking in your house. How could you raise the issue of keeping your home smokefree with her?

7) You are visiting a client who is pregnant. You know she smokes. She isn't interested in stopping smoking. How would you have a conversation with her about secondhand smoke?

8) You have raised the subject of secondhand smoke with a client. The house smells of smoke but the client denies they smoke in front of the children. How would you handle this situation?

Appendix 5

Smokefree Homes Training

Evaluation Form

We hope you enjoyed the session. We would welcome your comments.

Your Name ... ...

Your Job Title ... ...

1) Quiz

Very Useful Useful Somewhat useful Slightly useful Not at all useful

2) Effects of Secondhand Smoke

Very Useful Useful Somewhat useful Slightly useful Not at all useful

3) Smokefree Homes Campaign

Very Useful Useful Somewhat useful Slightly useful Not at all useful

4) Stop Smoking Support available in [redacted]

Very Useful Useful Somewhat useful Slightly useful Not at all useful

5) Behaviour Change

Very Useful Useful Somewhat useful Slightly useful Not at all useful

Delivering teaching and training

6) SFH Practice

Very Useful	Useful	Somewhat useful	Slightly useful	Not at all useful

7) How confident do you feel to be able to engage clients with the SFH campaign?

Very confident	Confident	Somewhat confident	Slightly confident	Not at all confident

8) Do you have any comments for improving the training?

Thank you for completing this form

Appendix 6

Summary of assessment, evaluation and recommendations

Nineteen feedback forms were returned. A summary of the 6 scale questions regarding the content of the session indicated an overall positive response to the training. 89% found the session either useful or very useful. No 'not at all useful' comments were received. The remainder indicated just one 'somewhat useful', with no 'slightly useful' or 'not at all useful'. In comparison there was more variability in the response to how confident they felt engaging clients. 69% felt 'very confident' or 'confident', 26% felt 'somewhat confident' with 5% feeling 'slightly confident'. Just two responded with suggestions for future training, including an opportunity for additional role-play, follow up sessions and a suggestion for another group of workers for whom the training might be suitable.

Verbal feedback indicated that the attendees appreciated all aspects of the training, especially the ability to practice different scenarios and the handbook, which was intended to accommodate the differing levels of interest and supplement the information covered in the session.

Despite the reservations noted earlier, a further assessment at the end would help the attendees identify areas where they may need to do some additional work, with the aid of the handbook, as it is often difficult to gauge your own level of knowledge without explicit questions being asked. This would also help identify a realistic confidence level while acting as a form of assessment of the session itself. Although time could be a limiting factor this could be overcome by the attendee taking it away to be completed in their own time as a self-test and then returned. Another possibility could be pre-learning, with the handbook, or a shorter version of it, sent out in advance of the training.

Appendix 7

Needs Analysis

Module: Competence 4: Teaching and Training

Subject: Behavioural Medicine - Diabetes

Presenter: Gareth Absalom

Date: 22nd March 2007 **Time:** 12.00 – 3.00pm

Venue: City University

Topic/Aim(s) of Session: To outline the contributory factors to the development and prevalence of diabetes, illustrating the health psychology input to the assessment and management of this chronic disease.
The needs analysis for this training session were considered from three perspectives: 4. **The client – City University** 5. **The provider – Stage 2 trainee** 6. **Stage 2 requirements** **The client was interested in the delivery of a lecture on diabetes to its MSc. health psychology students as part of the behavioural medicine module. They required that the level of training be aimed at the students having an undergraduate degree in psychology or a conversion degree. Therefore it was expected that academic terminology would be acceptable and expected. It was left to the discretion of the provider in how to convey this information.** **The provider wanted to use this session as an opportunity to convey expert information about diabetes and its management with a real-world perspective within the current health system in order to give the students a naturalistic view of managing chronic diseases. It was also felt that a clinical approach would be beneficial to give a sense of transferable skills to the group as it was expected that many had no clinical experience.** **The Stage 2 requirements dictated the areas that had to be covered in the training. These were to be built into the structure of the day within the above parameters.**

Session Plan

Module: Competence 4: Teaching and Training

Subject: Behavioural Medicine - Diabetes

Presenter: Gareth Absalom

Date: 22nd March 2007 **Time:** 12.00 – 3.00pm

Venue: City University

Topic/Aim(s) of Session: To outline the contributory factors to the development and prevalence of diabetes, illustrating the health psychology input to the assessment and management of this chronic disease.
Learning Outcomes: By the end of the session participants will: **Have increased knowledge of the contributory factors and prevalence of this chronic disease** **Understand how diabetes is addressed within the NHS** **Have a holistic view of diabetes within the biopsychosocial model** **Understand approaches to supporting this population** **Be given a local illustration of care**

Agenda

Module: **Competence 4: Teaching and Training**

Subject: **Behavioural Medicine - Diabetes**

Presenter: **Gareth Absalom**

Date: **22nd March 2007** **Time: 12.00 – 3.00pm**

Venue: **City University**

Time:	Outline Plan:	Participant activity
12.00	Introduction	Identify learning requirements
12.10	National overview	
12..20	Biomedical markers	
12.40	Psychosocial aspects	
13.15	Break	
13.45	Approaches to support	
14.00	Local illustration	
14.15	Discussion and questions	Whole class discussion
14.45	Handouts and Evaluation	Individual feedback from audience and fill in evaluation form

Appendix 8

DIABETES

Gareth Absalom
Behavioural Medicine Module

City University
22nd March 2007

Outline of Lecture

- Overview of Diabetes
  - The National picture
  - The BioPsychoSocial perspective
- A local illustration
  - Newham

National Picture

- Diabetes affects >1.4 million in UK
- Set to increase with ageing population and increasing obesity
- An important contributory factor in 'death from other causes'

National Service Framework

- One of the Dept of Health priorities
- NSF has 12 levels to be addressed

What are the 12 NSF levels?

- Prevention
- Identification
- Empowerment
- Clinical Care – Adults
- Clinical Care – Children and Young People
- Smooth transition from paediatric to adult services

What are the 12 NSF levels (2)

- Diabetic emergencies
- Acute care
- Diabetes and Pregnancy
- Detection and management of long-term complications
- Protocols and systems of care
- Integrated health and social care

1

Biological Aspects

What is Diabetes?

- Long term chronic condition
- Blood sugar level is too high
- Pancreas doesn't produce enough insulin or insulin produced is ineffective
- Insulin helps sugar move into body's cells where it is used for energy.
- Normal blood sugar level is between 4-6 mmol/L

What is Diabetes (2)?

- Affects approx. 3% of UK population
- Over 1 million people are undiagnosed
- 10% of NHS budget spent on diabetes & its complications

Types of Diabetes

- Type 1
- Type 2
- Gestational

Type 1 Diabetes - IDDM

- Insulin dependent diabetes mellitus
- Juvenile onset
- Most commonly due to destruction of cells in pancreas
- Possible viral trigger
- Pancreas produces little or no insulin
- Patients need insulin injections to survive

Type 2 Diabetes - NIDDM

- Non insulin dependent diabetes mellitus
- Late onset. Usually after 40 years old
- Usually overweight
- Due to insulin resistance
- Genetic predisposition
- Diet & tablet controlled
- May need insulin injections
- 90% of cases are Type 2

2

Gestational

- Develops during pregnancy
- Affects 2 - 5% of pregnancies
- Treated with diet and insulin
- If untreated, may affect baby
- Improves after delivery
- High risk of developing diabetes

Symptoms

- Frequent urination
- Excessive thirst
- Unexplained weight loss
- Tiredness
- Blurred vision
- Numbness & tingling in extremities
- Poor wound healing
- Increased infections

Risk factors

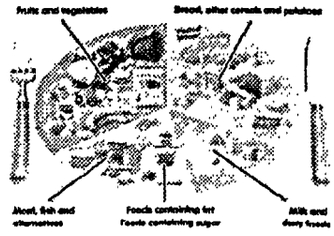
- Unhealthy diet
- Central obesity
- Lack of exercise
- Smoking
- High blood pressure
- Family history of diabetes
- High risk ethnic groups

Prevention

- PRIMARY PREVENTION
- Healthy eating
- Exercise
- Smoking cessation

- SECONDARY PREVENTION
- Early diagnosis & management
- Good blood glucose control
- Blood pressure control
- Reduce cholesterol
- Self monitoring
- Regular follow up

Healthy eating



Healthy eating

- Eat regular meals based on starchy foods
- Cut down on fat
- At least 5 portions fruit & vegetables
- 2 ltrs water
- Cut down on sugar
- Reduce salt
- Alcohol in moderation –max. 2 units a day for women, 3 units for men

Exercise

Helps to:

- Regulate blood glucose levels
- Makes insulin work more effectively
- Reduce weight
- Reduce blood pressure & cholesterol
- Prevent heart disease

Exercise

- At least 30 minutes physical activity 5 times week
- Build activity into daily life
- Brisk walk
- Take stairs instead of lift
- Get off bus a stop earlier and walk
- Turn housework into exercise
- Group exercise

Stop smoking

- To improve health
- To reduce diabetes complications
- Help available
- Contact doctor
- NHS Stop Smoking 0800 169 0169

Complications

- Blindness (retinopathy)
- Foot ulcers & amputation
- Kidney disease (nephropathy)
- Heart disease
- Nerve damage (neuropathy)
- Infections

Management

- Aim to maintain normal blood glucose levels
- Lifestyle changes
- Healthy eating
- Regular physical exercise
- Blood pressure control
- Reduce cholesterol
- Medication – tablets/insulin
- Attending doctor/nurse appointments

Psychosocial Aspects

Effecting Behaviour Change

4

Effect of Diagnosis

- Stages similar to bereavement
  - Disbelief
  - Denial
  - Anger
  - Depression

Implications

- Increased earlier diagnosis of Types 1 and 2 in childhood
  - Emotional support from the start is key
  - Recognised in NSF standard 5:

NSF Standard 5

- 'All children and young people with diabetes will receive consistently high quality care and they, with their families and others involved in their day to day care, will be supported to optimise the control of their blood glucose and their physical, psychological, intellectual, educational and social development'

Main Psychological Factors

- Self-management
- Individual variables
- Social and environmental variables
- Cultural differences
- Psychosocial adjustment and QoL

Approach to Self-management Interventions

- Based on behaviour change models
  - Self-regulatory model (Leventhal, 1984)
  - Health Belief Model (Rosenstock et al. 1988)
  - TTM (Prochaska and Diclemente, 1984)
  - Perceived self-efficacy (Bandura, 1977)
- Focus on sub-populations
- Focus on biobehavioural and psychosocial mechanisms

Psychological issues

- Psychosocial and cultural barriers
  - Dual processing model
- Illness Perception Questionnaire (Weinman et al 1996)
- Personal Model of Diabetes Interview (Hampson et al. 1995)
  - Lawson et al. (2004)

5

Psychological issues

- Dimensions of illness perceptions
  - Leventhal and Lau (1983)
    - 5 constructs
      - Identity
      - Consequence
      - Causes
      - Timeline
      - Cure/control

Psychological issues

- Other approaches include:
  - Develop a relationship with the illness
    - After the initial shock of diagnosis
      - Learn to live with it
      - Seek an optimal relationship
  - Intrapersonal threats and self-protective strategies
  - Interpersonal threats and self-protective strategies

Psychological issues

- Adherence
  - Influenced by higher social support
  - Improved by less social isolation
  - Social context and integration into life is an important part of adherence in any chronic disease

What are the main Psychological threats?

- Higher risk of developing:
  - Anxiety
  - Depression
  - Increased pain
  - Restrictions in daily life

Depression

- Research suggests that it is 2x as high in diabetics compared to the general population
- 24% of diabetics are affected by depression
- Other studies suggest depression and/or anxiety can be as high as 50% among young people with poorly controlled Type 1 diabetes

Why is risk higher?

- Psychosocial difficulties
- Possible organic factors

Other effects of Diabetes

- Eating disorders
- Phobias
- Obsessive Compulsive Disorder
- Alcohol and drug dependence
- Panic disorders

Implications

- Depression often linked with poor self-care
- For diabetics this can result in:
  - Reduced social functioning and quality of life
  - Decreased physical activity - increased risk of obesity
  - Reduced adherence to treatment
  - Reduced ability to follow recommended diet and/or exercise plan

Implications (2)

- Increased likelihood of unhealthy behaviours eg. Smoking, alcohol misuse
- Increased risk of micro and macro vascular complications eg retinopathy; amputation

All can result in poor glycaemic control - downwards spiral for the patient

Quality and Outcomes Framework

- Depression indicators and guidance now included in the QOF in two streams:
  - % of patients on the diabetes register for whom case finding for depression has been undertaken on one occasion during the previous 15/12 period using 2 standard screening questions
    - 'during the last month, have you been bothered by feeling down, depressed or hopeless?'
    - 'during the last month, have you been bothered by having little interest or pleasure in doing things?'

QOF (2)

- If newly diagnosed with depression in the preceding April 1 to March 31, the % of pts who have had an assessment of the severity at the outset of treatment
- Measures include:
  - Patient Health Questionnaire (PHQ-9)
    - 9 points, takes 3 minutes
  - Beck Depression Inventory Second Edition (BDI-II)
    - 21 items, takes 5 minutes
  - Hospital Anxiety and Depression Scale (HADS)
    - Takes up to 5 minutes to complete

Support Provision

- State of the Nations (Diabetes UK, 2005)
  - Gap in provision of emotional support, especially for children, young people and parents
    - 39% of non-members of Diabetes UK had been offered and accessed emotional help and support

Recommendations

- Doctors and nurses - more attention to listening to and supporting the emotional and psychological needs of individuals
- More resources needed to increase access to specialist psychological and emotional support for diabetics
- More research to investigate the types of emotional support people would benefit from

Recommendations (2)

- Employ a biopsychosocial approach
  - Both biological and psychological factors are important
    - Fatigue; weight loss and poor memory
    - Antidepressants

Main approaches to support

- Psychological
- Education
- Self Management

Basic techniques of Motivational Interviewing (MI)

- Use open ended questions
- Listen reflectively to what they are saying
- Affirm what they have said
- Summarise
- Elicit self-motivational statements

Five principles of MI

- Express empathy - show respect for their opinion
- Develop discrepancy - help them clarify their goals
- Don't argue - ask them why they hold certain views
- Roll with resistance - repeat statements back to the client
- Support self-efficacy - increase their belief that they can change and be successful

MI is useful with people who are reluctant to change or ambivalent about changing behaviour. Ambivalence is seen as normal

8

Useful phrases to use

- What are the things that you miss?
- What would be good about changing how you behave?
- How does diabetes affect you/ your family?

Useful phrases to use (cont'd)

- I realise it may be difficult to change but in what ways would you and your family benefit by changing your diet?
- What other changes have you been able to make in the past– maybe you could do the same with smoking/diet etc?
- Which change do you think you can do easily?

Useful phrases to use (cont'd)

- How has this change been good for your family?
- How could you avoid this happening again?

Impact of Interventions

- Improved self-management
- Improved blood glucose levels
- Increased engagement with treatment
- Cost-effective way of improving quality of life

Case Study - Newham

Present and Future

- Prevalence rate is 14,247 (QMAS, July '05)
- Impact of obesity, ageing population and low levels of activity
- Expected population growth

9

Multidisciplinary approach

- Aim to improve effectiveness and efficiency of patient care
- Direction of travel for the NHS is more community based care and less acute admissions
- Involves a multidisciplinary commitment

Local Picture

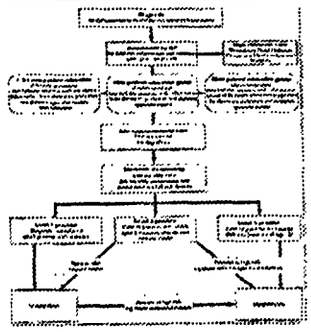
- Extreme deprivation
- Death from diabetes is higher than the London and National average
- Prevalence is increasing
- Under reporting of disease

BME differences

	Variance to General Population
Mortality Rate – South Asian migrant	+/- 350%
– Caribbean born – male	+/- 350%
Caribbean born – female	>800%
Diabetic nephropathy – South Asian migrant compared to Caucasian	≤ 1400%
End-stage Renal failure – South Asian migrant compared to Caucasian	≤ 1400%

How is this achieved?

- Integrated Care Pathway
  - Highest standard of care
  - Control Symptoms
  - Reduce long-term complications



How is this achieved (2)

- Map diabetes patient journey
- Empower patients
- Better data
  - Services accessed
  - Outcomes

Outcomes

- Better patient care
- Reduced DNA's
- Increased value for money
  - Less acute admissions
  - Increased well-being

Summary

- Diabetes can be prevented with lifestyle changes
- Diabetes is a serious condition and it can lead to complications
- However, by maintaining a healthy diet, exercise and taking prescribed medications, it is possible to lead a 'normal' life.

What can Health Psychology add?

- Research can inform treatments
- Research to date has generally lacked good methodologies to allow replication and been under-powered
- Apply health psychology principles to prevention, treatment and on-going care and support
  - Look at function rather than the disease
  - Management rather than cure
  - Integration of approaches

What can Health Psychology add (2)?

- Make treatments individual:
  - Contributing factors and maintaining factors = treatment regimen
  - Achieved through multidisciplinary mgmt
  - Self-care rather than one specific treatment

Take-Home Message

The challenge of Diabetes is to 'help patients balance short and long-term quality of life against the burden of daily intensive self-management' (Snoek, 2003)

Thank you for listening

Any questions, please contact me at:

gareth.absalom@camdenpct.nhs.uk

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Appendix 9

Diabetes: References and Links

www.nice.org.uk

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Appendix 10

Diabetes Presentation

Behavioural Medicine Module, 22nd March 2007

Evaluation Form

I hope you enjoyed the session. Could you please answer the following questions (please put your response in bold).

About the content:

1) Overview of Diabetes

Very Useful	Useful	Somewhat useful	Slightly useful	Not at all useful

2) Biological aspects of Diabetes

Very Useful	Useful	Somewhat useful	Slightly useful	Not at all useful

3) Psychosocial aspects of Diabetes

Very Useful	Useful	Somewhat useful	Slightly useful	Not at all useful

4) Motivational Interviewing

Very Useful	Useful	Somewhat useful	Slightly useful	Not at all useful

5) Case study illustration

Very Useful	Useful	Somewhat useful	Slightly useful	Not at all useful

About the presentation:

6) How could the presentation be improved (including the handouts, slides etc)?

7) Do you have any other comments?

Thank you for completing this form

Appendix 11

Summary of assessment, evaluation and recommendations

The objectives of the teaching were to raise the awareness of the contributory factors and prevalence of diabetes and illustrate the health psychology input to the management of this chronic disease. Of the twenty students in the session twelve completed an evaluation form. A summary of the five scale questions regarding the content of the session indicated that 90% of students found the session either useful or very useful. No 'not at all useful' comments were received.

Four responses to the two free text questions were given; the students appreciated the example of the management of this disease which I believe made diabetes real for them and put it into context within the National Health Service. The handouts were useful and appreciated as was the reference sheet provided as this could be used as a starting point for those who wanted to use this topic area for the assignment.

Reflection. This was the first time I had delivered this material and addressed this population. I believe this experience will improve future delivery; despite running through the material in advance, confidence with the material does not necessarily equate accurately to internal feelings when faced with a 'real' audience. However, despite these internalised feelings I felt in charge of the room, achieved through posture and maintaining eye contact with the audience.

Although feedback indicated that the material was interesting, the addition of a short quiz at the beginning of the session in future teaching could further stimulate concentration and engage the audience, despite it being time-consuming. To aid discussion I would also introduce a range of scenarios to be discussed in small groups regarding different populations with diabetes to stimulate the need for different strategies from which to approach this

chronic illness. These strategies could then be feedback to the wider groups. This would increase interaction with the subject area.

