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Opportunities for youth smoking cessation: Findings from a national focus group study

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To identify opportunities for smoking cessation among adolescents, we conducted six computer-assisted telephone focus groups with 48 male and female high school student smokers and former smokers from six states across the United States, all aged 15–17 years, in two groups each of "established smokers," "late experimenters," and "quitters." These adolescents considered addiction to cigarettes real, powerful, stealthy, insidious, harmful, and avoidable. They considered quitting smoking achievable and desirable. Many of the established smokers and some experimenters would not consider quitting until an indefinite future, when they expected adult responsibilities to help them quit. Quitters had been encouraged by friends who did not smoke around them or offer them cigarettes; they also associated more with nonsmoking friends. Some adolescents, especially quitters, reported that parents had tried to help them quit; some smokers reported that parents had provided them with cigarettes. Some adolescents reported school rules and enforcement that made it hard to smoke; others reported school rules and enforcement that made it easy and tempting to smoke. These adolescents were not aware of the availability of professional help or interested in it. Many did not consider smoking urgent or "intense" enough for professional help. Perceptions of cessation programs were nonexistent or negative. Participants were aware of nicotine replacement therapies but less so of prescription medications. These findings suggest that it is critical to educate adolescents about what good cessation programming is and is *not,* why it is needed, how it might help, and where it is offered.

Introduction

In the United States, tobacco use is currently the single leading preventable cause of death, and approximately 80% of tobacco users initiate use prior to 18 years of age (U.S. Department of Health and Human Services, 1994). If trends in cigarette smoking among youth continue, approximately five million children currently under age 18 years will eventually die prematurely in relation to smoking initiation during adolescence (Centers for Disease Control and Prevention [CDC], 1996). The serious consequences and health outcomes associated with youth smoking have emphasized the need for the establishment and maintenance of comprehensive tobacco control programs to reduce tobacco use and encourage tobacco cessation among youth.

Data from the 2000 National Youth Tobacco Survey indicate that 11% of middle school and 28% of high school students currently smoke cigarettes. Among these smokers, a majority (55% of middle school and 61% of high school smokers) wants to stop smoking completely (CDC, 2001). These findings represent a 7% increase among high school students since the 1998–1999 school year and indicate that the number of adolescents who want to stop smoking is on the rise (CDC, 2000, 2001). In 2000, approximately 59% of currently smoking high school students reported that they had seriously tried to quit smoking at least once during the 12 months preceding the survey (CDC, 2001). Data from the 1998–1999 National Youth Tobacco Survey indicated that, nationwide, approximately 84% of currently smoking

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high school students had reported that they could quit smoking if they wanted to; however, only 9% of high school students who had ever used tobacco had attended a program to help them quit (CDC, 2000).

Several authors have studied and observed the inability of youth to successfully quit smoking cigarettes. Sussman, Dent, Severson, Burton, and Flay (1998b) observed that although only 5% of adolescent smokers predicted that they would still be smoking in 5 years, 75% were smoking 8 years later. Ershler, Leventhal, Fleming, and Glynn (1989) surveyed over 600 middle school and high school students and reported that over half of those who smoked regularly were trying to quit; however, over three quarters of these students were smoking 6 months after their quit attempt. Burt and Peterson (1998) analyzed data from the Hutchinson Smoking Prevention Project, which included nearly 6,500 high school seniors from Washington state, and found that even among current smokers who had no intention to quit, 35% had made an unsuccessful quit attempt during a 1-year period. The Monitoring the Future survey reports 12th grade noncontinuance rates (i.e., the percentage of ever regular smokers who did not smoke during the 30-day period preceding the survey) of 16.0% in 1975, 21.4% in 1980, 13.1% in 1997, and 17.5% in 2001 (Johnston, O'Malley, & Bachman, 1999, 2002). These data emphasize the need for successful smoking cessation interventions targeted at youth, who are making quit attempts with some limited short-term success but need additional resources, help, and support to avoid relapse.

