

**FEMALE ADOLESCENT SMOKING: A DELPHI  
STUDY ON BEST PREVENTION PRACTICES\***

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**ABSTRACT**

The present researchers used a multi-wave Delphi methodology to determine what 14 knowledgeable substance abuse professionals believe are the most appropriate smoking prevention practices for female adolescents. While there was some agreement with the emerging literature, particularly on weight control issues and parental involvement, there was also endorsement of items that appear to be equally salient for both males and females. While the panelists generally acknowledged differential risk factors for females, and the need for prevention programming around these risk factors, more research on gender specific programming is needed before prevention experts are ready to agree on clear and specific practices for adolescent females.

More than 140,000 women die prematurely from smoking-related diseases each year, and 80% of them began smoking while they were adolescents [1]. While overall rates of smoking among adolescents have declined in the past three decades [2], rates for female adolescent smoking have actually increased slightly [3]. Now, females ages 12-17 smoke as much as males, a fact that was not true a decade ago [4].

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Since our culture puts different expectations on girls than boys, gender would logically play a part in differential risk and protective factors for smoking and other substance abuse. Females become addicted more quickly and for different reasons [5]. They appear to be influenced more by pressures to use or by observing the use of substances by friends, peers, and family members [6-9].

While relatively few studies have systematically examined gender differences and smoking behavior prevention programming [10], there does appear to be growing evidence that substance abuse risk factors more salient to girls include: negative self-image or self-esteem [11, 12]; weight concerns and dieting [13-15]; eating disorders [16,17]; physical and sexual abuse [18, 19]; early onset of puberty [20]; higher levels of anxiety [21]; depression [22]; and boyfriend's drug use [23].

It is reasonable to conclude that smoking prevention programs should be designed to deal with the risk factors that lead to female substance abuse. Joseph Califano, director of the National Center for Addictions and Substance Abuse (CASA) and former Secretary of Health, Education, and Welfare, states that, "We now know that girls are different than boys – let's recognize it, and let's help them" [24, p. 1].

While some empirical data exist, few prevention programs for adolescents tailor their interventions to the differential risk factors of one gender or another [10]. How do substance abuse experts see smoking prevention programs for adolescents ideally being sensitive to these differences? What prevention interventions do they recommend specifically for adolescent females and do they agree on how to tailor smoking prevention programs to this population? The present study is an attempt to determine what a panel of substance abuse experts believes are the ideal components of a model smoking prevention program for teenage girls.

## METHOD

### The Delphi Method

The Delphi methodology is designed to explore opinions of a group of knowledgeable persons in order to gain a consensus on a particular topic without bringing the group together [25, 26]. The Delphi methodology has been used in a wide range of decision making studies because of its ability to sidestep some of the limitations of group decisions, which are often slow, expensive, redundant, affected by the differential status of members, and dominated by one or a few individuals [27]. The Delphi format reduces many of these shortcomings by providing a structured format, systematic procedures, clear communication, feedback, and anonymity. The Delphi method pools expert judgment in an iterative process that involves anonymity and opportunity to reflect on and respond to other experts' opinions. Traditionally, questionnaires are mailed to

a group of expert panelists, soliciting their opinion on a topic of interest. Researchers then synthesize the results and distribute them to the panelists in additional waves for reflection and comment. In the present study, the iterative steps used both quantitative and qualitative methods. The present study differed from traditional mail Delphi surveys in that we conducted the process electronically through e-mail and multiple web-based surveys.

The Delphi methodology appears to be a good fit with the purposes of this study since prevention professionals are only just beginning to consider gender differences in prevention programming [10]. The Delphi methodology allowed us to examine whether a consensus is, in fact, emerging among knowledgeable professionals. We were particularly interested to see if our panelists' opinions were consistent with the emerging theoretical and empirical literatures on the differential risk factors for adolescent females.

### **Panelist Selection and Procedures**

It is essential that Delphi panelists be knowledgeable about the subject under study. Individuals meeting any one of the following criteria were invited initially to participate in this study: a) have at least one article (any authorship) in a PSYCHINFO search using the keywords "youth or adolescent and smoking prevention," in the past five years, and at least five articles related to youth tobacco smoking issues (any authorship) in their career; or b) be nominated by one of the initial panelists in the study (each panelist was asked to nominate up to three potential panelists).

Once the names of potential panelists meeting any of the above two criteria were identified, those whose e-mail addresses could be located through the Internet were contacted ( $n = 52$ ). In order to be eligible for final inclusion in the study, selected individuals were asked to indicate whether they had completed at least three of the following seven criteria: 1) published two journal articles/book chapters, or one book on substance abuse prevention; 2) been awarded a national grant within the past five years in the area of adolescent substance abuse prevention; 3) taught at least one course on substance abuse prevention; 4) had at least five years of experience in the field of substance abuse prevention; 5) conducted one or more state, regional, or national conference presentations on substance abuse prevention; 6) developed substance abuse prevention programming for adolescents; and 7) provided substance abuse prevention programming for adolescents.