Reflective Commentary on the video recording

Setting: Audience 1. Family Support Workers

I introduced myself and my colleague and explained the aim of the training. Asking the attendees to also introduce themselves was designed to identify the levels of skill and experience in the room. However, due to the start of the session beginning late (due to a previous meeting overrunning) and the attendees getting drinks etc. the session started without everyone being seated. This was meant to indicate to the attendees that the session was starting. However, there was quite a lot of background noise. In retrospect it would have been more effective to have made an announcement that the session was about to begin and possibly wait the few more minutes this would have taken before beginning.

Throughout the session I maintained eye contact with the attendees, scanning the room, nodding and making facial expressions that are encouraging and welcoming, e.g. smiling. However, I do sometimes appear as if I am fidgeting with the sleeves of my shirt and watch that could be construed as nervousness while the movement itself may be distracting for the audience. Although slighter, this continued when my colleague was speaking. Similarly I was looking at the paperwork of the presentation that may indicate I am not familiar with the material. As I have presented this work on previous occasions and I felt quite comfortable with the material, this was more an unconscious movement that I will be more aware of in the future.

It was not always possible to avoid medical terminology and I offered lay explanations of these terms. This was combined with personal examples to illustrate examples and to encourage group involvement as well as pitfalls that may be experienced, e.g. realising that using illnesses which may result in time-off school may not necessarily be a negative point with children. This was helped further by answering questions throughout and

probing further when needed, which with a light hearted approach was aimed at maintaining the interest of the audience.

Although the handbooks were used to aid teaching, this led to a time delay as people leafed through them. In future, I think it would be better to hand these out at the end of the session to reduce levels of distraction. Other distractions included a mobile phone ringing. Although the person apologised I did not use this as an opportunity to remind others to switch their phones off. By setting clear boundaries at the beginning of the session this could have been avoided.

Explaining the research illustrated how difficult it is to translate academic processes into lay language. Also, although giving out a paper version of the research process was meant to have been helpful, its explanation would have been clearer if I had also prepared a slide of this process. This would have allowed me to maintain eye contact with the audience rather than them looking down at their copies. Similarly, on a few occasions I was unable to find the right word; such mind blocks occur and I tried to handle this with humour rather than embarrassment.

Overall, I feel the training went well. This was the first time that a presentation had been recorded for my development and I found it useful to identify unconscious behaviours. Although suggestions for improving future presentations have been made earlier, I do not feel that internal feelings of nervousness were visible to the audience. As such the training remained credible. This was evidenced by positive feedback received at the end of the training from the participants.

Competence 5.1 Implement Interventions to Change Health-Related Behaviour

Facilitating a Stop Smoking Group

FACILITATING A STOP SMOKING GROUP

Background to the Approach

The group intervention follows the withdrawal-oriented model developed by the Maudsley Hospital Smokers Clinic (Hajek, 1989). This model for this closed group follows a standardised 7 week plan; weeks 1 and 2 are for preparation to quit, week 3 is the quit date and the following 4 weeks are support sessions following the quit date.

The primary objective of the abstinence model is to support smokers to quit all smoking on a specific day and not to cut down to quit, by helping them to overcome their addiction to nicotine and the withdrawal discomfort this causes. By 'normalising' the motivational system and maintaining the stability of the addiction, the ideal conclusion is a change in self-identity to that of a non-smoker (West, 2006). This approach follows a biopsychosocial approach addressing the biological, addictive aspect as well as the psychosocial elements of smoking. The aim is to bolster restraint to achieve a more lasting and pervasive shift in behaviour through replacing identified cues, motives and impulses, established through associative learning, with coping mechanisms.

The Group Intervention

Session One

No initial selection process of group members is undertaken in advance of the start of the group, with the exception of them establishing the time and venue of the group, usually by telephone. As such, the only advance information available is their name, address and telephone number. A personal information booklet and consent form is completed in the first session (Appendix 1). Each succeeding week a new section is completed to record the number of cigarettes smoked daily as well as physiological and emotional reactions during that week. This provides a reference tool for the client in future weeks to accurately follow

their experience over the seven-week intervention. Handouts were also distributed each week highlighting the main topic areas for that week such as the pros and cons of stopping, coping strategies etc. (Appendix 2).

I congratulated them all on showing the initial motivation to call and book themselves onto the group and then to actually attend. Timekeeping was the first issue to arise; just 2 (out of an expected 8) had arrived 10 minutes after the planned start time. After beginning with introductions, three more arrived, which required me to repeat the original welcome. To improve the chances of success for the group, boundaries, including timekeeping, had to be addressed to ensure respect for the other members that could impacting on the support they felt. This period is referred to by Tuckman and Jenson (1977) as 'forming', the first of 4 stages in group formation, where anxiety levels can be at their greatest for all members.

As well as these boundaries, the overall requirement of 7 weeks attendance was also made explicit. This reinforced the information given to them when they originally booked themselves into the group; it was essential that the group had clarity over what commitment was expected from them and what they could expect from the group. I also outlined alternative support available, such as individual support in the community to ensure the client had made most appropriate choice for themselves. They could then make an informed decision to participate in this style of smoking cessation intervention.

Reflection. I often feel uncertainty at the start of a new group as each individual can influence the group progression and consequently its outcomes. I felt that this discussion of shared goals and information, responsibility and commitment to the structure of the group helped the group to bond, averting the chance of conflict and moving to 'norming' (Tuckman & Jenson, 1977) where the members take ownership for the group and as such making successful 'performing' (Tuckman & Jenson, 1977) more likely.

I then outlined the structure of the seven-week intervention in more detail. The first two sessions deal with preparation for stopping, where the behaviour change goals are identified and negotiated. This also involves an assessment of the cognitive, behavioural and situational determinants of their smoking, including motivations to stop, past experiences and identifying specific aspects of their habit.

This is then followed by the development of a behaviour change plan based on cognitive behavioural principles, in particular developing coping strategies to change habitual behaviour as well as the prescription of pharmacological therapies. From the third week, quit week, the sessions become more client-led, with a focus on describing and monitoring their previous weeks' experiences and offering support to each other and suggestions to resolve any problems encountered in their behaviour change.

The approach in the first two sessions is more directive and didactic than the following sessions due to these being more information giving. This information includes sharing knowledge about smoking, the pharmacological aids available as well as ensuring that the clients have the necessary motivation to optimise their chances of success, including realistic and positive expectations. This is reinforced by research findings that this combination of pharmacotherapy and the positive effect of quitting with others, as well as highlighting a shared responsibility for the success of the other group members, results in an average 70% quit rate (Hajek, 1989).

When describing their motivations for wanting to quit some group members may identify with others in their motivations while also realising that there are many other reasons to stop smoking of which they may be unaware. Identifying and addressing each individual's expectations and beliefs can therefore benefit the group process (Bennett & Murphy, 1997).

Reflection. Although the goal of stopping smoking is implied by attendance at a stop smoking group, ambivalence of some can be a barrier to achieving this goal and makes the

process more difficult. Another challenge faced at this stage can also be difficulty of some to discuss their feelings in a group context; eliciting responses from some was more of a challenge than with others. At this stage a number of approaches are required including motivational interviewing (Miller & Rollnick, 1991) as well as tact so that the group members do not feel intimidated by the group process. Additionally, this may also be an indicator that they may prefer an individual intervention which can be followed up after the session to ensure that the group is the optimal support mechanism for them.

Attendance at a group is generally accepted as implying a motivation to quit. However, providing information may not result in changed attitudes and changed attitudes may not necessarily change behaviour (Collins, Thomas, Willis, & Wilsdon, 2003). Similarly an intention to change behaviour is not always successful. However, if these are cognitively elaborated and converted into an implementation intention, specifying when and where the intention will be enacted, intentions are more likely to be enacted, becoming an automatic response (Gollwitzer, 1999). These can be described as an 'if...then...' strategy. In a meta analysis Webb and Sheeran (2006) found that forming an implementation intention improves behaviour change and goal attainment compared to the formation of a behavioural intention alone.

In this context, best outcomes of behaviour change occur when the behaviour change is planned, initiated and maintained with the potential for relapse recognised and planned for (Sniehotta, Scholz, & Schwarzer, 2005). It is this approach upon which this intervention is based and is facilitated by action planning, increasing members' self-efficacy and action control to bridge this 'intention-behaviour gap' (Sniehotta et al., 2005).

Helping the client to identify their goal is facilitated by motivational interviewing (Miller & Rollnick, 1991) to help overcome any ambivalence especially as for most smokers there are advantages as well as disadvantages to smoking. By helping the client to identify

the pros and cons which affect this balance and to recognise the importance of trying to quit only when this decisional balance is in favour of the pros results in a more realistic outlook for the quit attempt (Rosenstock, 1990). For some group members, this was the first time they had to express these conflicting emotions.

Reflection. The relationship between the facilitator and the group members has to be one of respect for the client's independence and freedom of choice of their behaviour. I was aware that readiness to change is not a stable trait but a product of intrapersonal interaction, requiring modification to motivational strategies; trying to move the client to the decision to quit before they are ready may increase resistance and be detrimental to the quit attempt (Miller & Rollnick, 1991).

When the clients talk about their habit and their motivations to quit, active listening techniques (including reflection, acceptance, affirmation and summarising) can be employed to ensure an understanding of the meaning of this behaviour and can help reduce resistance to change (Rollnick, Mason, & Butler, 1999). The group was encouraged to discuss new, less destructive habits to replace smoking that could then be activated by everyday triggers or an everyday situation, becoming automatic and effortless.

Rewards for not smoking were an effective tool to encourage success. Positive reinforcement (Skinner, 1969) of a behaviour change can be a crucial encouragement to people quitting smoking and take a number of both short term and long-term forms. Suggestions arising from the group included material benefits such as the financial effects of stopping smoking, the favourable group response expected by returning the following week and reporting that they had not smoked as well as immediate and longer term health benefits.

A possible source of conflict emerged between two of the older members, a British man and a German lady. When discussing reasons for starting to smoke, the British man stated that when he was a teenager in the early 1940's everyone smoked; a cultural factor

which was continued in the army during and after the war. Repeating this point on a few occasions it was noticeable through her body language and audible 'tuts' that the German lady was becoming agitated at these references.

Another possible source of conflict arose when discussing the use that can be made of the money saved from stopping smoking. The extent of these varied from person to person and depended on the socioeconomic status of the client; for some this could be opening another bank account to save the money for a holiday while for others it meant they could afford a treat for their child.

Reflection. I was aware that discussions over motivations and rewards have the potential for differences of opinion, backgrounds and expectations to surface, which may impact on group dynamics. Factors that may be brought up in any group, including political, historical and religious aspects of people's lives, have to be managed sensitively. I wonder whether these should be mentioned in the 'forming' stage of the group when boundaries are set?

Other issues arising from this session included the fact that I had never smoked. This appeared to be more of an issue for the older German lady who believed that as a non-smoker I would not be able to understand what they were going through in their quit attempts. I asked the group for their perceptions of my role. A number clarified that they saw my role not as experiencing their discomfort but facilitating them through the acknowledged, evidence-based way to successfully quit. Asking whether everyone was happy with this explanation, I judged by the verbal responses and facial expressions that they were.

Reflection. This question arises in most groups. Group interventions benefit from the facilitator being able to directly address individuals' understanding of smoking, provide appropriate information specific for the group and identify and tackle any resistance or reluctance discerned from the participants (Bennett & Murphy, 1997). Could this question be

construed as a form of resistance to stopping smoking? I felt that the group discussion helped to reinforce my position as being able to offer encouragement using the cognitive-behavioural principles for behaviour change. However I was aware that resistance to change from just one group member at this stage could affect the ultimate outcome for the whole group (Rollnick et al., 1999).

When describing the pharmacotherapies available questions arose specifically around positive and negative experiences of previous quit attempts. This was also on opportunity to reinforce its role as a medical treatment, requiring correct usage for its success and being enhanced by psychological and behavioural strategies.

Reflection. These questions helped to identify the more informed members who helped drive the group forward. I could also use the group's past experiences to illustrate and discuss successful and unsuccessful strategies. I felt that this helped to encourage the members to perceive the wider benefits of belonging to a group.

Other quitting approaches also arose, especially the widely read Allen Carr (2006) approach which again stimulated discussion. This was an opportunity to reinforce how difficult quitting was for some and that if they thought it would help them they should avail themselves of all help possible in their attempt, with the caveat that all other approaches were not evidenced based approaches to quitting. To ensure that this did not result in undermining their attendance to this group, this encouragement was done in the context of reinforcing the addictive nature of smoking and the evidence base for this group approach.

Reflection. At the end of this first session I felt that given the interaction over the session the group had built a good rapport with one another. I also had an opportunity to speak to the German lady. It became clear that she was very nervous about this quit attempt and the fact that this was her first group, which she admitted was the reason for her agitation earlier in the session. This highlights the importance of trying to delve deeper into the

meaning of what is said or done by a person, although due to time constraints, this may not always be possible in a group session.

Session Two

Three new members arrived. As well as introductions, to ensure that two groups did not evolve e.g. an 'in-group' of the original members and an 'out-group' of these new members, I also asked those present in week one to reiterate their motivations for quitting before asking the new members to do the same. This resulted in encouragement and nods of recognition at their motivations.

This session contained more discussion around behaviour change and strategies to aid these changes. Suggestions were quite numerous and after my apprehension in the first week the older British man and the German lady were quite animated and friendly in their conversations with each other.

A technique suggested to help with successfully achieving goals is self-monitoring, including using a diary (Appendix 3). Bandura (1998) states that by paying attention to their performance individuals can influence their own actions and motivation, leading to setting harder goals, improving feelings of self-efficacy and the degree of perceived behavioural control and increasing a sense of mastery. As such, client recognition of small changes is important to reinforce the decision to enter the group and encourage their continuance with the programme (Korotitsch & Nelson-Gray, 1999).

As well as their weekly questionnaires and this detailed diary to reflect upon they were encouraged to reflect on previous successful behaviour changes and role modelling (thinking of people they know who have managed to stop smoking). It was also brought to their attention that a large number of people had used this process successfully and as such there was no reason why they should be any less successful than others in the group.

Furthermore the encouragement and support given to them by the other group members when self-doubt or personal failings may occur would enhance this.

The final strategy to increase their self-efficacy involved raising positive mood and reducing negative reactions to events and/or their physical state. This was achieved by giving the clients realistic information about the quit attempt. This included information contained on the weekly handouts (Appendix 2) about the effects of stopping smoking such as reduced concentration, irritability etc., weight gain to 'natural' levels, ensuring correct usage of the pharmacotherapy and making them aware of the side effects of nicotine replacement therapy (NRT) such as interrupted sleep and nausea. This is crucial to ensure adherence to what is a medical treatment and of itself may help to decrease their anxiety compared to any previous attempts.

A common question revolved around the safety and effectiveness of the NRT. As a service provided by the National Health Service, this was an opportunity to reiterate the accepted research regarding the success rates of this approach. The most frequent reference is made that using NRT alone significantly increases success rates for smoking cessation by up to 100% (Silagy, Lancaster, Stead, Mant, & Fowler, 2006) while the addition of behavioural support can double this rate again (Hajek, 1989).

Reflection. For purposes of communication to a lay population these are easily understood figures. However, a systematic review has more recently found that the use of NRT increases successful quit attempts by 50-70%, independent of whether this is with or without support, although they concluded that this support was beneficial in facilitating the person's likelihood of quitting; however this was not quantified (Stead, Perera, Bullen, Mant, & Lancaster, 2007). This reflects the difficulty in conveying accurate information within the needs of a large organization to the general population while maintaining ethical practice. If all studies results were discussed this would make the response very complicated and

unmanageable. As such this illustrates how it may sometimes be necessary to employ a simple heuristic in order to be understood by the audience.

The opportunity also arose to remind the group that there is not one correct way to stop smoking and that they would all have a different experience of the quit attempt for which they would find individual coping strategies.

Cross-discussions developed between members. Despite indicating engagement with the group, these individual discussions may have resulted in valuable ideas being lost to the rest of the group. Control was regained by interjecting conversations with a comment such as "I think ....has just come up with a good idea – could you repeat it for the rest of the group?" rather than being more directive and asking them to be quiet and take it in turns to speak.

This session finished with an outline of the next session, quit day. Specific reference was also made to the objective measure of carbon monoxide (CO) and its effect on the body. As this measure provides immediate feedback, usually a measurable fall in their CO levels, and can act as a motivator (Raw, McNeill, & West, 1998) this reading was to be taken at all successive sessions. They were also encouraged to bring a smoking-related item to symbolically throw away in front of the group to reinforce their commitment to themselves and to the group. It was at this point that one member advised me that he wanted to quit immediately. After assurances that he was prepared I agreed to his request.

Reflection. Compared to a 1 to 1 intervention, I was concerned by the effect this one member stopping in advance of the rest of the group may have had. The principle of any smoking cessation attempt is based on the client and the advisor agreeing a quit date at the outset, where individuals choose their quit date. This then becomes a verbal contract. However, to maintain structure for the whole group there is less flexibility in doing this and so requires a more rigid approach to ensure that the group timelines remain constant. If one or more group member stops smoking before the other members there is the possibility of

undermining any group effect, reducing the shared experience and possibly being detrimental to the remainder of the group. This would be more evident if that member had a difficult time stopping as it could impact on the confidence of the others whose quit attempt would be behind theirs. I had to balance this with evidence suggesting this more immediate strategy is successful for some (West & Sohal, 2006). I remained optimistic but this highlighted to me the need for flexibility with this client group.

Session Three

Despite all being eager to begin using their NRT and start their quit attempt, most were also apprehensive. Once again, advice was reiterated over its correct use and a reminder over the side effects of NRT and stopping smoking to encourage adherence and its continued use.

When strategies were exchanged for coping with not smoking it became clear that some had prepared more than others. One member brought copies of their strategy for all to share (Appendix 4a) which could be developed into a template (Appendix 4b). The idea of setting up their own support network was also raised and they all decided to exchange their phone numbers to be used at anytime the following week should they feel they needed additional support. This level of support made me feel very positive about the group's chance of a successful outcome.

Reflection. It is difficult to distinguish whether the different levels of preparation exhibited could indicate differing levels of motivation to stop or indicate that some may require less preparation than others. As such I decided to monitor whether this had any impact on their experiences of the quit attempt and at the end of the group it did not appear to affect the success of the individual.

The idea of stopping smoking 'forever' had already become daunting for some. This raised the question of realistic goal setting, which makes the behaviour change manageable

(Padesky & Greenberger, 1995). They were encouraged to use phrases such as 'I will not smoke for this week' or 'I will take each day at a time'; these are more concrete periods and allow monitoring of progress and taking remedial action if necessary. Such mini-goals are more manageable, helping confidence building and increasing motivation (Rollnick et al., 1999). This was reflected in the commitments to the group each member made at the end of this session.

Such commitments also represent an informal contract between the group members; they often return to the group making comments that they were tempted to smoke but that they did not want to let the group down any more than letting themselves down. As such, one of the aims of the intervention is that by the time the group ends they would have have practiced and developed their skills, and in effect negotiated their own rules in order to attain their goals (Kanfer & Goldstein, 1991).

Sessions Four – Seven

The following weeks fell into a pattern of comparing experiences over the previous week of both NRT use and cognitive and behavioural coping strategies employed. If anyone missed a session I called the following day to offer support and discuss any problems. One of these calls discovered that a member had smoked during that week and felt that they had failed everyone else. Despite reassuring them that the group would have been supportive they did not return. Another call established that they had decided this was not the right time for them to stop.