Unfortunately, little is known about why so few youths have tried a cessation program or about their preference for, and experience with different, cessation approaches. Hines (1996) reported that young smokers would be more likely to choose assisted cessation methods during quit attempts if they appreciated the increased likelihood of success with these methods and if the cost was not high. Smoking cessation interventions targeted at youth typically consist of group programs; other approaches include physician advice, telephone quitlines, peer-led interventions, parental involvement, nicotine replacement products, quit-and-win contests, and self-help approaches. Although few of these youth-focused approaches have been thoroughly evaluated and found to be uniformly successful (Sussman et al., 1998b), a recent review suggests that the use of adolescent tobacco use cessation interventions doubles quit rates on average (Sussman, 2002). Recruitment approaches to attract youth participants while maintaining confidentiality also are relatively unstudied.

The focus group study described here examines similarities and differences in cessation-related perceptions, attitudes, beliefs, and behaviors among adolescent experimenters, established smokers, and successful quitters to begin to address opportunities to increase the unmet need for, and effective use of, interventions to help adolescents and young adults quit smoking cigarettes.

Method

In winter 2001, we conducted six computer-assisted telephone focus groups with a total of 48 adolescent smokers and former smokers drawn from six states in the continental United States to explore their current perceptions and experiences of smoking and cessation. Focus groups are particularly well suited to identify and describe in-depth issues that are not well known or understood by researchers. Focus groups are guided discussions among a small group (6–12 participants), in which the interviewer serves as a moderator. Participants are the experts on the topic, because the topic is what they think, feel, or do. The moderator guides conversation gently through each topic on a discussion guide until it appears to have become unproductive, and returns to the topic later if it emerges in a different context. This flexibility allows the moderator to probe and clarify implied or unclear meanings. It allows participants to raise important issues and nuances that researchers do not foresee. Relatively homogeneous groups of participants have the opportunity to stimulate, support, and build on one another's ideas on the topic. They discuss the topic in their own framework and terms. As they become more sensitized to the topic and to each other, participants stimulate each other to take the discussion beyond the rhetorical or habitual. They "open up" and may reveal important material that would not have emerged in direct questioning (Goldman & McDonald, 1987; Krueger & Casey, 2000; Morgan, 1996; Morgan & Krueger, 1998; Wells, 1974).

With computer-assisted telephone focus groups, people can participate from the comfort of their home or other private place where they have access to a phone. Compared with face-to-face focus groups, this method provides geographically broader samples (such as multiple cities, states, and regions), greater access to rare or hard-to-reach samples (such as adolescent quitters), greater privacy, personal comfort, openness, and, if needed (as in this case), anonymity. The computer technology allows the moderator to identify who is talking—on a computer screen—and allows observers to call in from anywhere to listen without being heard and to pass notes to the moderator without interrupting the group. When moderated by a trained professional, these focus groups tend to interact intensely and openly (Balch, 2001; Silverman, 1996).

A national network of market research field offices called upon six of its facilities in regionally dispersed states (Arizona, Colorado, Illinois, Massachusetts, Minnesota, and Washington) to recruit qualified

adolescents to the focus groups. Each office recruited one sixth of the participants for each of the six groups, making each group a blend of regions in a timely and cost-efficient way. They drew telephone numbers of households with adolescents from their respective continually updated databases and invited these adolescents by telephone to participate in 90-min confidential, professionally moderated telephone discussions with peers from elsewhere in the United States in exchange for $50. On the phone, recruiters first spoke with the parent or guardian to ask permission to talk to the adolescent in confidence.[1] They screened the adolescent in confidence[2] and then confirmed the procedure with the parent or guardian, sending separate consent forms to be signed by the parent or guardian and the adolescent. No adolescent was allowed to participate without both signed forms. (Fewer than one per group failed to provide all signed forms in time.) All adolescents provided a telephone number at which they could be reached, to discuss the topic comfortably, at an appointed date and time in the early evening. Each session lasted about 90 min, as planned.