Reflection. This highlights how the group effect may be perceived differently by different personality types, where peer pressure to succeed may actually deter someone from returning. Similarly, the treatment approach and the requirements of the intervention to be considered a successful quitter may actually deter a member from returning and reporting their lapse. This may be overcome if a less rigid approach with a longer support period was

possible rather than conforming to the short timescale in which to be classified as a 'successful' quitter. Despite the best efforts made by motivational interviewing to prepare and develop cognitive-behavioural coping strategies which Brown et al. (2003) found increase intentions to quit, other external factors may exhibit a stronger influence, resulting in an unsuccessful quit attempt. I bore these factors in mind when reflecting on the group process and success rates.

Just as behaviour change is governed by an expectancy of a favourable outcome (Rothman, 2000; Rosenstock, 1990) found that failure to maintain this behaviour change is also governed by perceived satisfaction with the outcome of not smoking, leading to reduced motivation to continue with it. This could be seen with clients who had expected great changes in how they were feeling; their expectations could be described as unrealistic and had not been verbalised in the earlier stages of the quit attempt. These misconceptions required a lot of encouragement to overcome, making them realise that the effect of years of smoking would not be overcome in a matter of weeks. They were therefore encouraged by the group to identify even small improvements, such as the ability to climb one flight of stairs without stopping.

This dissatisfaction could result in lapsing. The reaction of those who had lapsed ranged from drop-out, disappointment at having let the group down to a belief that they would never be able to quit smoking. Within the Stages of Change model Prochaska, Norcross and Diclemente (1994) refer to lapse and relapse as an opportunity to learn. Increasing the self-efficacy of those who had lapsed was helped by the encouragement given by the group who pointed out that rather than continuing to smoke they had returned to tell the group. The learning point on most occasions was that they had not enjoyed the cigarettes, helping to reinforce the futility of smoking for them and making them more determined not to smoke again.

Reflection. I was aware that the experience of one group member had the possibility of affecting the rest of the group and therefore have to be dealt with effectively within the group. The question of lapsing is one such instance; it is difficult to maintain a balance between encouraging those who had lapsed to believe that they could still have a successful quit attempt without sending the message to the others that it would be acceptable to smoke. Similarly, another member found that by misusing the NRT patch, by putting a 16hour patch on before going to bed rather than first thing in the morning as directed, it was easier for them to cope with the desire to smoke first thing in the morning. It was necessary to be pragmatic and to explain to the group that although they did not want the 24-hour patch, what was important was that this approach made their quit attempt manageable. This was another illustration of how every quit attempt was a personal journey and how stopping smoking is quite an inexact science. This helps to illustrate one problem with a 'one-size-fits-all' approach to stopping in a closed group; some may require additional support to that which the evidence base has identified results in successful long term quitters. This approach does not set out to deny individual differences but has to work within an organised health economic framework that requires a structured intervention to be in place to ensure a measurable standard of intervention is delivered.

Completion of the group is set at week 7. In this final session, certificates were given to those who had been successful. However, anxiety was expressed at continuing the quit once the group finished. In this respect follow-up, or relapse prevention, sessions are made available if they feel additional support is required. They were also encouraged to set up their own informal meetings as appropriate.

Reflection. The certificates were appreciated by most and illustrated to me that for many it was important to recognise their achievement. However, with the completion of the intervention, anxiety is a common reaction for some. To encourage their longer-term

abstinence I reaffirmed that they had all developed the skills required to continue their success. I felt that encouragement to make their own meeting arrangements also helped to empower them. Although these additional support facilities are in place, anecdotally I have not found many attending the relapse prevention sessions or calling the stop smoking service for additional support once the support programme has been completed. One explanation could be that the skills learned over the 7 weeks are sufficient to maintain the quit attempt. This could be investigated further if long-term follow-up of clients was performed.

Overall Reflection

As there is no prior screening and no individual support in the group session, it is sometimes challenging to assess the clients within the group process. However, what reduced individual attention may lack is compensated for by the group effects and learning from others experiences.

The group approach to smoking cessation has been found to be the most effective method in comparison to individual support or quitting alone with no pharmacological support (Hajek, 1989). I was able to reflect on the progress of each session and found it very useful to be able to discuss its progress and my approach with colleagues. At the end of this group, 80% setting a quit date had quit which increased my confidence in my competence at delivering this intervention. Appendix 5 shows a summary of the setting up, implementation and evaluation of the group.

I also felt that a number of situations had arisen over the course of the seven weeks which have impacted my current practice, making me more aware of personalities within a group and how you must always be prepared to answer questions honestly while maintaining a tactful, professional respect for any issue that may arise.

Although there is insufficient evidence to support the use of any specific intervention for helping smokers who have successfully quit for a short time to avoid relapse (Hajek,

Stead, West, Jarvis & Lancaster, 2009) performing follow-up after 4 weeks may indicate the longer term efficacy of this approach and also encourage those who have relapsed to attempt to quit again. However there is not the resource available to follow these clients up further. It is therefore difficult to know whether the successful quitters return to smoking or whether those who were still trying to become abstinent are eventually able to successfully become abstinent, raising problems for assessing the long-term outcome of this approach.

Despite not being able to identify which part of the support is the most effective (Michie & Abraham, 2004) the synergy created by the programme appears to be successful. Similarly, there is a question over whether the 2-week preparation period is too long or whether for some quitting immediately is as effective as is preparation (West & Sohal, 2006). In this group, despite small differences in the approach taken, and although based on small numbers, there was no difference in outcome. As such, it is necessary to be constantly aware of the multiple needs of a group.

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Appendix 1

SMOKEFREE

[redacted] *PCT*

Stop Smoking Clinic

Group Name: .....

Client Name: .....

Personal Details

Client Number:		
First Name:	Surname:	
Address:		
Postcode:	Date of Birth:	
Home Tel:	Work Tel:	Mobile:
Sex M F	Pregnant Y N	E.D.D. / /

Please choose the ethnic group which best describes you.

- ☐ 1. White British
- ☐ 2. White Irish
- ☐ 3. White Other
- ☐ 4. Mixed White & Black Caribbean
- ☐ 5. Mixed White & Black African
- ☐ 6. Mixed White & Asian
- ☐ 7. Mixed Other
- ☐ 8. Asian/Asian Brit – Indian
- ☐ 9.Asian/Asian Brit – Pakistani
- ☐ 10. Asian/Asian Brit - Bangladeshi
- ☐ 11. Asian/Asian Brit - Other
- ☐ 12. Black/Black Brit - Caribbean
- ☐ 13. Black/Black Brit - African
- ☐ 14. Black/Black Brit - Other
- ☐ 15. Chinese
- ☐ 16. Turkish
- ☐ 17. Any other ethnic group
- ☐ 18. Not stated

GPs Name and Address

Name .....

Address .....

Consent

The Department of Health require that we collect certain information for service evaluation.

I understand the reasons for collecting this personal information and agree to the information that I have provided, being used for evaluation purposes. I agree to be contacted again for follow up.

Signature:_____ Date:_____

How did you hear about the service?

- ☐ GP
- ☐ Practice Nurse
- ☐ Pharmacist
- ☐ Other Professional
- ☐ NHS Quitline
- ☐ Sure Start (member no).....
- ☐ Family/Friends
- ☐ From a previous user of the service
- ☐ Newspaper/Magazine_____
- ☐ Tube/Bus shelter
- ☐ Other (please specify)_____

1) How soon after waking do you smoke your first cigarette of the day?

- ☐ Less than 5 mins
- ☐ 5-15 mins
- ☐ 15-30 mins
- ☐ 30-60 mins
- ☐ 1-2 hours
- ☐ More than 2 hours

2) How many cigarettes do you smoke per day? ☐

3) Health Screening Questionnaire

This questionnaire will help figure out the best treatment options for you and help us keep track of health improvements after you stop smoking.	Please Tick	
	YES	**NO**
Have you ever had an eating disorder? (anorexia or bulimia?)		
Are you pregnant/breast-feeding?		
Do you have liver disease (cirrhosis)?		
Do you suffer from manic-depressive illness?		
Do you have epilepsy?		
Have you ever had seizures following head injury?		
Are you under 18?		
Have you had heart attack, angina or heart surgery in the past 6 months?		
Do you have any other problems with your heart?		
Are you diabetic?		
Do you have high blood pressure?		
Do you have kidney problems?		
Do you suffer from depression (now or in the past)?		
Do you suffer with anxiety, severe worry, or panic attacks?		
Do you suffer from any mental illness not mentioned above?		

Please give any details you think may be important for us to know if you said yes to any of the above items:

Are you currently using any prescription medications? Please list them below

Medication **For What?**

1_____
2_____
3_____
4_____
5_____

Carbon Monoxide (CO)

Carbon Monoxide (CO) is a gas that you inhale when you smoke. It is very toxic and takes the place of oxygen in your red blood cells. The result is that you do not get the oxygen supply you deserve. In addition your blood compensates by producing more red blood cells, so you blood becomes thicker. This means that your heart has to work harder to pump the blood around your body.

The good news however, is that very soon after you stop smoking your CO levels fall and your body is then able to get the oxygen it so badly needs for a healthy life. In addition the blood becomes less thick so the workload on your heart is decreased, thereby reducing the chances of a heart attack.

The levels of CO can very easily be measured using a simple machine that you blow into. You will be asked to take a breath and hold it for 15 seconds (if you can) and then blow into the machine.

OFFICIAL USE ONLY: Record of Medication

We will measure this before and after you have stopped smoking. When you have stopped the levels will fall and stay down. This will indicate that you REALLY are doing something positive for your health.

Week	No of weeks supplied	Product 1	Product 2	GP/PGD	Comments
1					
2					
3					
4					
5					
6					
7					

Session 2

1) How many cigarettes have you smoked per day in the last week? Please fill in the table below.

Tues After group	Wed	Thurs	Fri	Sat	Sun	Mon	Tues Before group

2) Please tick each of the items below to show to what extent you have had these feelings or experiences <u>in the last week</u>.

	1	*2*	*3*	*4*	*5*	*6*
Felt or Experienced:-	**Not at all**	**Slightly**	**Moderately**	**Quite a bit**	**Very Much**	**Extremely**
Craving for sweet foods						
Irritable						
Hungry between meals						
Depressed						
Absent minded						
Tired						
Eating when not hungry						
Disturbed sleep						
Tense						
Craving to smoke						
Difficulty concentrating						
At a loose end						
Dry mouth						

3) Carbon Monoxide Reading ☐

Session 3

1) How many cigarettes have you smoked per day in the last week? Please fill in the table below.

Tues After group	Wed	Thurs	Fri	Sat	Sun	Mon	Tues Before group

Please tick each of the items below to show to what extent you have had these feelings or experiences in the last week.

	1	2	3	4	5	6
Felt or Experienced:-	**Not at all**	**Slightly**	**Moderately**	**Quite a bit**	**Very Much**	**Extremely**
Craving for sweet foods						
Irritable						
Hungry between meals						
Depressed						
Absent minded						
Tired						
Eating when not hungry						
Disturbed sleep						
Tense						
Craving to smoke						
Difficulty concentrating						
At a loose end						
Dry mouth						

Please circle a number to show how confident you are that you will manage not to smoke for the next week:

Not at all Confident 0 1 2 3 4 5 6 7 8 9 10 Extremely Confident

4) What treatment aid are you using?

Patch
Lozenge
Microtab
Zyban
Gum
Inhalator
Nasal Spray

5) Carbon Monoxide Reading

Session 4

1) How many cigarettes have you smoked per day in the last week? Please fill in the table below.

Tues After group	Wed	Thurs	Fri	Sat	Sun	Mon	Tues Before group

2) Please tick each of the items below to show to what extent you have had these feelings or experiences in the last week.

	1	2	3	4	5	6
Felt or Experienced:-	**Not at all**	**Slightly**	**Moderately**	**Quite a bit**	**Very Much**	**Extremely**
Craving for sweet foods						
Irritable						
Hungry between meals						
Depressed						
Absent minded						
Tired						
Eating when not hungry						
Disturbed sleep						
Tense						
Craving to smoke						
Difficulty concentrating						
At a loose end						
Dry mouth						

3) Please circle a number to show how confident you are that you will manage not to smoke for the next week:

Not at all Confident — Extremely Confident

0 1 2 3 4 5 6 7 8 9 10

4) What treatment aid are you using?

Patch
Lozenge
Microtab
Zyban
Gum
Inhalator
Nasal Spray

5) Carbon Monoxide Reading

Session 5

1) How many cigarettes have you smoked per day in the last week? Please fill in the table below.

Tues After group	Wed	Thurs	Fri	Sat	Sun	Mon	Tues Before group

2) Please tick each of the items below to show to what extent you have had these feelings or experiences in the last week.

	1	2	3	4	5	6
Felt or Experienced:-	**Not at all**	**Slightly**	**Moderately**	**Quite a bit**	**Very Much**	**Extremely**
Craving for sweet foods						
Irritable						
Hungry between meals						
Depressed						
Absent minded						
Tired						
Eating when not hungry						
Disturbed sleep						
Tense						
Craving to smoke						
Difficulty concentrating						
At a loose end						
Dry mouth						

3) Please circle a number to show how confident you are that you will manage not to smoke for the next week:

Not at all Confident — Extremely Confident

0 1 2 3 4 5 6 7 8 9 10

4) What treatment aid are you using?

Patch
Lozenge
Microtab
Zyban
Gum
Inhalator
Nasal Spray

5) Carbon Monoxide Reading

Session 6

1) How many cigarettes have you smoked per day in the last week? Please fill in the table below.

Tues After group	Wed	Thurs	Fri	Sat	Sun	Mon	Tues Before group

2) Please tick each of the items below to show to what extent you have had these feelings or experiences in the last week.

	1	2	3	4	5	6
Felt or Experienced:-	**Not at all**	**Slightly**	**Moderately**	**Quite a bit**	**Very Much**	**Extremely**
Craving for sweet foods						
Irritable						
Hungry between meals						
Depressed						
Absent minded						
Tired						
Eating when not hungry						
Disturbed sleep						
Tense						
Craving to smoke						
Difficulty concentrating						
At a loose end						
Dry mouth						

3) Please circle a number to show how confident you are that you will manage not to smoke for the next week:

Not at all Confident — Extremely Confident

0 1 2 3 4 5 6 7 8 9 10

4) What treatment aid are you using?

Patch
Lozenge
Microtab
Zyban
Gum
Inhalator
Nasal Spray

5) Carbon Monoxide Reading

Session 7

1) How many cigarettes have you smoked per day in the last week? Please fill in the table below.

Tues After group	Wed	Thurs	Fri	Sat	Sun	Mon	Tues Before group

2) Please tick each of the items below to show to what extent you have had these feelings or experiences in the last week.

	1	2	3	4	5	6
Felt or Experienced:-	**Not at all**	**Slightly**	**Moderately**	**Quite a bit**	**Very Much**	**Extremely**
Craving for sweet foods						
Irritable						
Hungry between meals						
Depressed						
Absent minded						
Tired						
Eating when not hungry						
Disturbed sleep						
Tense						
Craving to smoke						
Difficulty concentrating						
At a loose end						
Dry mouth						

3) Please circle a number to show how confident you are that you will manage not to smoke for the next week:

Not at all Confident — Extremely Confident

0 1 2 3 4 5 6 7 8 9 10

4) What treatment aid are you using?

Patch
Lozenge
Microtab
Zyban
Gum
Inhalator
Nasal Spray

5) Carbon Monoxide Reading

OFFICIAL USE ONLY: Four Week Follow Up

Has individual smoked in the last 2 weeks? Yes ☐ No ☐ Lost to follow up ☐

Advisor: _____ Registration Number:_____

FEEDBACK: PLEASE TELL US WHAT YOU THINK!

We'd like to know what you think of the course we offer so we can improve it. Do tell us what you found useful, and what you didn't, on the form below.

1. **The group started two weeks before the quit date. Did you find this preparation period..... (circle one below)**

   a) too long? *b) about right?* *c) too short?*

2. **In the information session (first session), did you feel you received enough information about Nicotine Replacement Therapy and Zyban to make a good choice? (circle one below)**

   a) not enough *b) about right* *c) too much*

3. **The course lasted for 7 weeks. Did you feel this was.... (circle one below)**

   a) too short *b) about right* *c) too long*

   If you felt the course was too short or too long, how many weeks would you realistically like to have attended, in total? _____(write here)

4. **Are there any suggestions you have for other people trying to give up smoking?**

_____

_____

5. **What did you think of the Smoker's Clinic groups overall? What did you find the most useful? How could we improve?**

_____

_____

6. **We sometimes like to feature successful quitters in material about the clinic. Tick the boxes below if you are happy to help with this.**

☐ Yes, I would be happy for my comments to be used for the Smoker's Clinic newsletter/website.

☐ Yes, I would be happy to be contacted in the future to tell the story of my quit attempt in more detail possibly in the local press

☐ Yes, I would be happy for any photographs to be used for the Smoker's Clinic newsletter/website.

Appendix 2

Week 1

PREPARING TO STOP SMOKING

Your decision to stop smoking is an excellent one as stopping smoking **is the most important thing that you can do for your health** both in the short and long term. When you stop you will quickly notice the benefits and this will motivate you to stay stopped.

You may find it helpful to view giving up smoking like a job that you've been putting off for a long time and have finally got round to. Now that you are ready to tackle it, make succeeding a priority in your life and give everything else second place for a while. Make this attempt a really serious attempt.

Making a good choice

When you stop smoking it is essential that you feel you have made a **really good choice** to stop. If you feel you have made a bad choice or no choice at all e.g. "I have to stop" "I can't stop" "I don't have a choice" then you will have less chance of success. To enable you to make this choice explore reasons why you want to stop smoking and also reasons why you **don't** want to stop smoking.

Reasons for giving up	**Reasons for not giving up**
... ...	... ...
... ...	... ...
... ...	... ...
... ...	... ...
... ...	... ...

When the reasons for giving up outweigh the reasons for not giving up, then you are well on the road to success. You will be able to make this choice to give up and although acknowledging that there may well be a sense of loss on quitting, the overall gains will be far higher.

Nicotine Replacement Therapy (NRT) and Zyban (bupropion)

Both these products can double your chances of successfully stopping. If you are taking Zyban, make an appointment with your doctor who can prescribe it to you. Zyban has to be taken at least a week before the quit date. Hang on to your NRT and bring it to the third session (your quit day) where you will start using it.

Phone Numbers and Websites

Smokefree [redacted] Team

To speak to one of our advisors, phone:

Freephone: [redacted]

Or

[redacted]

Or e-mail: stopsmoking@[redacted]pct.nhs.uk

Both these numbers also employ counsellors who are trained to work with smokers

Quitline: 0800 00 22 00
(9am - 9pm, 7 days a week)

The NHS Smoking Helpline: 0800 169 0 169
(7am – 11pm, 7 days a week)

Excellent websites for Health professionals, smokers and ex-smokers

www.givingupsmoking.co.uk

www.ash.org.uk

Week 2

THE FINAL PREPARATION

By now you will have thought about the pros and cons of giving up smoking and will have made the choice that you do want to give up.

Giving up smoking represents a (very positive) change in lifestyle. Discussions in the group today will have generated some ideas about changes that can be used to live a smoke–free life.

Changes in lifestyle

- **Have breakfast.** How about making this change instead of reaching for the cigarettes? You might find it very enjoyable.

- **Change your routine.** Over the years, your smoking has become associated with many cues in your environment. Changing your routine first thing, for example, by switching from coffee to orange juice, or having a shower immediately on waking, will help to break these patterns.

- **Get rid of your smoking bits and pieces.** Bring them along next week, and we'll throw them away together.