Adolescents were screened and recruited into three categories: One category comprised "established smokers" (smoked at least 100 cigarettes in their lifetime and smoked on at least 5 of the past 7 days; aged 15–17 years), one comprised "late experimenters" (smoked on 2–4 days in each of the past 2 weeks; smoked at least 20 cigarettes in their lifetime; aged 13–17 years; none younger than age 15 years were found to qualify), and one comprised "quitters" (ever smoked every day or nearly every day; smoked at least 100 cigarettes in their lifetime; had not smoked for past 3–12 months; aged 15–17 years). Two focus groups were conducted with each of these three categories, and eight adolescents participated in each focus group.

Consistent with the exploratory purpose of this research, a purposive sampling procedure rather than a probability sampling procedure was used. No claims of accuracy or generalizability are at issue nor are claims of independent observations. Participants can and do influence one another; therefore, the group is the more appropriate level of analysis than the individual. With six groups—two for each smoking status—we can claim only that we are not relying on the vagaries of a single group for any category or less than a handful of groups for those findings that are common across groups. For these reasons, as is common in exploratory market research, we did not incur the added time and costs of collecting data on the numbers of households contacted, screened, or interested, nor of randomizing selection from an unspecified, constantly changing set of databases from which they were drawn. However, we did informally monitor reasons for rejection and found that scheduling and not admitting to smoking were the two most common reasons. The former is common in focus group recruitment. The latter is consistent with the above-mentioned survey reports that most adolescents have not smoked in the past 30 days and that adolescents who were regular smokers in the past but had not smoked in the past 30 days are a small minority (Johnston et al., 2002). Clearly, it was hard to find established smokers, late experimenters, and quitters largely because so few adolescents comprise each category nationwide.

Focus group participants were aged 15–17 years and in high school (except for one who had just graduated). About 59% were male, 73% White, 10% Black, 13% Hispanic, 3% other, and 4% of unknown race and ethnicity. Each focus group was mixed in gender and included at least one member from each of the six states.

A professional moderator (the lead author) guided the groups through a discussion guide that focused on (a) addiction, (b) quitting, (c) social environment, and (d) cessation programming and aids. All group sessions were audiotaped, transcribed, and observed by telephone (with participants' consent). Observers (the coauthors) listened on muted telephone lines and were able to insert additional probes of issues for the moderator to ask the group before the discussion ended. (This happened for clarification of focus group issues, not for insertion of new ones.) After each session, the moderator and observers debriefed about what was learned. Subsequently the moderator analyzed the tapes and transcripts for themes that emerged across and within groups and categories of groups. Observers reviewed and elaborated the analysis, based on their observations and the transcripts. Results are reported below. Please note that we used three crude ordinal categories to describe some of the qualitative findings: "Few" (fewer than a handful, perhaps only two), "some" (definitely a minority, but more than a few), and "many" (a widely expressed view, perhaps a majority). These are consensual judgments among the researchers, not precise numerical ranges.

[1]Parents/guardians were asked: "We would like to invite [CHILD'S NAME] for the study we are conducting. Would you let your child participate in a confidential group discussion on the telephone with others their age from all over the United States, moderated by an experienced facilitator? If found eligible, your child will be paid $50.00 to participate in the group discussion." All parents were told that we were recruiting adolescents who do not smoke as well as those who do, and in order to have an accurate study we would keep all student responses confidential from parents or guardians and anyone else but the researchers.

[2]All adolescent respondents were told, "Whatever you tell me will be between us and will not be repeated to anyone including your parents. These are multiple-choice questions. *You only have to give us the letter for your response—don't say the whole answer*."

Results

Addiction

The adolescents in this study considered addiction to cigarettes real, powerful, stealthy, and insidious. They described addiction in terms of (a) feelings of dependency—cravings, (b) behavioral and emotional manifestations of withdrawal—for example, chewing on pencils and irritability, respectively, and (c) habitual smoking behavior that puts obtaining cigarettes and smoking above convenience or basic activities (including friendships) or pairs it with them.

Participants had no clear idea or framework to describe quantitatively the process of addiction: How long, how many cigarettes in total or per day. They believed that addiction occurs gradually and stealthily. They believed addiction to be avoidable at early stages, either by remaining a social smoker (e.g., smoking only with others at parties) or by associating with peers who are not smokers or who will encourage one not to continue smoking.

Many of the smokers considered themselves addicted, had not expected to become addicted, and had not noticed a particular moment at which they became addicted. A few recognized a transition moment, usually in retrospect. Such moments included the following: Realizing that they needed a cigarette to relax, their friends were telling them they were getting addicted, or they found themselves sacrificing normal behavior (such as being with friends) to smoke or found themselves smoking after they no longer enjoyed it (''Smoking became like a job.''). Others reported smoking alone or buying their first pack of cigarettes as indicators of addiction.

Self-perceptions of addiction differed by actual smoking status. Nearly all established smokers considered themselves addicted. Experimenters were mixed: Some considered themselves addicted, and some considered themselves social smokers. Many quitters considered themselves addicted, despite not smoking, because they still had cravings. Some thought that they might never overcome the cravings but could eventually remain quit.

Participants were reluctant or ambivalent to associate addiction with particular types of adolescents, especially implicitly judgmental types. Some said that all kinds of adolescents smoke and get addicted; others named types of adolescents as likely to smoke (e.g., ''stoners,'' rebels, ''dirties'') or not to smoke (e.g., ''straight-edge kids'').

Participants recognized that smoking could cause serious health consequences. Experimenters placed these consequences in the distant future. Established smokers saw more current consequences, some of which they had experienced: Shortness of breath, decreased physical or athletic ability, coughing, and more frequent and more intense sickness. However, these adolescent smokers—whether experimenters or established smokers—indicated that they did not think about or discuss the health consequences of smoking when involved in the pleasurable, social, or stress-reducing activities in which they engaged while smoking with friends. Nor, on probing, did they express any elaborate rationales for continuing to smoke, such as ''science will save me.''

Quitting

Participants considered quitting smoking achievable and desirable. However, established smokers considered it too hard for them in the immediate future, and some would not consider it until an indefinite future, when they expected their lives to be more under their own control. They thought that responsibilities of their own choice, such as career, marriage, college, or parenthood would improve their ability to quit, giving them more willpower, less stress, and more maturity. So, too, did some experimenters.

> I'm going to try to quit when I get older. Like when I get a career I'm going to quit. But once I have something…a career…then that will get my mind off of it. Because when I have free time that's when I smoke.'' (Established smoker)

> Like by the time like I get to college and like three years goes by in college I'll have no need for cigarettes. Like there won't be like the same stresses. Like you won't be getting pissed at teachers and rebel…hopefully. (Experimenter)

Many experimenters considered quitting just a matter of willpower, requiring them to make no change in their lives. They seemed to think they could quit when they wanted to. Quitters considered quitting hard to do and maintain, based on their experience. All participants claimed to know someone who had tried to quit. Many had tried themselves. All admired successful quitters a great deal.

Many of the current smokers had tried to reduce the harm of smoking by switching to ''light'' brands. A few indicated that they smoked more cigarettes when they switched to lights. Many also tried to cut down or reduce the number of cigarettes smoked.

Current quitters had quit several times (2–5 times; from a few weeks to a year), typically relapsing at parties, often while drinking alcohol. Their most common strategies included finding alternative, competing activities (such as working out) and engaging the support of encouraging friends, while avoiding friends who might discourage them.

Social environment

Smoking and quitting seem to be heavily influenced by the immediate social environment: Friends, parents, and school. Friends figured heavily in the success of efforts to quit. Those smokers (not current quitters) who had quit the longest—up to 1½ years—reported quitting with mutual support from friends who were trying to quit. All had relapsed at some point around friends who smoked and offered them cigarettes, usually at parties. Quitters had received particular encouragement from friends who did not smoke in their presence or offer or get them cigarettes; they also had made a point of associating with friends who did not smoke. They considered the presence of others who were smoking the most common challenge, especially at parties.