- **Make some positive changes.** Stopping smoking can be a golden opportunity to revamp your life. Good strategies include taking up a hobby or activity (such as exercise), visiting no-smoking places (such as cinemas) and seeing more of supportive friends and family. These will help distract you and make giving up a more positive experience.

For next week: These are some suggestions of lifestyle changes you could make. I'm sure you will think of plenty more yourself that will suit you and your lifestyle. Bring along your ideas next week to share with the group.

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Week 3

YOUR FIRST WEEK WITHOUT SMOKING

A lot of the difficulties people have when they stop smoking are due to giving up the drug nicotine. This is why you are using nicotine replacement therapy: it will ease some of the withdrawal symptoms. Although NRT does not remove the symptoms completely, it will make them less severe.

Symptoms that you may experience in the first few days:

Irritable: You may be short tempered at times.

Concentration: You may find it harder than usual to concentrate.

Changes in mood: You may feel more depressed than usual.

Appetite: You may feel more hungry than usual.

Restlessness: You may feel unsettled or "at a loose end".

Sleep disturbance: Your normal pattern may change. You may experience improved or longer sleep or insomnia.

Other changes: Some people complain of headaches, constipation, lethargy, disorientation, stomach cramps.

Coping with withdrawal symptoms and urges to smoke: There is no foolproof way of dealing with them but keeping as busy as you can and altering your daily routine will help. For example, avoid the pub if you think you will be strongly tempted to smoke there. Wash up and go for a walk after meals rather than sit in front of the TV.

The good news is that the symptoms will go away. After about three weeks of not smoking you will start feeling more like your old self. The urge to smoke will be strong at first and come back from time to time, but you will be able to resist this urge more easily as time goes on.

Coping with daily stress: Besides having withdrawal symptoms you will still experience every day stressors that you used to cope with by smoking.

You may find it helpful to view giving up smoking like a job that you've been putting off for a long time and have finally got round to. Now that you are ready to tackle it, make succeeding a priority in your life and give everything else second place for a while.

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Week 4

YOUR SECOND AND THIRD WEEKS WITHOUT SMOKING

The second and third week can seem harder than the first!

This is because the ***novelty*** of doing something new is beginning to wear off. Stick at it, and remember to ***live one day at a time.*** Just aim to go to bed each night without smoking.

- Cheer yourself up by buying something with the money saved from your first week without cigarettes.
- You may develop a sore mouth with small ulcers. These are not serious and will go away.
- Some people develop a cough after stopping smoking. This is harmless and will go away in due course.
- Your health really does ***improve*** from the time when you put out your last cigarette. Your carbon monoxide level is now the same as any other non-smoker.
- Your lungs will be working much more efficiently and you will be less breathless.
- Your heart rate will have decreased and you will have a healthier blood supply to your hands and feet.
- Be wary of pubs and parties. Too much alcohol will increase ***craving*** and reduce your ability to handle it sensibly.

By the end of the third week you may find that the worst of the withdrawal symptoms are over. These may be replaced by some rather confusing emotions. On the one hand you may feel glad to be rid of cigarettes but at the same time have very definite feelings of loss - 'like losing a friend' - is the way people often put it.

Be patient as over time you will become used to coping without cigarettes

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Week 5

COPING WITH A LAPSE AND PREVENTING A RELAPSE

After stopping smoking, it is not too unusual to have a slip or lapse--whether it be a few puffs or a few cigarettes. It does not mean that you've failed or that you will inevitably relapse to regular smoking as before. Rather, it means that you have come across a situation or mood that is very risky for you, and that you need to plan a better way to handle these circumstances in the future. In short, try to look at a lapse as a learning experience rather than a failure.

If you expect to be perfect after your quit date, you may feel guilty or bad about yourself for temporarily losing control. You may say things to yourself like "I have no willpower." These feelings and thoughts are common, but they are not rational or justified, and definitely not helpful. They can lead you to give up your efforts and say "I might as well continue to smoke." *However you don't have to give into these feelings and thoughts – you can still be successful at stopping smoking.*

After a lapse, the most important thing to do is get back to your routine of non-smoking as soon as possible. Don't wait for tomorrow or the beginning of next week or next month. Throw away any cigarettes you might have purchased and start fresh right away. If you don't respond quickly and actively to your lapse, you face a serious risk of relapse. But if you act quickly, and evaluate what happened, you can turn your lapse into learning experience that improves your chances of success.

Specifically, think about the situation and circumstances that led you to smoke. Ask yourself "What could I have done to cope instead of smoking?" or "Is this a situation I should avoid for a while?" If you are prepared for risky situations, you are less likely to lapse when they arises again. In this way, a lapse can be turned into a positive learning experience to protect against a full-blown relapse.

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Week 6

STAYING OFF CIGARETTES

Congratulations! Stopping smoking is a great achievement and so far you're doing well. The important thing now is to make sure that you ***stay off*** cigarettes. These are some situations that might take you by surprise, and put everything that you've gained at risk.

(1) **Irrational thoughts:** Such as "I could just have one", "one wouldn't matter", or "I'll just have one puff". Recognise that these thoughts will lead you down the path towards relapse, and undo all your hard work.

(2) **Trips away from home:** Usually holidays where you are more likely to be relaxed or conferences where you are likely to be anxious, but any sort of travel. Expect to be tempted, but expect to beat it. Come back a non-smoker.

(3) **At parties and celebrations:** There's always alcohol and always people offering cigarettes. Say "I'm going to enjoy myself but I'm going home tonight as a non-smoker". Be aware of the power of alcohol – it will weaken your resolve. If you are drinking alcohol perhaps choose a drink that you don't associate with smoking.

(4) **Feeling depressed, angry and frustrated:** Cigarettes promise support and comfort during difficult times. It's not easy to manage your feelings when you feel like this but try reminding yourself that your anger / frustration / depression will still be there to deal with if you have a cigarette. If you start again you will have to tackle giving-up smoking from scratch.

One of the most common mistakes that people make is to stop using their nicotine replacement therapy treatment too soon, thinking that the worst of the withdrawal symptoms are over. Use your nicotine replacement as advised by following the manufacturer's instructions. It is sensible to use these treatments for a minimum of 8 weeks after your quit date or for longer if you feel the need to.

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Week 7

RELAPSE PREVENTION

Giving up smoking and maintaining abstinence are very different problems. In order to remain abstinent in the long term, it is helpful to make changes in three different aspects of your life.

1. **Your behaviour**
2. **Your thoughts**
3. **Your awareness of feelings and how to cope with them**

1) Changing your behaviour - To change your behaviour you will need to think of 'people, places and things' that you associate with smoking. For example, it could be that you crave for a cigarette after a meal, when you are bored or hungry, in social situations, when drinking alcohol, when feeling energetic or sad etc.
At first, it might be helpful to avoid the people, places and things that make you want to smoke, but there are certain situations that you may not be able to avoid forever. Try to identify what makes you want to smoke in this situation and think about alternatives that you could do. Remind yourself that smoking does come as a package with lots of negative effects!

2) Changing your thoughts - Try to recognise thoughts that may lead you to relapse. For example, common thoughts that lead to relapse include:

- **Romanticising thoughts about smoking,**
- **Trying to test the strength of your abstinence**
- **Attributing a lapse to lack of willpower**

If you should lapse, thoughts such as 'I am no good' or 'I have no willpower' are not helpful and will only lower your self-esteem. It is more important to identify what went wrong in this particular situation and learn from this experience.

3) Changing your awareness of emotions and how to cope with them – Many smokers use smoking as a tool to deal with intense feelings like stress, frustration or sadness. You might feel that stopping smoking has taken this 'tool' away from you, but this loss might also help you to become more aware of your emotional household. It is important to bear in mind that putting your feelings into words and addressing them is more healthy and effective in the long-term as a method of coping with overwhelming emotions.

The most common situational factors associated with relapse are 1: ***Lack of support*** *during the giving up process and 2:* ***Weight gain.***

When the support group meetings have stopped we would like to encourage you to find a new source of support in your everyday life. Maybe you can contact a person from the group, or you know somebody in your life that is able and willing to support you to remain a non-smoker. There is always the opportunity to arrange a booster session with us as well. Please call us on [redacted].

Excessive weight gain can bring down your self-esteem and make you feel extremely uncomfortable. If you are concerned about your weight, rather than using cigarettes to control your weight you could try a more healthier option: a) speed up your metabolism by being more active and/or b) cut down on fatty foods in your diet. Keep reminding yourself that you are doing more for your health by giving up smoking than you could ever do by being slim!

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Appendix 3

Smoking Diary

Filling in this diary sheet will help you think about your smoking patterns. Try to do it over the course of a few days before your quit date. Understanding when and why you smoke is important to help you plan what you can do at these times instead of smoking. This may help you get through the first few weeks without cigarettes.

Day	Time	In what situation did I smoke (e.g. with others, alone, location)	How I felt before (e.g. bored, happy)	How I felt after (e.g. stressed, relaxed)	When I quit, I plan to deal with the situation by...

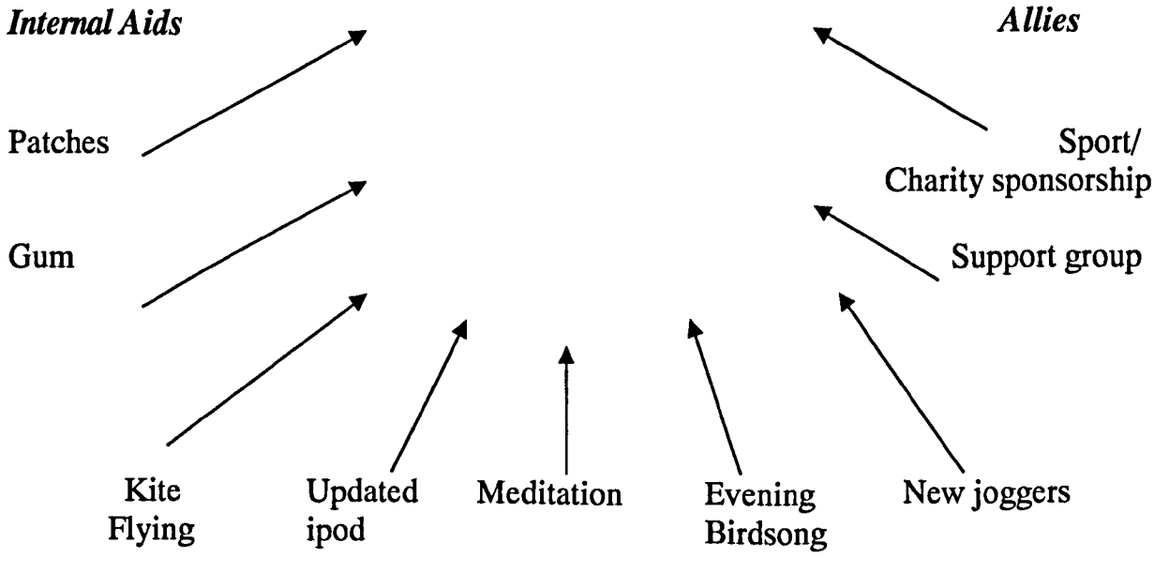
Day	Time	In what situation did I smoke (e.g. with others, alone, location)	How I felt before (e.g. bored, happy)	How I felt after (e.g. stressed, relaxed)	When I quit, I plan to deal with the situation by...

Appendix 4a

BATTLE PLAN

ADVANTAGES	REPLACEMENTS
Skin	Kite flying
Hair	Creative cooking
Easy breathing	Guitar
Fresh smelling clothes	Gardening
£1000/year	Updating ipod
Flat smells fresh	Jogging
Bright eyes	Swimming in the ponds
Less wrinkles	Lots of water
Stronger health and heart	Meditation
Better image	Evening birdsong
Evidence of will-power	Charity fundraising
More exercise	Fresh flowers
Less alcohol	Reading in the bath/ on the Heath
Consideration for others	Cleaning
	Cinema
	Writing email

The Enemy: Cigarettes



MAIN ARTILLERY

SUCCESS = PERSONAL BREAKTHROUGH

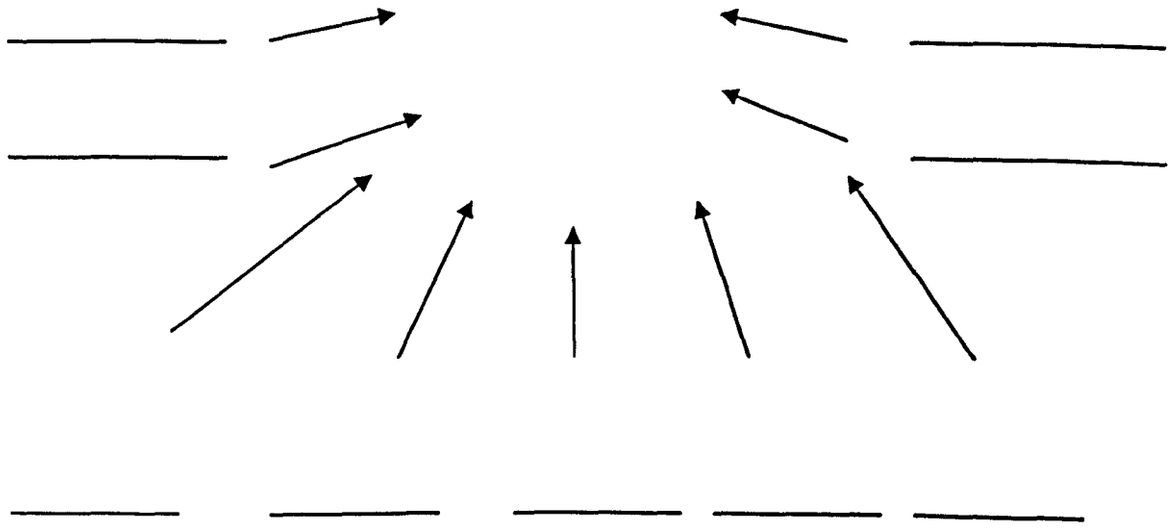
Appendix 4b

BATTLE PLAN

ADVANTAGES	REPLACEMENTS

The Enemy: Cigarettes

Internal Aids *Allies*



MAIN ARTILLERY

SUCCESS = PERSONAL BREAKTHROUGH!! (YAY!!)

Appendix 5

Setting up, implementation and evaluating the intervention

The Smokefree service run by the Primary Care Trust (PCT) is a specialist service offering training and support in stop smoking interventions to advisors in primary care and community settings. The minimum standards for this support are set by the Department of Health (DH) as well as the requirements for a client to be considered a successful quitter (Department of Health, 2007).

The group intervention follows the withdrawal-oriented model developed by the Maudsley Hospital Smokers Clinic (Hajek, 1989). This model for this closed group follows a standardised 7 week plan; weeks 1 and 2 are for preparation to quit, week 3 is the quit date and the following 4 weeks are support sessions following the quit date.

This support consists of advice, discussion and exercises with the aim of helping clients cope with urges to smoke, maximise the motivation to remain abstinent, boosting self-confidence, maximising self-control and optimising the use of pharmacotherapy through compliance and adherence (Department of Health 2009). The average success rate for group interventions is 32-74% while for individual support the success rate is 22-52% success rate (Department of Health 2009). As such the NHS smoking cessation programmes have been identified as extremely cost effective interventions (West, McNeill & Raw, 2000). As such it is recognised that this combined approach of behavioural support and pharmacotherapy can increase a smoker's chance of stopping by up to four times than trying alone with no pharmacotherapy (West, McNeill & Raw, 2000). These support factors are inextricably linked with features of the interventions resulting in a synergistic effect (Lawrence & Haslam, 2007; Michie & Abraham, 2004).

The group offered locally by the Smokefree service, in this case in a medical setting, followed this outline and resulted in an 80% quit rate. Upon completion, feedback was

requested using the evaluation form on the information booklet in Appendix 1 and was generally positive about the support offered and the beneficial effect of the group.

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Competence 5.2 Direct the implementation of interventions

Clinical supervision of Health Trainers

CLINICAL SUPERVISION OF HEALTH TRAINERS

Background to the intervention

The health psychologist in training role offers a number of opportunities to supervise the progress of clinicians. The Smokefree service run by the Primary Care Trust (PCT) is a specialist service offering training and support in stop smoking interventions to advisors in primary care and community settings. The minimum standards for this support are set by the Department of Health (DH) as well as the requirements for a client to be considered a successful quitter (Department of Health, 2007).

Those delivering this intervention, generically referred to as "Level 2 advisors", come from a diverse work base, possess a wide range of skills and prior training and may be based in traditional health-care settings or community settings. They include GP's, practice nurses, pharmacists, midwives, health visitors and health trainers etc. The Level 2 training covers a range of areas to ensure all advisors have similar knowledge of smoking and its consequences as well as psychologically-based behaviour change techniques to foster the best evidence-based approach when supporting clients in quit attempts. On-going training is also provided with attendance of an annual update session being a prerequisite to maintain continued professional development. For the purposes of this case study I will initially outline the general intervention before focussing on the more intensive supervision provided to one of these groups; the health trainer.

Establish needs and implement strategies for the procurement of intervention resources

Once trained, one of the main intervention materials available is a resource pack provided at the training session and that is produced within the service. This pack includes information on smoking and a breakdown of each session with appropriate handouts to assist clients over each week of their quit attempt. As well as supporting the advisor it also aims to ensure a standardised level of service in order to optimise the outcome for the client. As well

as this clinical information the resource pack also contains administrative materials to record data on the clients seen which also allows accurate auditing for the service. Appendix 1 shows a guide of the contents of the resource pack. As well as the client self-reporting their smoking status an objective measure of carbon monoxide is also taken each week using a 'smokerlyzer' monitor that is provided and maintained by the specialist service. This maintenance includes annual recalibration of the carbon monoxide level to ensure accurate readings. Where possible this is done at update sessions to promote efficient use of the specialist service resources or by a member of the specialist service visiting the advisor at their place of work.

Reflection

Although advisors agree to attend regular update sessions there is at present no procedure in place to ensure that they do so. As such, this could have two possible explanations; either those attending the update sessions are a self-selecting cohort ie. those who are active advisors, or some active advisors may not be following the latest guidelines for best practice. This raises challenges for the service, solutions for which are currently being investigated.

Assess the capabilities of the people required to conduct and monitor a planned intervention

Historically, if a person expressed an interest to become a stop smoking advisor, they were usually accepted onto the training day if there was an available place. As the training was designed to require no prior knowledge this lack of initial screening was not necessarily seen to be a negative point, and resulted in the borough having a large number of level 2 trained advisors capable of offering the service. However, many of these advisors were inactive.

Rather than accepting that a degree of non-engagement should be expected two main changes were made to the training to meet this challenge; a more stringent application

procedure requiring greater engagement prior to the training day by a pre-assessment process using a series of questions (Appendix 2) based on a handbook produced by the service. To progress to the training a pass level of 90% has to be achieved. The second change made was the inclusion of action planning to the training try to reduce this level of newly trained inactive advisors (Appendix 3).

Monitoring activity of the intervention has included the borough being divided into 5 localities with a member of the specialist team being responsible for each locality. This team member is then available to the level 2 advisors to offer both clinical and administrative support, for example over issues relating to the behaviour change support offered, guidance on pharmacotherapies or more administrative queries around completion of monitoring forms.

Advise and guide the activities of designated others

In addition to on-going support and supervision to all Level 2 advisors there is one role within the smokefree organisation that has more structured clinical supervision from the health psychologist in training; the Health Trainer (HT). Originating from the recommendations of the 2004 Department of Health White Paper "Choosing Health: Making healthy choices easier" HTs are recruited from the local community (see Appendix 4 for a needs assessment for the intervention with the HT).

The behaviour changes supported by the HT include not only smoking cessation but also increasing physical activity and encouraging healthy eating, with the techniques used based on theory-driven psychological evidence.