Friends' reactions to smokers' quitting intentions and efforts were critical, and varied by smoking status. Nearly all of the adolescents who had tried to quit also had told their friends, in the hope of getting their support. Several established smokers mentioned discouragement from friends who did not think they could quit ("They did not want to believe I could do it."). One established smoker wanted to keep his quitting intention a secret to avoid hearing "I told you so" if he failed. Some experimenters and many quitters admired and encouraged friends who tried and succeeded ("Every time I try they wish me luck."). One quitter "quit hanging" with friends who tried to "get me to break [relapse]"; he was the only quitter to report such discouraging friends.

Some participants reported that parents had tried to help smokers to quit in several ways: Prohibiting smoking inside; forbidding smoking; quitting together; and providing nicotine replacement products, such as the nicotine patch or gum. Experimenters believed that some of these parental efforts could help them quit. Consistent with that belief, quitters were most likely to report such help from their parents. Other participants—not quitters—reported that their parents had provided cigarettes to them.

Some participants reported that their schools had and enforced rules that made it hard to smoke, as well as mandatory cessation programs. Many participants agreed that strict rules and enforcement might help adolescents quit. Other participants reported that their schools had rules that were poorly enforced or that even allowed congregations of adolescents to smoke on school grounds – making smoking easy and tempting.

Cessation programming and aids

General perceptions of ways to quit. When asked how one might go about quitting smoking, these adolescents revealed virtually no awareness of the availability of professional help (such as counseling or programs) or, when made aware through more direct probes, showed no interest in it. Only 2 of the 48 participants spontaneously mentioned individual professional help or a program. In response to direct probes, participants were generally unfamiliar with advertised cessation services. Many did not consider smoking a sufficiently urgent or "intense" problem to require professional help.

Quitting with the help, support, and encouragement of friends was by far the most commonly mentioned component of ways to quit. This component included avoiding peers who smoke or situations in which they will smoke, associating with friends who do not smoke, and quitting with a friend or a group of friends. A few participants mentioned using nicotine replacement products, such as the patch, gum, or inhaler, and prescription medications, such as Zyban, to help them quit. A few also mentioned trying hypnosis as a quitting technique.

Quitters, especially, reported using some of the tactics and tools used in some cessation programs (although they were not aware of it), such as activities that compete with smoking as well as imaging about being proud and having quit. They had suggestions for programs consistent with some current practices, such as making them voluntary, staffing them with counselors who have quit, adding appealing recreational activities that compete with smoking, helping the smoker to set a goal, and providing nonjudgmental counseling.

Current perceptions of programs were either nonexistent or negative. The few participants who were aware of school cessation programs usually saw them as unnecessary and ineffective. Several had heard of quitlines via advertising, but none were familiar with them and many thought they would be irrelevant to their needs.

School programs. Several participants were aware of school programs; however, only a few believed that their own school had one, usually as a mandatory part of the disciplinary process of rule enforcement. Adolescent smokers saw these programs as unnecessary and ineffective, even making some students want to smoke more. They thought that the programs provided candy, lectures, and discussion, not help. They believed that these programs should be voluntary, rather than mandatory, in order to succeed, since "you have to be ready to quit." One quitter had attended an unspecified school program and was the only one in his program to quit and stay quit ("I think I was the only one ready.")

Although some participants said they might attend school programs to get out of class, they would be more interested if these programs (as they perceived them) were modified. Before trying one, they would want to see advertised testimonials from other

students whom the program had helped. In the program itself, they thought that staffing by counselors who had quit, or by other adolescents, would increase appeal and credibility. Having quit was a more important criterion for counselors than being the same age as the participants. Participants wanted to include recreational activities, such as physical activities and crafts, to make the programs more appealing. Many suggested a peer program in which students quit with friends.

Quitlines. Several participants had heard about quitlines or had seen them advertised. None had tried them or were familiar with what they offered or how they worked. Expectations were negative: Being nagged to quit, being put on hold, being unavailable when one has a craving to smoke, and being too personal for a stranger. Only one participant said she might call for support when stressed and wanting a cigarette.