It has been suggested that healthcare work can be one of the most stressful and personally costly areas of work (Cottrell, 2002). In this respect alone, it could be argued that supervision could be a means for the employer to fulfil a duty of care to the employee. However, supervision is much broader than this; it is multifaceted and affords the opportunity

to communicate and information-share, to problem solve, discuss and review clients, plan and decide future development and offer support within a safe environment in which to reflect on overall practice. As such, the relationship between the clinical supervisor and the supervisee is a complex one, with the supervisor assuming the role of observer, teacher, colleague and evaluator, with the evaluative element often a source of anxiety (Ellis, Kregel, & Beck, 2002). In comparison to this possible anxiety Winstanley and White (2003) found an overwhelming response to clinical supervision from nurses who welcomed an opportunity to talk meaningfully to a trusted colleague about their work. Although many definitions of clinical supervision have been given, in essence they are similar; clinical supervision is focused upon the provision of empathetic support to improve therapeutic skills, the transmission of knowledge and the facilitation of reflective practice. This ensures adherence to high standards of governance.

These requirements have been formulated into a model by Proctor (1986) who summarised supervision into three components; normative (managerial) to promote and comply with policies and procedures, develop standards and contribute to clinical audit; formative (educative), concerned with skill development and developing evidence-based practice; and finally restorative (pastoral support) to enable practitioners to understand and manage the emotional stress of practice.

These aspects are all considered in supervision when monitoring the delivery of interventions by the HT. This is structured through individual supervision, observation of practice as well as through group supervision which encompasses both the administrative aspect of the role as well as continuing professional development for the team of HT's. Within this structure, I am immediately responsible for the individual supervision of one HT as well as planning and carrying out the group clinical supervision for the team of 5 HT's.

Consequently, these dual roles have allowed for a comparison to be made of the differences between the processes.

Individual supervision is usually conducted monthly and lasts for at least one hour. This process is supported by Winstanley and White (2003) as being an effective length of supervision for community-based staff; community-based supervisees also felt that advice and support given in group sessions was more effective than a one-to-one session, as they gained from the advice and support offered by the other members. The HT receives supervision in both contexts.

Requirements of the supervisor are also key to this process. Vasquez (1992) stipulated that supervisors are obliged to promote ethical practice. Developing this further Lamb, Cochran, and Jackson (1991) have broken this down into three main components for which the supervisor is ethically responsible: ethical knowledge and behaviour, competency to ensure the welfare of clients and personal functioning to assess the supervisees limitations and blind spots in order to protect the welfare of their clients.

The initial individual session involved establishing expectations for the meetings. As well as ascertaining the normal week and the disparate locations where the HT was based this also included stipulating my clinical responsibilities to them, as well as reviewing particular areas where they felt they wanted to spend time developing. Appendix 5 shows a selection of supervision minutes, group supervision planning and outcomes and feedback of an observation of clinical practice.

Reflection

I hoped to establish not only their confidence in my clinical knowledge but also helping to build a relationship based on trust. The aim of this was so that in time they would feel comfortable in approaching me about concerns about clients on a more conceptual level that may have gone unremarked if this trust was not in place. It was also an opportunity to

establish the competence of the HT and for me to gain an insight into their practice. However, one area which I omitted was my role in the organisation with regards to others involved in the HT project who had responsibility in other areas, such as line management.

These themes were expanded upon in succeeding sessions where client work was discussed as well as attempting to develop their service and client base further, which included discussions around the problems they faced being based in a number of localities. I established a good relationship with the HT providing a safe environment within which to discuss clients and areas requiring greater clarity. This is of importance as Kilminster and Jolly (2000) found that the relationship between the supervisor and supervisee is the most significant feature of effective supervision and can be facilitated by empathy, offers of support, flexibility, knowledge and respect while also being practical when dealing with problems. Although there was initially no choice over who was supervised by whom, changes in the structure of the HT service led to the question of possibly changing my supervisee. When given the choice the HT was content to continue supervision with me.

Although the HT was competent in practice I believe that some of the guidance requested indicated that they were aware of their limitations in knowledge and client practice. This indicated an ethical approach to their role so as not to put their client at risk. This was evidenced by the HT making a few calls to me in between sessions regarding questions over medications used and questions arising in clinics, such as a dilemma faced when they thought that their practice with a new client may have been affected due to inter-personal difficulties they had encountered with that person in a previous job role.

Reflection

Awareness of such areas and knowledge of boundaries is an essential part of anyone's clinical practice and I was relieved that this did not appear to be problematic. Furthermore this latter point regarding interpersonal difficulties highlighted to me the

challenges that may be faced when members of a community are recruited to target services at that same community, many of whom have complex needs. Also, although we developed a good relationship, I was aware of the importance of maintaining a professional persona and was conscience of being empathetic and approachable without being overfriendly. I believe that this was achieved as I was contacted on an ad hoc basis in between supervisions for advice and guidance. However, this can sometimes be a difficult balance to reach and is something of which I am aware for the future.

In comparison to the individual supervision, the 3 hour monthly group sessions were different in their development. I feel my approach to these was more one of evolution and less explicitly approached than the individual session. A number of people were involved in these sessions including my line manager and a research fellow who was evaluating the HT scheme for the organisation.

Reflection

The structure of these sessions had already been in place for 2 years and I felt that I had to fit into this structure, without feeling the need to lay down any boundaries as I assumed they were already in place; as such it was me who had to adapt to the status quo. In future I would ensure that I explicitly established the current expectations and boundaries from the outset as it is often difficult to make changes later in the process.

After a few months in order to develop the groups in a structured way the HTs were approached to ask their opinions on what areas they felt were in need of improvement or which may have been of interest to them for their continued professional development. Appendix 5 shows these and progress made one year later.

It was within the group sessions that ethical responsibilities and practice 'grey areas' became more evident. For example, working with minority groups in the community it became clear that the HTs had no issues working with diverse populations. However, in an

effort to help everyone they came into contact with, for a couple of the HTs there were issues of going beyond the boundaries of their responsibilities, the negative effect of which had to be pointed out to them. For example, despite having structured guidelines for those they were able to provide an intervention to, when seeing clients who were above a body mass index (BMI) of 39 a couple of the HTs felt obliged to help them. This arose from the fact that there was no service in place to which to refer these clients to and these specific HTs felt a duty to help these clients reduce their BMI to a level at which they would then officially able to see these clients for a specific intervention. Despite outlining the consequences for the HT if any adverse outcome were to occur to this client it took longer than expected for this message to become clear.

However this understanding was helped by discussion between all 5 HTs; most understood the consequences and through peer discussion and highlighting alternative courses of action were able to convince their colleagues of the danger in continuing this practice. Just as there had to be clear boundaries set for effective supervision, it was essential that clear boundaries were communicated to a client on what service the HT could provide as well as the responsibilities expected of the client.

Reflection

This situation shows the dichotomy between the automatic human response whereby the HT wants to assist a client in any way possible and the professional boundaries of their role. This could help to explain the difficulty some had in assimilating the fact that their actions could have adverse outcomes not only for the client but also for themselves. As a group of non-health professionals this highlighted the need to take more time discussing practice guidelines as well as the requirement to develop a code of conduct for this group.

For the majority of time, while working within the clinical governance framework of the PCT, the HT works remotely from other team members. This previous example shows

how important it is to develop a trusting relationship with the HT so that these occurrences can be openly discussed in supervision otherwise there is a danger that the practice may continue unnoticed and so affect the level of care provided and the legal risk this may pose to the HT.

There are also a number of parties involved in the overall HT programme and in the early stage of my involvement these competing agendas at times impinged on the group sessions whereby the requirements of non-clinical line-management were presented as needing to be taken to these meetings.

Reflection

The time needed for non-clinical issues used a block of time from the clinical allowance. As such, trying to accommodate everyone's requests is difficult and was a learning point for me to be firmer with these other requests. However, it is important to acknowledge that this has to be done in a spirit of joint working in order to progress the overall role of the HT.

Ensure technical support for a planned intervention

As well as discussion of the psychology-based techniques used with clients in the one to one supervision, one of the on-going topics for the group supervision was revisiting the initial training the HT's had received. This training was based on psychology-led techniques to help support behaviour change. All of these are covered in the main document resource produced by Michie et al. (2004) and include motivational interviewing techniques (Rollnick & Miller, 1995), active listening (Rollnick, Mason, & Butler, 1999), goal setting (Carver & Schneider, 1998), action planning (Sniehotta, Scholz, & Schwarzer, 2005), and self-monitoring and boosting confidence (Bandura, 1998). Such a task of linking theory and practice allowed a greater insight into the HT practice and when conducting role play based on a previous client in the group session it was possible to get the HTs to reflect together on

their practice and to identify areas which they felt may have required more attention.

Reflection

This exercise was useful in a number of respects; a background in psychology was not a prerequisite for this role and as such I was always conscious of the different abilities to understand concepts used and the information being given. As such it was kept as concrete as possible. It was always necessary to refer to the training being based on psychology-based techniques; one HT wrongly referred to being trained in cognitive behaviour therapy rather than an appreciation that a 1 day course is a very basic introduction. This obviously has ethical implications for what the client understands they may be receiving as well as for other health professionals' understanding of the role of the HT. Furthermore, when observing role play and real interventions, it became evident that although the HT may not have been able to clearly verbalise in supervision the techniques they used, in reality they were putting these techniques into practice. I am consequently aware of the pitfalls in making the training too theory driven as the HTs do not necessarily have the background knowledge to deal with this level of information and so may limit its usefulness. This also highlighted the need of more than one method of establishing clinical abilities and approaches, as here through individual supervision and observation. This would also be pertinent to consider when dealing with any other external department, whether or not they are members of a recognised health profession, e.g. practice nurses.

As well as their own technical knowledge relating to behaviour change, it was also necessary to ensure that the HTs had access to contacts for other health professionals such as dieticians and physical activity teams to support those clients they were able to support as well as being able to either refer inappropriate referrals to or gain additional information, e.g. those with BMI over 39, uncontrolled diabetes and under 18 years of age. There is consequently a biopsychosocial approach in their role requiring an understanding of the

biological and physiological aspects as well as knowledge of behaviour change techniques. Negotiating this complex role, on the one hand being a community worker and on the other being seen by clients they support as a healthcare professional, requires clear clinical supervision as well as an appreciation of their role in the wider healthcare system (Hallas, 2004).

Similarly, through access to computerised patient records they have access to sensitive client information and so it was also necessary to spend time on the ethics of confidentiality, asking for informed consent on forms as well as not referring to areas outside of their remit or expertise as this would be inappropriate e.g. commenting on other medical conditions recorded on the database.

Another requirement was to broaden their service. It was necessary for the HTs to feel comfortable communicating clearly with other health professionals to raise awareness and educate them of their role in order to reduce inappropriate referrals that are inconvenient and not cost-effective. To improve this, a series of presentations were devised with the HTs aimed at informing a specific audience of their role, whether a health professional or to the general public. It emerged in group sessions that there were varying levels of confidence within the team regarding doing this with different audiences and so the aim was twofold; to increase this confidence and help to give the HTs one standardised message.

Oversee and direct the conduct of a planned intervention

Observing the HT in a clinical situation is probably the most effective way to oversee a planned intervention and to be able to evaluate how effective the training and supervision has been. It gives an opportunity to not only observe but importantly to feedback on good performance and also to offer suggestions for areas of improvement. This should be done in a constructive manner and I was aware that the delivery of negative feedback if done insensitively can affect the relationship between the supervisor and supervisee. For this

reason I was mindful of a range of feelings such as embarrassment, anger etc. The main concern is to make the HT aware that supervision is a means to improve clinical practice. Appendix 5 shows an example of one observation session held. As can be seen, the main concern was that the HT was a

little too directive in helping the client complete their forms.

Reflection

This was the first occasion I had formally observed clinical practice and as such I was not sure how the feedback would be received. This session occurred a few months after the supervisory relationship had developed and so it was possible that this helped the feedback process in that it was aimed at improving practice. This was aided by the HT's mature approach to their practice and development. The positive and negative feedback was given verbally at the end of the clinical session to ensure that it was still fresh in both of our minds and allowed discussion over any points raised. I also had occasion to contradict some negative perceptions held on the progress of the work done. Although unsure of how negative feedback would be received I tried to empathise with the HT in what was an uncommon procedure as well as think about how I would like to be told of areas for improvement if I was receiving the feedback. This could then be reflected upon and discussed further at the next one-to-one supervision session.

Appendix 6 illustrates reflective analysis of the problems that could be encountered in implementing and supervising the intervention.

Overall reflection

The process of supervision has at times been intense and it has been necessary to consult with my own supervisor to ensure my competency in the provision of this clinical supervision. As noted earlier, there is a fine balance in developing a relationship in order to incorporate trust, clinical respect and approachability while also being authoritative when

necessary. It has also been important for me not to confuse it with line management issues such as appraisal or review, although grey areas such as timekeeping, while a line management issue, can impact on supervision. This highlights the importance of not only the supervisee seeing their role in the wider healthcare system (Hallas, 2004) but also the supervisor.

The supervision process has been accomplished in the structure of the supervisor, supervisee, client group and employer (Kavanagh, Spence, Wilson, and Crow, 2002) in order to provide practice-related problems, reassurance about practice and resolution of emotional reactions to some difficult clinical situations. This supervisory combination has been essential to protect not only the supervisee but also their clients, and has led to fulfilling my professional and ethical responsibility as a clinical supervisor as well as my development and training as a health psychologist.

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Appendix 1

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Appendix 2

SMOKING QUIZ

Please answer each question and circle the correct answer(s)

Name_____

General Information

1. What is the legal minimum age at which tobacco can be bought in England?
a) 14 b) 16 c) 18 d) 21

2. What percentage of adults smoke in England?
a) 15% b) 20% c) 25% d) 30%

3. What percentage of smokers would like to quit smoking?
a) 34% b) 60% c) 74% d) 90%

Effects of Smoking

4. What percentage of smokers will die early due to their habit?
a) 10% b) 20% c) 35% d) 50%

5. What percentage of lung cancer deaths are caused by smoking?
a) 10% b) 40% c) 60% d) 90%

6. The health effects of smoking in pregnancy are:
a) Miscarriage b) Low Birth Weight c) Diabetes d) All of them

7. What proportion of children in the UK are exposed to secondhand smoke at home?
a) A quarter b) A third c) Half d) Three quarters

Effects of Nicotine

8. Dopamine is associated with:
a) Improved alertness b) Improved concentration

c) Improved memory d) Pleasure

9. Smoking relieves stress
a) True b) False

10. Which of the following is a withdrawal symptom of stopping smoking?
a) Lightheadedness b) Hair Loss c) Ear ache d) Bruising

11. The key message to note regarding nicotine withdrawal is that withdrawal symptoms are?

a) Permanent and abnormal
b) Temporary and normal
c) Temporary and abnormal
d) Permanent and normal

12. Nicotine is the substance in cigarettes that causes cancer.

a) True
b) False

NRT, Zyban and Champix

13. In general how often during the day should quitters use their NRT (excluding patches)?

_____

14. An advantage of using the microtab is:

a) Its strong dosage
b) Its nice taste
c) It simulates hand to mouth activity of smoking
d) It is discrete

15. Describe the technique for using the NRT gum

_____

_____

16. Which NRT product is the most effective?

a) Patch b) Inhalator c) Nasal spray d) They are all equally effective

17. Which NRT product delivers nicotine fastest?

a) Patch b) Inhalator c) Nasal spray d) Lozenge

18. What are some of the side effects of NRT?

_____

_____

19. Pregnant women should not use NRT

a) True
b) False

20. What is the only contraindication for NRT?

a) Breastfeeding mothers
b) Under 18 year olds
c) Under 12 year olds
d) People taking anti-depressants

21. What should someone with diabetes mellitus do whilst taking NRT?

a) Increase sugar levels
b) Monitor blood pressure regularly
c) Check thyroxin levels
d) Monitor blood sugar levels more closely

22. Why do people not tend to get addicted to NRT?
a) NRT delivers nicotine in a lower steady dose than cigarettes
b) Nicotine is not addictive
c) Because the taste is so bad
d) NRT should only be used for 4 weeks

23. How can a client obtain Zyban?
a) Over the counter b) Through the specialist stop smoking service
c) On prescription from their GP d) Zyban is not yet available in Camden

24. Can a person with epilepsy take Zyban?
a) Yes, but they need to inform their GP b) Yes, they can
c) No, it is a contraindication d) Yes, but they can only take 1 tablet a day

25. A caution of Zyban is:
a) Previous adverse reactions to Zyban b) Alcohol abuse
c) Previous use of Zyban d) Pregnant women

26. How long is the Zyban treatment course?
a) 4 weeks b) 8 weeks c) 12 weeks d) 16 weeks

27. One of the most common side-effects of Zyban is:
a) Irritability b) Weight loss c) Weight gain d) Insomnia

28. How can a client obtain Champix?
a) Over the counter b) Through the specialist stop smoking service
c) On prescription from their GP d) Champix is not yet available in Camden

29. Champix is contraindicated for
a) Alcohol abuse b) People with hypersensitivity to varenicline
c) People not living in Camden d) People with a history of psychiatric illness

30. Champix is not recommended for:
a) People with end-stage renal disease b) People on anti-depressants
c) People who have previously tried to stop with NRT d) People over 65

31. A caution of Champix is:
a) Pregnant women b) People using Zyban
c) Adolescent d) People with epilepsy

32. How long is the Champix treatment course?

a) 4 weeks b) 8 weeks c) 12 weeks d) 16 weeks

33. The most common side-effect of Champix is:

a) Nausea b) Insomnia c) Its unpleasant taste d) Reduced concentration

34. What is the recommended dosage for:

a. Zyban _____
b. Champix
_____

35. How long before quitting should clients start using:

a. NRT _____
b. Zyban _____
c. Champix _____

Stop Smoking Sessions

36. Carbon monoxide replaces what in the body?

a) Oxygen b) Water c) White blood cells d) Glucose

37. The NHS Stop Smoking Service is based on which approach?

a) Abstinence b) Acupuncture c) Hypnotherapy d) Cut down to quit

38. Who is able to provide group support?

a) Level II advisors b) Level III specialist stop smoking advisors
c) Any health professional d) The general public

39. In the preparation session it is important to:

a) Discuss client's motivation to quit b) Recommend follow-up prescription for Zyban
c) Encourage client to cut down d) Pressurise client into quitting

40. What is a necessary part of each stop smoking session?

a) Measure the client's CO reading b) Provide an NRT prescription
c) Set a quit date d) Provide the client with a quit certificate

41. Which of the following is a coping strategy for giving up smoking?

a) Identifying ways to avoid or handle trigger points b) Cutting down on NRT

c) Keeping cigarettes at home as a safety blanket d) Increasing alcohol intake

42. In which session would the advisor discuss relapse prevention?
a) First session b) Second session c) Third /fourth session d) Fifth session

43. In which session would the client start using NRT?
a) First session b) Second session c) Third/ fourth session d) Fifth session

44. In which session would the advisor help the client prepare for quitting?
a) First session b) Second session c) Third/fourth session d) Fifth session

Appendix 3

Action Plan For Level II Stop Smoking Training

Objective	How will I achieve this objective?	Date to be completed by	Date of completion

Appendix 4

Needs assessment for the intervention with the Health Trainer

The Wanless (2004) report stated that in order to improve the health of the population approaches to behaviour change require an appreciation of the social, economic and environmental contexts that create the lived reality of the person as people from socioeconomic disadvantage are more likely to suffer from health inequalities. In addition, the 2004 Department of Health White Paper "Choosing Health: Making healthy choices easier" recommended that Health trainers (HTs) are recruited from the local community.