Products. In general, participants were aware of nicotine replacement products, such as the patch and gum, but were less aware of prescription medications, such as Zyban, and still less aware of nicotine inhalers. They were not much interested in these products: Patch use was thought to be embarrassing, gum was thought to taste bad, and Zyban was thought to be too powerful and also was not considered because it requires a prescription. Inhalers were new and sounded like they might help. Price and access would be major obstacles, if participants were interested in any of these products. Participants had heard that these products were expensive ($20–$50); therefore, they might try a free sample if offered. The few who had tried these products got them from parents.

Patch. All participants seemed to be aware of the patch. A few had tried it, but only one quitter. Negative perceptions were that it itches, it is embarrassing (it can be seen and is for ''older'' people, in their 30s or 40s), and it is dangerous to smoke while wearing it.

Gum. Participants all seemed aware of nicotine gum and often mentioned a brand name. A few had tried it and rejected it. They had experienced or heard about a bad taste or burning sensation (but a few thought that the orange flavor, which none had tried, might taste better). Some considered the idea of chewing nicotine gum inherently unappealing or thought it would turn their teeth yellow. Some participants knew people who had used it and failed, whereas others (only among quitters) knew people who had quit using the gum.

Zyban. Several participants had seen TV commercials for Zyban, but it is not at the top of their minds. A few knew it as a prescription drug that reduces craving. None had tried it. One had considered it but rejected the idea because it requires a prescription and might result in parental involvement. One quitter knew a friend for whom it was working. A few vaguely perceived it as powerful, for heavy smokers, and perhaps addictive.

Inhaler. A few participants were aware of the inhaler, mainly through TV advertising. One (quitter) had tried it and found it not helpful. The premise of keeping the hand and mouth occupied was intuitively appealing to a few participants.

Conclusions

Qualitative research such as that described in this article provides rich data most useful for understanding what and how people think, feel, and behave. Although suggestive for the development of program strategy, tactics, and future research, the findings are not statistically projectable to any population. Where findings are similar across groups, as they often are in this study, confidence in the findings is enhanced.

Confidence is enhanced further when findings agree with previously published findings. For example, as in the present study, the National Youth Tobacco Survey found considerable adolescent interest in quitting and unsuccessful attempts to quit, as well as low adolescent usage of cessation programs (CDC, 2000). Other focus groups with adolescent smokers also found low awareness and usage of these services, as well as misconceptions about what they are and a sense that quitting is neither serious nor urgent enough to require professional help (Balch, 1998; G. S. Black Corporation, 1999). Balch also found that keeping adolescents' smoking confidential from their parents was extremely important to adolescent smokers considering cessation services. Still other focus groups with adolescent smokers and nonsmokers found reluctance and ambivalence in attributing smoking to particular kinds of adolescents, particularly judgmental types (Balch, 1996; Luke et al., 2001). In addition, focus group research and survey research studies have found health consequences and concerns about addiction as concerns that may motivate adolescents to avoid starting or to quit smoking (Mermelstein, 1999; Stanton, 1995; Stone & Kristeller, 1992). Also, quantitative studies have reported low self-efficacy of quitting among adolescent smokers (Sussman, Dent, Nezami, Stacy, Burton & Flay, 1998a).

In addition to these confidence-building findings on topics that overlap previous research, the present study offers some new contributions to the literature.

We explored and compared in-depth perceptions of three different, precisely defined categories of teen smokers (established smokers, late experimenters, and quitters) distributed broadly across the United States, and found useful commonalities and differences. Participants identified, in their own thoughts, experiences, and language, symptoms and indicators of addiction that can be built on for further communication and program elements. We obtained rich information about the perceived stealth of the addiction process (again, in their own way that can be built on, especially by having quitters and established smokers reinforce the point verbally to experimenters). We explored the use of "light" cigarettes among teens as a misguided effort to reduce harm or quit smoking. And we enriched prior findings to help explain why the need and desire for quitting among adolescent smokers coexists with low demand for cessation services and products.

Although further research is needed to corroborate the findings of this exploratory research, several ideas for adolescent smoking cessation services seem worth developing for pilot testing or for modifying programs currently under way. We consider them below under the categories we have explored: Addiction, quitting, social environment, and cessation programming and aids. Because our research focuses on perceptions and experiences of smoking and cessation, these ideas focus primarily on communication, where considerable opportunity exists for increasing demand for, and effective use of, cessation services.

Addiction

Adolescents accept addiction as real, powerful, stealthy, insidious, harmful, and avoidable. Relief from addiction may be an important basis on which to plan and advertise smoking cessation programs and products, as well as to support public policy for adolescent cessation. Advertising and programs might focus on the stealthy, insidious, and avoidable nature of the process of addiction. Established smokers and quitters already believe in this. They may provide testimonial confirmation to experimenters. Consistent with this proposed approach, Choi, Ahluwalia, Harris, and Okuyemi (2002) suggest that perceived ability to quit made adolescents more likely to progress from experimenters to established smokers, and that tobacco counter-marketing campaigns should include messages about addiction and difficulties associated with quitting.

It seems wise to avoid describing or measuring addiction in a quantitative framework, because adolescents do not approach addiction quantitatively. (It may be useful to associate addiction with a personal behavior or event so that adolescents can reflect on their own personal addiction process, for example, when they started smoking alone or buying their own cigarettes.) It also is important to address cravings, not just smoking behavior. Adolescent smokers consider cravings critical to self-perceptions of addiction, whether or not they still smoke. It seems wise to avoid describing addicted adolescents in social categories—especially categories that lend themselves to evaluative judgment. Such an approach would likely seem unrealistic to some adolescents and would alienate others.

It may be useful to help experimenters to recognize their addiction. Some experimenters may be in denial, and others seem unaware. Recognition might incline them more toward cessation. Perhaps if they are made aware that friends often see another's addiction before one does oneself, they may become more open to inviting, hearing, and accepting their friends' perceptions. Friends may feel freer to offer such perceptions.

Quitting

It may be important to publicize the high percentage of adolescents who want to quit and try to quit. Such information may help adolescent smokers realize they are not alone in wanting or trying to quit. The perceptions that quitting is possible and quitters are admirable may help motivate adolescent smokers, particularly established smokers, to try to quit. For example, one might publicize the number or percentage of adolescents who have quit—or at least to highlight a variety of exemplars. Such an approach may inspire action among adolescents, public health personnel, and policy makers.

Adolescents' low awareness, familiarity, use, and recognition of the value of cessation programs suggest a need for more advertising and public discussion about why a cessation program is needed or can help. Such advertising and discussion might frame smoking as a drug addiction and, therefore, an appropriate and legitimate problem for which one might need or seek help quitting. However, some adolescents did not like the idea of obtaining cessation help to deal with tobacco addiction and discussed counseling, calling a quitline, and getting professional help as the sorts of things a heroin (drug) addict needs to do. Yet, they are reluctant to identify with this aspect of addiction and smoking cessation. Again, we need further market analysis related to the most effective messages related to quitting and recruitment services (to encourage quit attempts and to recruit adolescents to cessation programs).

Advertising may be needed to enlighten adolescents about "light" brands as an ineffective or counterproductive means of reducing the harm of smoking. Many adolescent smokers seem unaware that they are making counterproductive efforts to reduce harm. Such information should be included in public service or other informational campaigns.

Established smokers may be a prime target for cessation services. Such smokers seem more ready to quit than are experimenters, as Stone and Kristeller (1992) have found. They are more likely to realize they are addicted, perceive current health consequences, and report having experienced them. For established smokers, the attainability of quitting should be emphasized. These smokers seem to have a particularly low sense of self-efficacy about quitting.