HTs do not require formal health training but their main goal is to help reduce health inequalities by reaching members of the community who may wish to adopt healthier lifestyles but who may not make contact with more traditional services. This is especially so with 'hard to reach' communities who have been identified as being more likely to suffer from such health inequalities. These client groups may also require the intervention to be adapted to their needs e.g. experience of more frequent relapse, or require the HT to gain support from the supervisor regarding maintaining contact and problems interacting with the client.

The HT remit is to not only offer advice and support but also to enable members of the community to actively set their own behavioural goals and manage this behaviour (Michie et al., 2004). This approach has been designed within a health psychology framework in order to identify areas which may cause ill-health, triggers for this behaviour, set goals and devise plans for changing this behaviour, build confidence to make these changes and reinforce changes made, as well as signposting to other services (Department of Health, 2004). Within this framework I was responsible for the supervision of one HT as well as the planning and implementation of the group clinical supervision for the team of 5 HT's to ensure appropriate clinical interventions.

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Appendix 5

Plan of supervision for the intervention

A number of people were involved in the individual supervision of the health trainer team. In addition to the individual supervision shared between myself and two other health psychologists in training the group sessions were organised in conjunction with myself and a research fellow who was evaluating the HT scheme as part of the pilot scheme for the academic organisation evaluating the scheme as a whole and the PCT. I then reported progress to my line manager. This required good communication lines to be set up to ensure continuity in the supervision provided. With this level of involvement it was necessary to not only be aware of the training received as part of the initial programme set up but also to gain a sense of their requirements and expectations. As well as administrative issues the main areas discussed regularly involved client issues, including client presentations, ethical procedures in work and reflection on their practice.

Once in post for a number of months, the HTs were consulted for their views on the areas they felt were in need of development or which were of interest to them for their continued professional development (CPD). An example of the minutes of an individual supervision session, feedback on an observation of an intervention and the plans for group CPD and its subsequent progress can be seen below.

Supervision Minutes 23rd June 2006

Date	Area discussed	Issues discussed	Action points
23rd June	General work procedures	▪ Localities and times of clinics ▪ [redacted] Health Centre, Monday and Friday. Also uses this time for paper work ▪ [redacted] Surgery, Tuesday. Small practice (2 GPs), slow but picking up ▪ [redacted] Practice, Wednesday. Large practice but referrals slow due to turnover of GPs ▪ [redacted] Medical Centre, Thursday. Large practice and busy clinic ▪ Levels of referrals at practices in the locality. More of a problem with those surgeries where she does not have a clinic	▪ GA and [redacted] to arrange suitable time to observe sessions ▪ [redacted] has contacted all practices to remind them of her role. Will discuss with practice managers about attending practice meetings
	▪ Clinical issues	• Problem of space at [redacted] for referrals from other surgeries ▪ Used to be able to take BPs – not clear about why this has been changed • No specific client issues. Feels confident about job, most clients for diet and smoking. • Would like more guidance on complex clients; feels that sometimes not able to complete forms properly due to their other issues which may impact evaluation of her performance and PHA programme	• [redacted] to discuss with [redacted] to identify room availability • GA to check with [redacted] • GA to discuss with [redacted] developing guidance for approaching these clients
	▪ General points	• Enjoys role but would like more time to see clients and less on meetings	
	▪ GA role	Discussed supervision, [redacted] expectations and frequency of meetings	Agreed monthly meetings. Next meeting 28/7

Health Trainer development arising from meeting 25th April, 2007

Future monthly topics:

1. **Administrative issues following up clients**
2. **Presentations: Promoting selves and service**
3. Blood Pressure follow-up training – (consent from GP's – SS)
4. **Motivational interviewing**
5. Starting services, managing expectations, directive practice – weight and exercise
6. Developing community work – invite HT from other PCT's to share ideas
7. Time management – how to manage/utilise free time
8. Mental Health – Awareness training, using BoP
9. Becoming your own health trainer – final section of handbook
10. Alcohol – refresher, criteria to refer on

People to invite to speak at sessions:

1. Non-health professionals, e.g. fire service
2. Boots – 'Change one thing'
3. Weight watchers
4. Health visitors, district nurses, midwives
5. Community agencies, e.g. VAC

Strategic issues:

1. SS re KSF – changing profile
2. HV and DN referrals
3. Dieticians / Diabetic nurses referrals

*Those items in bold are a priority

Health Trainer CPD status March 2008.

Topic	Month	Completed
1 Administrative issues following up clients	**May**	**Y**
2 Presentations: Promoting selves and service	**June, July, Sept**	**Y**
3 Blood Pressure follow-up training – (consent from GP's – SS)	On hold	
4 Motivational interviewing	**July, Oct**	**Y**
5 Starting services, managing expectations, directive practice – weight and exercise		
6 Developing community work – invite HT from other PCT's to share ideas		
7 Time management – how to manage/utilise free time		
8 Mental Health – Awareness training, using BoP	Jan	Y
9 Screening update	Feb	Y
10 Becoming your own health trainer – final section of handbook		
11. Healthy Start	Jan	Y
12. Alcohol – Information, brief intervention techniques	Sept, Nov	Y

People to invite to speak at sessions:

13 Non-health professionals, e.g. fire service		
14 Boots – 'Change one thing'		
15 Weight watchers		
16 Health visitors, district nurses, midwives		[redacted] (HV) spoke in Jan 08
17 Community agencies, e.g. VAC		

Strategic issues:

18 SS re KSF – changing profile -	Aug	Y
19 HV and DN referrals		
20 Dieticians/Diabetic referrals		

[redacted] CPD Observation 03/08/06

Did well:

- Good body language/eye contact/open, friendly manner
- Good listening skills
- Good explanations e.g. why doing questionnaire
- Summarises well, reflecting body language, empathy
- Responds to questions well
- Asks open-ended questions
- Rewords questions well and gives examples
- Joins together answers given/uses HAPA to explore e.g. what foods crave and what alternatives could be
- Positive feedback to client/says what client doing well (lots of veg in curry) as well as what not so good
- Offers good tailored strategies
- Negotiates a small number of goals
- Identifies rewards-short term and long term
- Looking for client to reward self and recover from lapse

Did not so well:

- Picking number on scale herself rather than client
- Sometimes leads on making suggestions
- Moving into action whilst still establishing motivation
- Seems to discuss many options-confusing/Set too many small steps
- Jumps about a bit
- Are goals realistic?
- Action plan not specific enough (anytime etc). How will action goals be measured?

General comments

[redacted] is using the psychological models and theories well and has a good rapport with clients.

Appendix 6

Reflective analysis of the problems that could be encountered in implementing and supervising the intervention

Supervision is a multifaceted process and allows an opportunity to communicate and problem-solve, review clients, plan future development and offer a safe environment within which to reflect. This puts a complex range of requirements on the supervisor to be observer, teacher, colleague and evaluator, with this latter point being a potential source of anxiety (Ellis, Kregel & Beck, 2002). This dynamic relationship could also be affected by a number of other variables such as the interaction of gender, age and cultural issues, as well as language ability, between the supervisor and supervisee.

To reduce any potential problems in this relationship it was essential to build an approachable empathetic relationship based on trust, not only in my clinical knowledge but also for the general well-being of the HT in their diverse role. This was especially the case given that many of the HTs had no prior psychological knowledge and yet they had to operate within the parameters of interventions based on psychological knowledge. Therefore they needed to not only be approachable and personable with the client but also technically proficient in the techniques they were using.

Recognising the individual strengths and developmental needs of the different team members was paramount, especially in the group supervision sessions. Managing these differences was facilitated by regular meetings with the other supervisors involved with the HTs. These meetings gave an opportunity for the supervisors to discuss the different needs and personalities of the HTs and helped to develop the approach taken to enhance their receptiveness to feedback and advice. For example, some were reported by their dedicated supervisor as being quite defensive while others, like my supervisee, were receptive and engaged to improve and develop their skills. This particularly helped in group supervision.

Feedback was also given as a result of observations of practice. In this situation their 'performance' may be affected by nerves of being observed even though they are technically able; I was aware that the intervention could be affected by the presence of a third person (the observer) as well as the personality of the client. Such observations may also work in reverse; the supervisee may not be verbally dextrous enough to describe their practice in theory but can be very good at delivering an intervention 'in situ'. As such there is a need to evaluate and feedback to supervisees having taken into account a variety of intervention scenarios and to not base judgements of ability on just one snapshot. This also gives a rich background against which to reflect on different situations in supervision.

Finally I was aware of the need for the supervision to reinforce not just my ethical practice towards the supervisee but also to ensure their ethical practice. An illustration of this was the need to delineate clear boundaries of their practice and abilities and to make them aware of the consequences of not adhering to these, especially as for the majority of time they work remotely from other team members.

This brief review highlight a number of areas where potential problems may arise in the supervisory relationship but which may be minimised with clear boundaries and expectations as well as the use of reflection.

References

Ellis, M.V., Krengel, M., & Beck, M. (2002). Testing self-focused attention theory in clinical supervision: Effects of supervisee anxiety and performance. *Journal of Counseling Psychology. 49 (1),* 101-116.

SECTION D

SYSTEMATIC REVIEW

Smoking Cessation Interventions for Chronic Obstructive Pulmonary Disease

SMOKING CESSATION INTERVENTIONS FOR CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Abstract

Background. Stopping smoking is the most important thing someone can do to alleviate symptoms and reduce progression of chronic obstructive pulmonary disease (COPD). However, supporting people to stop remains challenging.

Objectives. The aim of this systematic review is to establish the most effective stop smoking intervention approach for smokers with COPD.

Search strategy. Electronic databases searched were MEDLINE, EMBASE, AMED, PsycINFO, DARE, Cochrane Library and CINAHL. The search dates for all databases were from January 2006 to November 2009. References of the included studies were also screened for additional papers and the following journals were searched by Internet or by hand; Health Psychology, British Journal of Health Psychology, Journal of Health Psychology, Addiction and Nicotine and Tobacco Research.

Selection criteria. This review included only randomised control trials or quasi-randomised control trials with at least one group comprised of participants diagnosed with COPD.

Data collection and analysis. Two reviewers using a quality assessment form that was developed from the selection criteria reviewed the selected studies independently. Divergence of quality assessment scores was resolved by the two reviewers meeting to discuss differences in ratings and agree a score.

Main results. Four studies were included in this systematic review. The studies show the effectiveness of psychosocial interventions combined with pharmacotherapy at 12 months post-intervention (χ^2 = 71.52, p<. 001; OR 4.98, 95% CI 3.36-7.37, effect size r = 0.32). However, despite this medium effect size, due to a lack of universal use of pharmacotherapies in most of the studies makes a definitive comparison of efficacy difficult. The review also

shows the effectiveness of psychosocial treatment for people with or without COPD symptoms at 12 months, although the effect of disease severity is not clear. The review also highlights the difficulty of maintaining attendance at community-based locations compared to acute or research settings.

Conclusions. This review shows that psychosocial and pharmacological support for patients diagnosed with COPD are effective. However, it is unclear what the effect of a number of the key variables have on these outcomes, e.g. nicotine addiction levels, motivation levels and disease severity. While positive, further research should be completed with more sub-analysis of participant variables such as disease severity and time since diagnosis.

Background

Chronic Obstructive Pulmonary Disease (COPD) is the umbrella term for a range of progressive respiratory conditions including chronic bronchitis, chronic airways obstruction and emphysema and which result in inflammation and damage to the airways (Department of Health, 2009). This reduction in air-flow to the lungs is not fully reversible.

The risk factors for developing COPD vary depending on socio-demographics: in comparison to low-income countries where exposure to indoor air pollution, such as the use of biomass fuels for cooking and heating, is recognized as the primary cause of COPD in high- and middle- income countries exposure to tobacco smoke is the biggest cause of COPD (World Health Organisation, WHO, 2007). This exposure can be the direct effect of smoking tobacco as well as being exposed to either second-hand or passive smoke. This causal relationship has been recognised as the major factor in the development of COPD for decades for people who are susceptible to this disease (Anzueto, 2005; Fletcher & Peto, 1977).

Stopping smoking can not only reduce the risk of developing this disease; if diagnosed with COPD stopping smoking can also slow the progression of the reduced airflow (Anthonisen, Connett, Kiley, Altose, Bailey et al., 1994) as well as greatly reducing mortality (Anthonisen, Skeans, Wise, Manfreda, Kanner et al., 2005).

In 2007, the WHO estimated that COPD affected 210 million people and reported that in 2005 3 million people had died of COPD, corresponding to 5% of all global deaths. In 2002, Mannino estimated that by 2020 this disease would be the 5th largest contributor of disability-adjusted life-years worldwide while more recently the WHO (2007) has predicted that by 2030 this disease will become the third leading cause of death worldwide; not all of these cases will be directly attributable to smoking but it is thought that smoking will play a significant factor.

In the United Kingdom (UK) nearly 900,000 people have been diagnosed with COPD

(National Health Service, NHS, 2009). However, the NHS (2009) estimates that the majority of people with COPD are unaware of their condition and that the real figure is approximately 3 million people in the UK with older people more likely to develop COPD. In the UK this is reflected in the average age at diagnosis of COPD being 67 years, usually after many years of less severe symptoms such as breathlessness and/or a 'smokers cough' (NHS, 2009).

Smoking cessation and COPD

The National Institute for Health and Clinical Excellence (NICE; 2004) recommends that all COPD patients who smoke should be encouraged to stop at every opportunity and offered pharmacotherapy combined with a behavioural support programme. However, while guidelines are set out by the Department of Health (DH; 2009) on supporting smokers in the general population to stop smoking no guidance is yet available as to the most effective way to support this chronic disease group in stopping smoking.

Many studies have found that this group differs from the general population in a number of ways that may affect not only their attempt to stop smoking but also the success of this attempt. Some of these differences include the type of smoker they are (Jimenez-Ruiz et al., 2001), their beliefs about how their smoking behaviour relates to their COPD condition (Walters & Coleman, 2002) as well as the effect that having a chronic disease has had on their psychological and emotional well-being (Hill, Geist, Goldstein & Lacasse, 2008). These factors need to be considered when designing effective stop smoking interventions.

Jimenez-Ruiz et al. (2001) found that smokers with COPD tend to have higher tobacco consumption, higher nicotine dependence and a higher concentration of carbon monoxide (CO) in exhaled air, all of which suggest a different pattern of smoking. This study concluded that cases of COPD among smokers predominate in men and in those with lower educational levels, a large proportion of whom had not tried to stop smoking previously. These findings suggest that an alternative approach may be needed with these groups to not

only raise awareness of the dangers of smoking but also to motivate them to stop as well as ensuring that information resources are accessible.

Perception of the aetiology of the illness is also an important factor. Walters and Coleman (2002) found that patients who attribute their respiratory symptoms to smoking are eight times (95% confidence interval [CI] = 3.0-23.3) more likely to believe that their health will improve if they stop smoking and six times (95% CI = 1.4-23.3) more likely to intend to stop smoking. Thus as well as knowledge about the impact of smoking on health, perceptions, attitudes and motivation to stop smoking are interdependent variables which play a role when an individual considers changing their behaviour.

As well as these factors, a key factor for patients with chronic diseases is adherence to treatment and long-term maintenance of the recommended behaviour changes. Bourbeau and Bartlett (2008) found that adherence to medications and lifestyle changes such as smoking cessation and physical exercise is low in this group. They attribute this to a range of factors including patients' perception of their disease, type of treatment or medication, the quality of patient provider communication, the social environment and a raised level of anxiety and depression found in patients with COPD, although estimates of prevalence vary.

A combination of these factors has been associated with lower levels of self-efficacy and an impaired overall health status, such as dyspnoea, and loss and grief associated with the disability of COPD (Coventry & Gellatly, 2008; Hill, Geist, Goldstein & Lacasse, 2008). Stage, Middelboe, Stage & Sorensen (2006) reported that depression is common in COPD patients with around 40% being affected by severe depressive symptoms or clinical depression. Despite these findings it is not always possible to identify the exact cause when making a diagnosis of depression in COPD patients because of common symptoms present in both COPD and depression such as fatigue and altered sleep patterns (Hill, Geist, Goldstein & Lacasse, 2008). Differences may also occur due to the measurement tool used; for example

between the Beck Depression Inventory and the Hospital Anxiety Depression Scale that also takes into account somatic health symptoms. Depression constitutes an additional stressor to people whose quality of life can already be strongly impaired due to their chronic illness; Stage et al. (2006) report that quality of life can be more correlated with the presence of depressive symptoms than it is with the severity of COPD.

It is difficult to quantify how many people with COPD continue to smoke after diagnosis. However, a number of clinical studies investigating the effectiveness of medications for the treatment of COPD have reported figures ranging between 38% and 43% of patients with moderately severe to severe disease levels continuing to smoke (Wedzicha, Calverley, Seemungal, Hagan, Zainab et al. (2008); Calverley et al., 2007). A similar level of smoking was found in a study investigating a smoking cessation intervention (Monninkhof et al., 2004). These figures are higher in comparison to the general 'healthy' population where the prevalence is 21% (Department of Health, 2010).

Such additional variables, including increased depression and anxiety, impaired general health and an increased addiction to nicotine found in smokers with COPD, confound the success of standard stop smoking interventions. They also highlight the requirement for an understanding of the psychological background and coping mechanisms employed by the patient when disease symptoms occur. With such a range of negative effects of a diagnosis of COPD on the person there are many barriers for this patient group to overcome which exert pressures and limits on their daily lived experience, resulting in an impaired health-related quality of life. These barriers may also delay initiation of an attempt to stop smoking and/or, once started, can affect the outcome of this attempt. In this latter context the content and structure of the intervention design is crucial. The challenge is therefore to identify the factors that help to maintain the smoking behaviour of someone with COPD.

Attempts to identify the most effective approach for this group to stop smoking has been made in previous systematic reviews and have included a combination of behavioural support and nicotine replacement therapy (NRT) or alternative pharmacotherapies, such as bupropion, varenicline and nortriptyline as the most effective way to achieve successful cessation in this population. However, it is not clear whether, and if so how, the intervention to support an individual with COPD should differ from that offered to smoker from the general population.

In their review of 5 studies undertaken between 1991 and 2001, Wagena, van der Meer, Ostelo, Jacobs, and van Schaych (2004) concluded that combining psychosocial interventions and pharmacological interventions resulted in better outcomes than either no intervention or psychosocial interventions alone. This latter finding for the lack of evidence to support the effectiveness of any psychosocial intervention alone for smokers with COPD was due to a lack of high-quality studies comparing a combination of interventions with no intervention. They also found that stage of severity of COPD of the participants was unclear, making it difficult to determine which treatment benefits which patients. Furthermore, some outcome measurements were also unclear with regard to how to classify smoking status; some studies used point prevalence (measurement at a specific time) while others regarded period prevalence, or continuous abstinence, as the appropriate outcome measure. Similarly, the quantity and quality of these outcomes are not standard between studies; timing of baseline and follow-up periods were not consistent and some outcomes were supported by an objective biomarker while others relied on self-report.

A later review (Strassman et al., 2009) comprising 8 studies published between 1991 and 2006 had a similar overall finding that combining psychosocial interventions and pharmacological interventions resulted in better outcomes than either no intervention or psychosocial interventions alone. When this was investigated further there was an indication

that 'high intensity' smoking cessation counselling (SCC) was more effective than 'low intensity' SCC although this was significant only when provided in combination with NRT. A similar limitation in this review was that motivation levels and the reporting of the severity of COPD of the participants were inconsistent.

The authors concluded that the success rates found with this patient group were similar to those in non-COPD trials. A major barrier also was the lack of clarity over standardization of the SCC for this group as the intervention is often individualized to the patients needs and therefore difficult to quantify and generalize these findings.

Objectives

The aim of this systematic review is to build on and improve the findings of the earlier reviews by Wagena et al. (2004) and Strassman et al., (2009) in order to establish the most effective stop smoking intervention approach for smokers with COPD. Changes were made to the search criteria in order to identify relevant studies, such as terms to identify studies with a psychological element to the intervention. To improve the quality of the included studies only those using a biochemical validation of smoking status were included.

Methods of the Review

Criteria for Considering Studies for this Review

Type of Study

This review included only randomised control trials or quasi-randomised control trials

Types of Participants

Participants were included in the studies if their diagnosis of COPD had been made as 'mild', 'moderate' or 'severe' after assessment using guidelines outlined by the American Thoracic Society/European Respiratory Society Task Force (ATS/ERS; 2004) or NICE guidelines (2004). Studies that also comprised non-COPD diagnosed participants in at least one comparison group were also considered for inclusion.

Types of Intervention

This systematic review included studies that investigated the effectiveness of smoking cessation interventions for smokers diagnosed with COPD with a minimum follow up at six months after the conclusion of the intervention. Smoking status at follow-up was also required to be validated using a biochemical marker, such a CO in expired breath reading and/or saliva cotinine or urine cotinine measure. Monninkhof et al., (2004) report that self-reported smoking abstinence in those with smoking related diseases are less reliable than in healthy smokers, with a 'deception' level ranging from 6.5% to 26%. The intervention was also required to include a psychosocial and behavioural support element to its design with a standard stop smoking pharmacological component (nicotine replacement therapy, bupropion or varenicline) or nortriptyline. This psychosocial and behavioural support included either individual or group-based face-to-face sessions or telephone contact with the participant. There was no expectation of the profession of the person delivering the intervention, e.g. psychologist, nurse or other health worker.

Types of Outcome Measures

The minimum outcome measure for inclusion was point prevalence quit status with a biochemical validation.

Search Strategy to Identify Studies

Electronic databases searched were MEDLINE, EMBASE, AMED, PsycINFO, DARE, Cochrane Library and CINAHL. The initial search dates for all databases were from January 2006 to November 2009 to allow for overlap with the Strassman et al (2009) review. References of the included studies were also screened for additional papers and the following journals were searched by Internet or by hand; Health Psychology, British Journal of Health Psychology, Journal of Health Psychology, Addiction and Nicotine and Tobacco Research.

Search terms

The following search terms used in the original systematic review by Wagena et al. (2004) were used:

copd*, lung-diseases-obstructive*, emphysem*, bronchit*, tobacco, nicotine, smoking, smoking-cessation, tobacco-use-disorder, tobacco-smokeless, anti-smoking, quit*, stop*, cessat*, ceas*, abstin*, abstain*, control*, smok*, giv*, tobacco*.

The search terms used in the Strassman et al. (2009) review followed broader categories due to this being part of a larger review project on various treatments for COPD. With one exception these terms had been included in the Wagena et al. (2004) review; the one exception was 'treatment outcome' which was considered by the author to be too broad for the purposes of this review.

To identify relevant studies the following additional search terms were used: interven*, NRT, nicotine, bupropion, zyban, varenicline, champix, chantix, nortript*, anti-depress*, counsel*, behavio*, CBT and psycho*.

Study Selection Criteria

The search yielded 81 papers between January 2006 and December 2009. The abstracts were read and papers not meeting the full inclusion criteria were eliminated. This process resulted in 4 articles that were considered relevant for inclusion in this review.

In an attempt to expand the pool of studies for this review the same database search was repeated from March 2002 (the end of the journal search for the Wagena et al. (2004) review) to December 2005 to identify any additional papers which may have been missed from the Strassman et al. (2009) review. This yielded one additional study but it was excluded due to the lack of a 12-month follow up.

Methodological Quality Assessment

A quality assessment tool was designed for this review. In comparison to the previous two systematic reviews (Wagena et al., 2004 and Strassman et al., 2009) this review did not

use the full Delphi list (Verhagen, 1998) to assess quality of the studies. The Delphi list was developed as a minimum reference standard for RCTs on many different research topics, and, rather than replace, was intended to be used alongside other criteria lists. It was felt that the subject area of this review required an active role on the part of the participant in terms of behavioural support and a degree of control over their level of engagement with behaviour change techniques. Consequently it was decided that the elements of blinding of the care provider and the participant were not valid items that, as Wagena et al. (2004) discussed, led to internal validity difficulties for their systematic review when comparing psychosocial interventions. To overcome this, a number of quality assessment points were added which also aimed to increase the validity of the studies selected.

The items in the quality assessment list and the scores attached to each were:

1) Selection bias: How were participants randomized? Score: 2 = computer randomised, 1 = other randomisation, 0 = no explanation
2) Comparable at baseline (did the groups appear comparable at baseline regarding the most important prognostic indicators, e.g. numbers smoked, addiction level, age?): Score: 1 = yes, 0 = no
3) Detection bias (Was a biomarker used to validate self-report at follow-up?): Score: 2 = used at >1 follow-up point, 1=used at 1 follow-up point, 0 = not used/not clear
4) Biomarker used to validate self-report at completion of intervention: Score: 3 = >75%, 2 = 50-75%, 1 = <50%
5) Description of intervention procedure: Score: 3 = step by step and psychological principles, 2 = step-by-step, 1 = some description, 0 = barely any description
6) Suitable comparison interventions (medications): Score 2 = comparable, 1 = some comparison, 0 = no comparison

7) Description of stage of disease: Score: 1= information given, 0 = no information given
8) Description of type of smoker (light/heavy): Score: 1 = information given, 0 = no information given
9) Time points of follow-up: Score: 4 = >12 months post intervention, 3 = ≥6 months ≤12 months post intervention, 2 = >end of intervention <6 months, 1 = end of intervention
10) Sample size justification: Score: 1 = power analysis used, 0 = power analysis not used
11) Drop out rate by conclusion of intervention. Score: 2 = drop out rate ≤25%, 1 = drop out rate >25% ≤50%, 0 = >50 or not known
12) Intention to treat analysis (non-attendees at completion classed as smokers)Score: 1 = yes, 0 = no

The selected studies were reviewed independently by two reviewers (G.Absalom and R. Kalhar) using the quality assessment form that was developed from the selection criteria. Divergence of quality assessment scores was resolved by the two reviewers meeting to discuss differences in ratings and agree a score.

Data Analysis

As found in previous systematic reviews, the studies were heterogeneous with regards to: 1. The study population and its level of COPD; classified as 'mild' ($FEV_1 \geq 80\%$), 'moderate' (FEV_1 50–79%), or 'severe' (FEV_1 30–49%), as defined by the ATS/ERS (2004). 2. Format of treatment (individual, group or telephone) of behavioural/psychological support. 3. Use of pharmacological treatments (no treatment, NRT, bupropion). 4. Level of psychological assessment including motivation measures. 5. Different levels of included study quality.

Significance levels, effect sizes, odds ratios (OR) and 95% confidence intervals (CI) have been calculated where possible and some statistical information in the primary research has been reported where it is been considered appropriate.

Description of Studies

This review includes 4 studies. The Characteristics of Included Studies are summarized in Appendix 1.

The included studies were completed in the Netherlands (Christenhusz, Pieterse, Seydel, & van de Palen, 2007 and Willemse, Lesman-Leegte, Timens, Postma, & ten Hacken, 2005), Sweden (Sundblad, Larsson, & Nathell, 2008) and the UK (Wilson, Fitzsimons, Bradbury, & Elborn, 2008). Two studies were carried out in COPD outpatients' clinics (Christenhusz et al., 2007 and Willemse et al., 2005), one study was carried out as inpatients in an acute setting, with the control group in primary care settings (Sundblad et al., 2008) and one study was carried out in a respiratory outpatients clinic, with the control receiving no support after initial brief advice (Wilson et al., 2008). All studies had elements of psychological intervention. One study included group, individual and telephone support (Christenhusz et al., 2007) compared to a control with individual and telephone support, one offered group support compared to a control of unspecified usual care (Sundblad et al., 2008), one offered group support for both experimental and control groups (Willemse, 2005) and one study comprised 2 experimental arms, one with individual support and one with group support, with a control group receiving no additional support after initial brief advice (Wilson et al., 2008).

No studies had the expressed aim of assessing the effectiveness of pharmacotherapy alone and provision of pharmacotherapy treatments varied between the studies. One study provided bupropion free of charge to the experimental group but not to the control group (Christenhusz et al., 2007), one study reported the use of pharmacotherapy but no

information is given on access to it (Sundblad et al., 2007), one study did not report its use (Willemse et al., 2005) and one provided 12 weeks supply NRT to the intervention groups only (Wilson et al., 2008). The interventions were led by a range of healthcare professionals; respiratory nurses delivered the interventions to the experimental and control groups in one study (Christenhusz et al., 2007), a smoking cessation nurse was part of wider support input from healthcare professionals (Sundblad, 2008), nurse specialists trained in asthma and COPD and a researcher trained in smoking cessation in another study (Willemse et al., 2005) and by a respiratory nurse in the experimental groups of the final study (Wilson et al., 2008). In this latter study, the control group received a brief intervention from a doctor. No information is available on usual care provided in primary care (Sundblad et al., 2008).

The level of COPD disease was given for all participants. All were diagnosed using the ATS/ERS (2004) or the NICE (2004) classification as 'mild', 'moderate' or 'severe'. One study comprised 'moderate' and 'severe' samples (Christenhusz et al., 2007), two studies comprised participants with three levels of diagnosis (Sundblad et al., 2008 and Wilson et al., 2008) and one study compared an experimental group comprising participants with an average 'mild' diagnosis with a control group of asymptomatic participants (Willemse et al., 2005).

The reviewers concluded that one study gave little description of the intervention (Christenhusz et al., 2007), one study gave a step-by-step description (Sundblad et al., 2008) and two studies gave a step-by-step description and the psychological principles (Willemse et al., 2005, and Wilson et al., 2008).

The smoking status of participants was measured using a number of tools in all studies; cigarettes smoked ranged from 17.5 - 24.1 (Christenhusz et al., 2007, Willemse et al., 2005 and Wilson et al., 2008); nicotine dependence measured using the Fagerstrom Test for Nicotine Dependence (FTND, 1991) ranged from 4.7 - 4.8 (Sundblad et al., 2008) and pack

years (calculated as numbers smoked x number of years smoked / 20) ranged from 25 – 45.5 (Sundblad et al., 2008, Willemse et al., 2005 and Wilson et al., 2008).

Methodological Quality

Appendix 2 shows the final quality assessment results reached after consensus between the two reviewers. The quality scores of the studies range from 11 to 20. There were two inclusion criteria; the studies had to be randomized controlled trials and outcomes had to be validated by the use of a biomarker. One study used computer-generated list of random numbers (Wilson et al., 2008), one study was randomized according to other criteria, e.g., the level of COPD (Willemse et al., 2005), and two studies gave no explanation (Christenhusz et al., 2007 and Sundblad et al., 2008). Biomarker validation was used for more than 75% of outcomes in three studies using a range of measures; salivary cotinine test (<20ng/ml) (Christenhusz et al., 2007), urinary cotinine measure with a cut off set at <25 ng/ml (Willemse et al., 2005) and in one of these studies two measures were used; expired breath carbon monoxide (CO) with a cut off at ≤ 10 parts per million (PPM) and salivary cotinine with a cut off level of ≤ 10 ng/ml (Wilson et al., 2008) and less than 50% in one study using expired breath CO monitoring with a cut off set at <8ppm (Sundblad et al., 2008). Two studies (Willemse et al., 2005 and Wilson et al., 2008) used biomarkers on more than one follow –up, one study (Christenhusz et al., 2007) used biomarkers on one follow-up and one study (Sundblad et al., 2008) did not use a biomarker until the end of the study.

Three studies had measured continuous abstinence at 12 months post intervention (Christenhusz et al., 2007, Willemse et al., 2005 and Wilson et al., 2008) and one study measured prolonged abstinence in the previous 12 months annually until 36 months post intervention (Sundblad et al., 2008).

Only one study (Wilson et al., 2008) included a sample size justification or power analysis, yet failed to achieve the sample size required. Two studies had over 100 participants

in each group (Christenhusz et al., 2007 and Sundblad et al., 2008) and two studies had less than 40 participants per group (Willemse et al., 2005 and Wilson et al., 2008). Two studies had a drop out rate of less than 25% (Sundblad et al., 2008 and Willemse et al., 2005) while two studies had drop out rates of 25% - 50% (Christenhusz et al., 2007 and Wilson et al., 2008). Explanations for these drop outs were not consistently reported.

Results

The primary aim of the four studies identified for this review was the effect of the interventions on smoking cessation. Table 1 shows the outcomes of the studies included in this review.

All four measured abstinence 12 months post-intervention. Just one, (Willemse et al. 2005), reported follow-up outcomes at points before this, while one reported follow-up outcomes 24 months after this point. The results for the 12 months will be reported and the results at 36 months follow-up will be discussed in the context of that study. The overall difference in the effectiveness of all the studies at 12 months between the experimental groups and the control groups was significant (χ^2 = 71.52, p< 0. 001) with 35.5% of participants quitting in the experimental groups and 10% quitting in the control groups (OR 4.98, 95% CI 3.36-7.37). Total numbers of participants were similar, with 394 in the experimental groups and 381 in the control groups. Pooling of the individual effect sizes resulted in an overall effect size of r = 0.32, indicating a medium effect.

Different psychosocial interventions with pharmacotherapy.

a. Christenhusz et al. (2007) compared two interventions with participants diagnosed with either moderate or severe COPD. One group received 595 minutes of support (high intensity), although the number of sessions was not stated. Delivered in group, individual and telephone format, 100% were prescribed bupropion free of charge, with 6% also reported using NRT. The control group received 180 minutes (medium intensity) of individual and

Table 1. Outcomes of studies

	Paper	IG n (%) 12m	CG n (%) 12m	Difference n (%)	p	Odds Ratio	95% CI	Effect Size r	IG n (%) 36m	CG n (%) 36m	Difference n (%)	Quality score
1	Christenhusz, et al. (2007)	18/96 (19)	6/67 (9)	12 (10)	ns	2.35	0.88-6.27	0.14	*	*	*	11
2	Sundblad, et al. (2008)	106/204 (52) a	15/219 (7) a	91 (45) a	<0.001	14.71	8.14-26.59	0.49	73/192 (38) a	20/196 (10) a	53 (28) a	13
3	Willemse, et al. (2005)	16/38 (42)	17/25 (68)	-1 (-26)	<0.05	0.34	0.12-0.99	0.25	*	*	*	20
4a	Wilson, et al. (2008)	0/27 (0)	0/35 (0)	0 (0)	-	-	-	-	*	*	*	19
4b	Wilson, et al. (2008)	0/29 (0)	0/35 (0)	0 (0)	-	-	-	-	*	*	*	19
	Total	140/394 (35.5)	38/381 (10)	102 (25.5)	<0.001	4.98	3.36-7.37	0.32				
	Means	28	8	20								

IG denotes intervention group

CG denotes Control group

"a" denotes point prevalence (abstinence in previous 6 months)

* outcome not applicable

telephone support, although again it is not reported over how many sessions. 28% used bupropion and 14% used NRT although these were not free of charge. Respiratory nurses delivered both interventions. At 12 month follow-up 19% were abstinent in the experimental group and 9% were abstinent in the control group (OR 2.35, 95% CI 0.88 – 6.27). Chi square analysis showed this to be non-significant and a small effect size was found, r = 0.14. The high intensity group had a higher nicotine addiction score measured by Fagerstrom (59% compared to 42% scoring ≥ 6). Other independent variables measured included attitude to smoking cessation, self-efficacy and quality of life although these were non-significant (p= 0.08) in the experimental group outcome. For the control group a higher cotinine value at baseline led the authors to indicate that each rise of 100ng/ml doubled the likelihood of quitting and that a positive attitude towards stopping success increased by 12 times; both variables p= 0. 003. However, a large confidence interval of the odds ratio was reported (OR 22.52, 95% CI 1.55-327.97) and indicates low precision in this estimate.

b. Sundblad et al. (2008) compared a high intensity in-patient intervention with usual care provided in primary care health centres. A smoking cessation nurse delivered the experimental arm for 1 hour per day in groups of 4-8 people over 11 days as part of a wider lifestyle intervention with additional input from a doctor, a physiotherapist, a dietician, a laboratory technician, a psychologist and occupational therapist and a nurse. NRT was recommended and used by 28% in the experimental group and 14% in the control group. There were also regular follow-up telephone calls for 2-3 months after discharge and the participant and their spouse then returned for 2-4 days as in-patients, followed by additional telephone support follow-up until 12 months post intervention. No information is given on the usual care offered for the control group although just 20% (46) accessed this. At 1 year, point prevalence abstinence (in the previous 6 months) was significant (χ^2 = 105.2, p< 0.001) with 52% in the intervention group and 7% in the control stopping (OR 14.71, 95% CI 8.14 –

26.59). With r = 0.49 there was a medium-large effect size. At 3 years, these figures had reduced to 38% and 10% respectively but were still significant (χ^2 = 44.0, p< 0.001), resulting in a medium effect size of r = 0.32. There was no difference in outcome based on the severity of the disease. There were no differences reported in nicotine dependence between the groups at baseline although the authors acknowledge that which part of the intervention is effective is difficult to deduce given the mixed use of pharmacotherapy and the extensive format of the wider intervention.

c. Wilson et al. (2008) compared a high intensity individual intervention and a high intensity group intervention (5 sessions of one hour each) provided by one respiratory nurse and two respiratory nurses respectively (including an initial 5-10 minute brief intervention) with an individual usual care, brief intervention (5-10 minutes) only, delivered by a doctor, in an outpatients department. The experimental arms also offered 12 weeks of NRT while no information is available for the control group. No quitters were reported in both groups at 12 month follow up and no effect size has been calculated. However it was reported that all groups had a significant reduction in nicotine addiction over this period with values reported between the control and group intervention p= 0.006 and between the control and individual support p= 0.03.

2. Comparison by disease presence.

Willemse et al. (2005) compared a group intervention (8-10 per group) in an outpatients setting. The experimental group had been diagnosed with mild COPD and the control group was asymptomatic. A respiratory nurse specialist and a researcher trained in smoking cessation delivered the same intervention. Nine 2-hour sessions were initially offered over 6 weeks. Based on programmes developed in the Netherlands they incorporated CBT techniques to build motivation, self-efficacy and coping skills. Additional telephone support was offered in between sessions, and 6 additional group sessions were offered, ad

hoc, over the remaining time to 12 months, provided by the same facilitators. No pharmacotherapy was recommended. At 12 months continuous abstinence was significant ($\chi^2 = 4.05$, $p < 0.05$) although with 42% in the intervention group and 68% in the control group the control group was more successful (OR 0.342, 95% CI 0.119 - 0.987) with a small-medium effect size of 0.25.

Discussion

Disease severity

The studies in this review involved participants with various levels of COPD diagnosis, with one study comparing COPD participants with asymptomatic participants. With this one exception, in all other groups there was mix of disease severity. Where separate clear analysis was made according to disease severity any differences found appeared to be balanced out across the experimental and control groups making no clear conclusions on particular efficacy and severity of disease possible. Therefore, as was also recommended in the Wagena et al. (2001) review sub-analysis would be preferable wherever possible. For example, Sundblad et al. (2008) reported different quit rates according to diagnosis; 53% in mild, 46% in moderate and 50% in severe participants in the same experimental group.