Social environment

One cannot overestimate the importance of adolescents' social environment: Friends, parents, and school. These social actors do much to encourage or discourage smoking among adolescents. They are potential targets of change for advertising, for cessation programming, and, in the case of schools, for rules and enforcement. One might consider advertising directed at friends of smokers. Such advertising might suggest, "Friends don't help friends get addicted," "friends help friends quit," "friends let friends quit," or "friends quit with friends." Cessation services must help quitters to deal with friends who smoke, and even harness their support. Such services may enhance their effectiveness by helping adolescents learn how to screen their friends about their readiness to help. Such friends—if they are smokers—also may be more ready to quit themselves. Choi et al. (2002) reported that adolescents exposed to both family and friends who smoke were more than twice as likely to progress from experimenters to established smokers, compared with those not exposed to these smokers in their social environment.

Cessation programming and aids

Most important, these findings suggest that opportunities seem substantial for making smoking cessation programs available and making adolescents aware of their availability. Few adolescents are aware of them, understand them, or have them available.

It will be critical to educate adolescents about what good cessation programming is and what it is not (especially that it is not judgments and nagging), why it is needed, how it might help, and where it is offered. Efforts to overcome lack of awareness and knowledge, as well as negative perceptions of programming, are likely to be productive, because these barriers are based on ignorance and misconceptions and they are very common.

It may be helpful to enlighten adolescent smokers in cessation programs about the cessation process, particularly the role of relapse in preparing to quit. In programs (but not advertising), it may be helpful to communicate that not succeeding in a first or several quit attempts is normal. Adolescents may be more willing to try and to persist if they know that multiple quit attempts may be part of the successful quitting process—so that they do not feel like failures. However, it may be wise to avoid advertising that multiple quit attempts are the norm. Adolescents, especially, want immediate satisfaction from their efforts, and such advertising may discourage participation. The norm of multiple quit attempts might thus best be addressed in the program, not in ads for the program.

Quitlines and nicotine replacement products require additional, adolescent-specific efforts to overcome current negative perceptions and misperceptions among adolescent smokers. Some of the negative images associated with these resources might be overcome with appropriate adolescent-relevant advertising and promotion. Our findings about adolescent beliefs and attitudes about the nicotine patch seem consistent with the relatively low post-program smoking abstinence rates among pack-a-day adolescent smokers in two separate cessation programs that used the patch and counseling (Hurt et al. 2000; Smith et al., 1996). Clear, factual information on product safety, use, and effectiveness must be provided. Testing the distribution of free nicotine replacement product samples to adolescents in monitored, school-based or other cessation programs also may be useful to encourage adolescents to try them.

Programs must be adapted to adolescent needs. For example, one might use ex-smokers—preferably some adolescents—as counselors, make the programs voluntary for adolescents who are ready to quit, screen participants' friends as potential supporters, and encourage those friends to join together or quit together. Some of these adaptations already have research support. Sussman, Dent, and Lichtman (2001) used extensive input from adolescents in a high school to develop program activities for its "Project EX" that were well rated by participants and that yielded substantially higher quit rates than a standard care control program. These program activities included components to address coping with social influence (including dealing with family and friends), and withdrawal symptoms and cessation maintenance, as well as social reinforcers to quit. They used entertaining formats (a game and a talk show), alternative medicine activities that compete with smoking and smoking triggers (yoga and meditation), and the testimony of ex-smokers and others along various stages of the transtheoretical model of change.

Many adolescent smokers want to quit. These focus group findings begin to suggest important modifications to current cessation programming designed for adults. Tailoring programs to the population in need is known to increase quit effectiveness rates. Cessation programming or educational information that targets special populations, such as specific age, cultural, or racial groups, also has been suggested (Fiore et al.,

2000). As mentioned above, Project EX developed an effective program with extensive input from its target audience. This type of tailoring may help to increase the receptivity and efficacy of these programs or materials among youth. Adapting adult cessation programming to adolescent cessation programming is often challenging and complicated by lifestyle and developmental factors that distinguish youths from adults; however, this adaptation is necessary to develop effective interventions among youths (Henningfield, Michaelides, & Sussman, 2000; Mermelstein, 2003). Given the sizable number of adolescents who are *en route* to becoming lifelong smokers, further research must be conducted to design effective interventions for youth smokers and to recommend successful recruitment strategies.

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