Levels of addiction and length of intervention

Reporting according to disease severity would help clarify the results found in the present studies such as the effect of different intensity of interventions in the Christenhusz et al. (2007) study. They found that higher cotinine levels resulted in a better outcome which is contrary to popular assumptions regarding level of addiction and successful quitting. For the high intensity intervention no variable was predictive of success therefore it was suggested that the higher intensity could compensate for higher addiction in one group and a higher favourable attitude score to cessation found in the less intense control could compensate for the higher addiction. One hypothesis by the authors is that smokers with a high cotinine level

may have a more internal motivation as they may experience worse symptoms whereas those with a smaller cotinine level may have a more external, less stable motivation such as being advised to stop by a practitioner. It is however difficult to unravel the findings in this study as it was found that for the high intensity intervention no baseline variable predicted continuous abstinence in comparison to the medium intensity intervention.

In another study (Willemse et al., 2005) the intervention group had mild COPD but higher pack years than the control group. The high quit rate in both groups was thought to be possibly due to high contact time, and intense baseline and follow up measures regarding quality of life, respiratory symptoms questionnaire and cognitive dysfunction tests, as well as biomedical tests such as sputum induction and bronchial hyper responsiveness. This resulted in frequent and intensive motivational support proposed to account for high cessation rates (15 group meetings for the smoking cessation programme, 7 hospital visits for tests before the start of the programme and 3 hospital visits for follow-up sessions. These findings would suggest a two-tiered approach to cessation for this population with interventions more targeted depending on initial findings of screening used in this study.

Inclusion criteria

The primary aim of the studies identified in this review was to establish the effectiveness of psychosocial interventions, with the effect of pharmacotherapy being a secondary outcome. This was the reason to amend the quality indicators from the Delphi criteria used in Wagena et al. (2004); although they did discuss a possibility of bias in outcome assessment by the researcher or facilitator, it would be difficult to measure a discrete outcome such as quit/not quit in any other way when delivering a psychosocial intervention. This would be in comparison to other studies, for example Bittoun (2006), that found that using more NRT without psychosocial intervention or setting a quit date can be more

effective at achieving a non-smoking status and which would also support a medical model approach for certain groups.

Effect of healthcare professional

As found by the Strassman et al. review (2009) there were a number of points in the studies in this review where the person delivering the intervention could have individualised the intervention, for example during ad hoc telephone support, at respiratory medical checks etc. While maintaining the continuity of service provider throughout the year is believed to be beneficial this additional support is also a good form of relapse prevention or maintenance but is not always reported and so can make it more difficult to generalise the findings.

COPD specific factors

As discussed in the introduction a number of factors may influence the success of someone with COPD quitting smoking, including the type of smoker someone is (Jimenez-Ruiz et al., 2001), their beliefs about how their smoking behaviour relates to their COPD condition, or attribution, (Walters & Coleman, 2002) as well as the effect that having a chronic disease has had on their psychological and emotional well-being (Hill, Geist, Goldstein & Lacasse, 2008). For example, while the studies in this review described the stage or level of disease the time since diagnosis was not clear. This could impact on how they perceive their smoking behaviour; they could have already developed coping strategies to live with and manage exacerbations, which can be seen as reasons to quit for some while for others smoking can help cope with these exacerbations in the short term. A future study could therefore investigate the effect of time from diagnosis on smoking cessation outcomes as another inclusion criteria.

Attendance

Poor attendance was an issue for usual care conditions as found in the studies by Sundblad et al., (2008) and Wilson et al., (2008); for example, the success of the Sundblad et

al. (2008) intervention was skewed by the small number accessing usual care. Also highlighted by Wilson et al., (2008) they recommend that research investigates more acceptable interventions or that this study is repeated in a community setting. This is contrary to the finding in another study reported in this review, Willemse et al. (2005) who found that a medical setting may have had an effect on their study and hypothesized that being conducted in the research setting in an outpatients clinic may have made the participants feel more responsible for the outcome. This would then raise questions over the balance between 'medicalising' an intervention and ease of access in a community setting. In addition, it could be hypothesised that those participants with COPD can suffer exacerbations of symptoms that may affect attendance and compliance with the use of stop smoking medications and that they may be more likely to attend a medical setting during such episodes. Additional information on the health of the participants during the course of the studies could be useful.

Social support and motivation

Social circumstances should be considered. Wilson et al., (2008) reported that 42% lived with a smoker and this may have affected their perception of the importance of cessation or they may not have received the peer support that could have affected a successfully outcome. Similarly, motivation of participants to take part was not measured consistently and varied from a measured 'stage of change' identification to being estimated by attendance at an information session and the signing of an informed consent form as a proxy measure for motivation (Sundblad et al., 2008 and Christenhusz et al., 2007 respectively). For example, Sundblad et al. (2008) reported that in those cases where motivation to quit was significant, those in the action and maintenance stage having more successful outcomes between the experimental and control groups ($\chi^2 = 105.9, p < .0001$).

In addition, poorer outcomes could possibly be a function of the disease group under study. At recruitment a number of the studies indicated that a high proportion of the patients

had already quit smoking, leaving a potential sub-group of participants who could be described as 'recalcitrant' smokers.

Follow-up and biomarkers

Follow up at 12 months post intervention was an inclusion criteria for this review. For a complex group such as COPD patients this could be considered too long a period, especially as it is acknowledged that a large percentage of the general population relapse within the first 12 months post-quitting. This could also indicate that the level of initial support, or follow-up relapse prevention support, is not sufficient for both of these groups as the initial aim is to provide smokers with the skills and strategy formation to maintain abstinence.

In addition, 3 out of the 4 studies used continuous abstinence as a measure while one study used a long duration point prevalence marker of 6 months. This helps to make the findings more valid than in previous reviews (Wagena et al. 2004). Van der meer, Wagena, Ostelo, Jacobs, and van Schayck (2001) recognised that based on the findings of Velicer, Prochaska, Rossi, and Snow (1992) a combination of continuous abstinence and point prevalence measures should be used to assess outcomes to reach a clearer picture of the quitting process.

In the current review no studies used a combination making a comparison of these two approaches to measuring outcomes difficult, but which would help to illustrate the dynamic nature of smoking cessation. These two measures would have different utility; point prevalence may raise quit rates in the short term and help increase someone's self-efficacy with regards to feeling that they can stop rather than being labeled a 'failure' for not achieving continuous abstinence status, while continuous abstinence would help to identify better assessment of the longer-term effects of an intervention.

In comparison to previous reviews, having biomarker validation as an inclusion criteria has added weight to the studies discussed, despite the variety of measures being used making a direct comparison difficult.

Limitations

Although a significant difference was found between the intervention and control groups this can be problematic to interpret in the context of this review as suitable comparison interventions were not applied regarding the use of pharmacotherapies within the studies. This lack of standardisation is a possible confounding issue as it might be that in one or more of the studies what made a difference was access and use of free medication, which although an intervention does not reflect on the efficacy of the psychological component of the intervention. This is a significant factor affecting the validity of the findings as this could in itself affect motivation to maintain a quit attempt due to potential adverse withdrawal symptoms not being treated in the control groups.

A small number of studies were identified for this review. Despite ranging in quality from 11 – 20 they all reported at least one biomarker to validate the findings. However, these have had varying levels of stringency in their cut off points to accept a valid self-report.

The heterogeneous nature of the studies and small sample sizes make it difficult to generalise from the effect sizes. It could be posited from the required number estimated by the power calculation by Wilson et al. (2008) where 101 participants per group were needed to achieve a significance of p=.05, power .08, that these effect sizes should be treated with caution in the smaller studies. All studies should have reported a priori power and, failing to reach the required sample, they could have considered post-hoc power analysis e.g. Cohen's d, to indicate the likelihood of committing type II errors which is more likely with smaller samples.

Despite an attempt to make the inclusion criteria more robust and improve the focus of the study, publication bias can sometimes also be a limiting factor. However, it is hoped that this may have been minimal in this current review, especially as one study did not report any successful continuous quitters.

Conclusion

It is difficult to establish from the studies in this review the most effective approach to smoking cessation to take with this population. Despite stricter inclusion criteria there were still many differences in the level of intensity of interventions, the disease severity mix of the populations as well as different amounts of pharmacotherapy used. Strassman et al. (2009) found that a combination of pharmacotherapy and psychosocial support was the best approach to take to stopping smoking and this still appears to be the case, although a lengthy intervention does not always result in better outcomes. In addition it could be hypothesized that locating the interventions in a medical setting does appear to have a positive impact on initiation of a treatment. Although this may not result in an immediate successful outcome it may be a method of improving on-going engagement with support services in comparison to being referred to the standard usual care services in primary care or community settings.

As seen in the current review, there are a number of psychological effects that have differing effects in different situations that may positively or negatively impact on interventions delivered. The challenge for future research is to tailor interventions to optimise resources to reduce smoking prevalence in a clinical population where smoking is still a barrier to health improvement in terms of general well being and reducing medications required, although direct cost savings and comparisons are difficult due to medication and care still being required by many in this disease group.

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Appendix 1 Characteristics of included studies

Study 1 Christenhusz, Pieterse, Seydel, & van de Palen. (2007)

Methods	Setting: 3 hospitals COPD outpatients clinic in the Netherlands. Recruitment: Non-dutch speakers excluded. Randomisation: No information given. Two intervention groups between sample comparisons Drop-outs: reasons not given Intention-to-treat: No
Participants	Participant health: Clinically diagnosed moderate COPD (FEV_1 = 50-69%) or severe COPD (FEV_1 <50%), defined by ATS/ERS (2004). 'Heavy' smokers, experimental group 24.1 per day; control group 20.5 per day Age: Between 40 – 75 years Male: 52.4% Motivation: No measurement taken.
Interventions	1. Experimental (n 114): Format: Group counseling, individual counseling and telephone support. Intensity: High Time: Total counseling time 595 minutes N session: n/a Pharmacotherapy: Bupropion (free of charge) 100% used this, with 6% also using NRT Delivered by: Respiratory nurses 2. Control (n 111): Format: Individual counseling and telephone support Intensity: Medium Time: Total counseling time 180 minutes N session: n/a Pharmacotherapy: Recommended but not provided. Not free of charge. 28% used bupropion and 14% used NRT Delivered by: Respiratory nurses
Follow-up points	Measurements at baseline, 6 months and 12 months
Outcomes	Abstinence: Continuous abstinence 1 year after intervention. Experimental 19% Control 9%; RR = 2.22; 95% CI: 1.06-4.65 Validation: Salivary cotinine test (<20ng/ml)
Difference	10%
Quality Score	11

Notes	Experimental group had higher nicotine dependence measured using Fagerstrom, (59% compared to 42% scoring ≥ 6). Other independent variables were measured in both groups, including attitude, self efficacy and quality of life.

Study 2 Sundblad, Larsson, & Nathell. (2008).

Methods	Setting: Hospital setting in Sweden. Recruitment: Participants were recruited in the vicinity of 9 Swedish towns and cities using a questionnaire survey regarding smoking habits of current smokers on sick leave. Exclusion criteria included linguistic difficulties, presence of severe comorbidities or an inability to stay away from home for the required period of time Randomisation: No information given except a 'prearranged schedule' by a person not involved with the study Drop-outs: reasons not given Intention to treat: No
Participants	Participant health: Of those smoking more than 8 cigarettes per day 674 were diagnosed with COPD using spirometry. Smoking status measured by Fagerstrom (experimental group score 4.7 and control group 4.8) and pack years (experimental group 35.9 per day and control group 33.9 per day). Following the European Respiratory Society guidelines the COPD was classed as 'mild' (71%), 'moderate' (23%) or 'severe' (6%). Of these, 196 were excluded. Of those randomized to the intervention group, 35 did not participate. Age: Mean 53 years (Range 41-62) Male: 220 (49.7%) Motivation: Assessed using Stages of Change model
Interventions	1. Experimental (n=212) Format: Group support face to face Intensity: High Time: 1 hour N session: 11 inpatient Pharmacotherapy: NRT recommended Delivered by: Smoking cessation nurse 2. Control (n=231) Format: Referral to primary care health centres for usual care Intensity: n/a Time: n/a N session: n/a Pharmacotherapy: n/a

	Delivered by: n/a
Follow-up points	Weekly telephone calls lasting 5-30 minutes from a nurse for 2-3 months after initial discharge from the intervention. Participants and spouses returned for 2-4 days after 2-3 months from initial discharge. Subsequent to this the participants received 2 phone calls every month for 4 months and then 1 phone call every month for 8 months. Questionnaires on smoking habits were also completed at 1 year and 3 year follow up
Outcomes	Abstinence: At 1 year: Point prevalence quit rate (self report) at 1 year was 52% in the intervention group and 7% in the control group. Classed as successful quitters if smokefree (self report) for the last 6 months, quit rate was 53% for 'mild', 46% for 'moderate' and 50% for 'severe' COPD At 3 year follow up, 38% in the intervention group and 10% in the control group were smokefree. Validation: Expired breath CO verification at 3 year follow up in a random sample of the quitters. Of this sample of 35, 33 (94%) had a CO <8 ppm confirming smokefree status
Difference	45
Quality Score	13
Notes	Only 46 (20%) of the control group accessed smoking cessation programme in the primary care centres. The composition of this care is not described. The intervention also included a structured education programme led by a doctor, a physiotherapist, a dietician, a laboratory technician, a psychologist, an occupational therapist and a nurse. The aim of this was to increase knowledge of COPD and how to live with it.

Study 3 Willemse, Lesman-Leegte, Timens, Postma, & ten Hacken (2005).

Methods	Setting: Acute respiratory outpatients department in the Netherlands Recruitment: Advertisements in the outpatient department Randomisation: by condition – diagnosis of mild COPD or asymptomatic COPD Drop-outs: None Intention-to-treat: Yes
Participants	Participant health: Intervention group - COPD diagnosed according to the ATS/ERS (2004). Performed biomedical tests as well as quality of life, respiratory symptom questionnaires, cognitive dysfunction tests. No information given on tests used. Control group - asymptomatic smokers. Control group pack years 25, cigarettes smoked 21 per day; experimental group 35, cigarettes smoked 22 per day Age: Mean 55(SD 5.8) intervention; 50 (SD 3.7) control

	Male: 49.2% (52.3 % intervention; 44% control) Motivation: Not measured
Interventions	1. Experimental (n 33): Format: Group intervention (8-10 smokers) based on smoking cessation programme Defacto used in the Netherlands. Made use of CBT, especially motivation and self-efficacy and coping with increased weight and benefits of cessation. Also focused on relapse prevention, following a recognized Dutch format. Ad hoc telephone /face to face additional support offered in between sessions Intensity: High Time: 2 hour sessions N session: Initially 9 meetings over 6 weeks. Participants quit after 2nd session. Sessions 2-6 used to guide participants through cessation; sessions 7-9 used to maintain cessation and coping with side effects and difficult situations. An additional 6 sessions added throughout the year. Pharmacotherapy: None Delivered by: Nurse specialist trained in asthma and COPD and a researcher and smoking cessation 2. Control (n 27): Format: As intervention Intensity: As intervention Time: As intervention N session: As intervention Pharmacotherapy: None Delivered by: Nurse specialist trained in asthma and COPD and smoking cessation and a researcher
Follow-up points	2 months, 6 months and 12 months. Baseline tests also repeated at 12 months.
Outcomes	Abstinence: 42% intervention and 68% control at 12 months Validation: Urinary cotinine (<25 ng/ml)
Difference	-26
Quality Score	20
Notes	Intervention group had higher pack years, similar number smoked per day and an average FEV_1 of 80% (SD 24), indicating mild COPD. High intensity of contact – 15 group stop smoking sessions, 7 hospital visits before programme started and 3 visits through the year for follow up.

Study 4 Wilson, Fitzsimons, Bradbury, & Elborn (2008).

Methods	Setting: An outpatient facility of a Regional Respiratory Centre in Northern Ireland.

	Recruitment: Participants were recruited from an outpatient facility. They were excluded if they had any alcohol/drug related problems, contraindications to nicotine replacement therapy or they stated they had no intention to stop smoking Randomisation: A sequentially sealed envelope containing computer generated list of random numbers allocated the participants to one of three treatment groups Drop-outs: Reasons stated Intention to treat: Yes
Participants	Participant health: Using NICE classification guidelines (2004) participants level of COPD was measured and stated as either 'mild' (53%), 'moderate' (34%) or 'severe' (13%). Classed as 'heavy' smokers, average 19 per day, control group pack years 38.9, cigarettes smoked per day 17.5; experimental group 1 pack years 45.5, cigarettes smoked per day 20.8; experimental group 2 pack years 40.8, cigarettes smoked per day 20.1. Sample: 516 assessed for eligibility; 425 excluded as not meeting inclusion criteria, being an ex smoker or refusing to participate Sample size justification. Power analysis discussed and estimated but the quantity was not achieved Age: mean age 61 years (Range 38-80 years) Male: 48% Motivation: Stage of change assessment at recruitment
Interventions	All participants received brief advice to stop smoking, face to face, by a doctor for 5-10 minutes. This training was standardized at each medical rotation but no information is given. 1. Experimental 1 (n=27): Psychosocial and pharmacoptherapy Format: Individual support face to face Intensity: High Time: up to 60 minutes N session: 5 Pharmacotherapy: 12 weeks NRT 16 hour patch; 8 weeks 15mg, 2 weeks 10mg, 2 weeks 5 mg Delivered by: 1 experienced respiratory nurse, with 6 hours standardized training from a Health Promotion Officer and Pharmacist. 2. Experimental 2 (n29): Psychosocial and pharmacoptherapy Format: Group support face to face Intensity: High Time: up to 60 minutes N session: 5

	Pharmacotherapy: 12 weeks NRT 16 hour patch; 8 weeks 15mg, 2 weeks 10mg, 2 weeks 5 mg. Delivered by: 2 experienced respiratory nurse, with 6 hours standardized training from a Health Promotion Officer and Pharmacist. 3. Control (n 35): No additional intervention after generic brief advice to stop smoking Format: Individual face to face Intensity: Usual care Time: 5-10 minutes N session: 1 Pharmacotherapy: None Delivered by: Doctor
Follow-up points	2 months, 3 months, 6 months, 9 months and 12 months
Outcomes	Abstinence: two biochemical measures at each follow up point as well as 1) self report of complete cessation or 2) self report of intermittent cessation. At 1 year follow up no one had achieved complete cessation, 2 (6%) of the Control group (usual care) and 3 (10%) of the Experimental 2 (group) achieved intermittent cessation but not specified at what time point Validation: Expired breath CO and salivary cotinine at each follow up point
Difference	0
Quality Score	19
Notes	NRT was not available on prescription at the beginning of the study. 50% of the intervention groups used NRT; no figure is available for the control group Participants lost to follow up were recorded as smokers. Other outcomes included position in stage of change, and perceived dyspnoea using the MRC Dyspnoea Scale (1996). Non-smoking status confirmed by expired breath CO reading of $\leq$ 10 parts per million and salivary cotinine reading of $\leq$ 10 ng/ml Attendance at sessions was poor

Appendix 2 Quality Assessment Table

		1	2	3	4	5	6	7	8	9	10	11	12	
	Paper	Selection bias	Comparable at baseline	Detection bias	Biomarker – end of intervention	Description of intervention	Suitable comparison intervention	Description of disease severity	Description of type of smoker	Time scale of follow up points	Sample size (power)	Drop out rate at end of intervention	Intention to treat analysis	Total Score
1	Christenhusz et al. (2007)	0	1	1	3	0	0	1	1	3	0	1	0	11
2	Sundblad et al. (2008)	0	1	0	1	2	1	1	1	4	0	2	0	13
3	Willemse et al. (2005)	1	1	2	3	3	2	1	1	3	0	2	1	20
4	Wilson et al. (2008)	2	1	2	3	3	0	1	1	3	1	1	1	19