An e-mail soliciting potential involvement and supplying a link to the online survey was sent to the 52 potential panelists. Three professionals declined to take the questionnaire at this point. The rest ( $n = 49$ ) read the selection criteria at the beginning of the survey to determine whether they met three of the above criteria. After two weeks, a reminder e-mail was sent to the potential panelists who had not responded. Fourteen professionals agreed that they met at least three of the

seven final criteria and followed through by completing the initial questionnaire, thus constituting our initial panel of 14 experts.<sup>1</sup>

### **Delphi I Questionnaire (DQI)**

On the first survey, panelists were asked to respond to seven open-ended questions and, if they wished, explain or reflect on their responses in spaces provided below each question. The questions were:

1. In what ways do you believe that tobacco prevention programs should be different for adolescent girls versus adolescent boys?
2. What tobacco prevention interventions will be most effective for adolescent girls?
3. What information do you believe is the most important to include in a model tobacco prevention program for adolescent girls?
4. What educational techniques would you suggest to increase the adolescent girls' perceptions of the usefulness of the information in the prevention program?
5. What do you believe is the ideal format for a tobacco prevention program for adolescent girls?
6. What readings, audio, or video materials would you recommend to be part of a model prevention program for adolescent girls?
7. What readings, audio, or video materials would you recommend for professionals working in the area of adolescent smoking prevention?

Few respondents answered questions 6 and 7, so they were excluded from the second Delphi questionnaire.

### **Delphi Questionnaire II (DQII)**

DQII consisted of 29 statements compiled from the responses on the first Delphi questionnaire. Each item had a 5-point Likert-type scale (1 = Strongly Disagree, 2 = Disagree, 3 = No Opinion, 4 = Agree, 5 = Strongly Agree). Two members of the research team eliminated redundancy in the original responses and achieved consensus in grouping the large amount of data into the following two main categories:

1. In what ways do you believe that tobacco prevention programs should be different for adolescent girls versus adolescent boys?

<sup>1</sup>This is not an unreasonable number of participants for the Delphi method. Seven experts participated in one of the first Delphi surveys which examined experts' opinions regarding the capability of American nuclear bombs to blow up selected Russian cities. The goal of Delphi research is to explore consensus of experts, not opinions of random samples of practitioners. Since the Delphi is a selective polling device and not a random survey, its purpose was met through the selection of the final 14 panelists.

2. What tobacco prevention *interventions, techniques, information, and/or formats* (not mentioned above) would you recommend for adolescent females?

The second question had a subcategory in which respondents rated three specific programs mentioned by panelists in the first Delphi questionnaire. Every effort was made to retain the original language used by the panelists. Each statement contained a hyperlink that allowed a panelist to see the explanation(s) given (if any) on DQI for any of the 29 items in DQII (see Appendix A).

Items that received a median of four and standard deviation of one were included in the final profile of components of a model smoking prevention program for adolescent females. The mean and standard deviation are set at these levels to ensure that the items meeting these criteria are those items judged to be most important by the panelists. A median score of four and above indicates that most respondents rated that item as agree or strongly agree. A standard deviation of one indicates a high degree of consensus among the panelists as to the inclusion of a response.

Panelists received an initial e-mail inviting them to complete DQII and two reminder e-mails, each one week apart. These procedures are consistent with those that Dillman and his colleagues [28, 29] suggest for Internet surveys. Thirteen of the 14 panelists completed DQII, for a 93% response rate. We contacted three of the respondents by telephone (who identified in DQII their openness to being interviewed) for follow-up qualitative interviews to better understand the thinking behind the panelists' ratings.

## RESULTS

The final profile of all items agreed upon by the panelists (combining answers to questions one and two above) is included in Table 1 along with the means and standard deviations of each item.

Table 2 includes the marginal items, the means for which were between 3.5 and 3.99. None of the marginal items were rated as highly as those in the final profile (Table 1).

Finally, Table 3 includes the lowest rated items, those with means less than 3.49 and/or standard deviations greater than 1.

## DISCUSSION

An emerging literature points to certain differential risk factors for tobacco use among boys and girls [10]. For example, girls are more concerned about weight loss [13], and substance abuse has been predicted more highly for girls (than boys) who are depressed [22], anxious [21], or have a poor self-concept [12]. It seems reasonable to plan differential prevention interventions around these different

Table 1. Items Meeting Criteria for Final Profile

Responses	Mean <sup>a</sup>	Standard deviation <sup>a</sup>
Interactive teaching methods <sup>b</sup>	4.69	0.48
Weight control skills <sup>c</sup>	4.23	0.93
Media campaigns <sup>b</sup>	4.15	0.38
Involvement of parents <sup>b</sup>	4.15	0.55
Policy activities <sup>b</sup>	4.15	0.69
Involve adolescents in curriculum development <sup>b</sup>	4.15	0.99
Address policies that will reduce tobacco use <sup>b</sup>	4.15	0.55
Project "Towards No Tobacco Use" (TNT)	4.00	0.58
Project "Stay Healthy—Oppose Using Tobacco" (SHOUT)	4.00	0.60

<sup>a</sup>Inclusion criteria for the final profile are a mean of 4 or above and a standard deviation of 1 or less.

<sup>b</sup>Responses to the question, "What tobacco prevention interventions, techniques, information, and/or formats (not mentioned above) would you recommend for adolescent females?"

<sup>c</sup>Responses to the question, "In what ways do you believe tobacco prevention programs should be different for adolescent girls versus adolescent boys?"

vulnerabilities. While few intervention studies have examined effectiveness of substance abuse programs by gender, about one-third of those have found that boys and girls do, in fact, respond differently to certain prevention interventions [10].

In this study, we wanted to see what a panel of substance abuse professionals would suggest as smoking prevention interventions most suited for female teens, and to what degree their recommendations would be consistent with the current (albeit emerging) literature.

Our findings were mixed. On the one hand, some of the items that made up the final profile (see Table 1) appear to be consistent with the literature. Specifically, previous research seems to suggest that involving parents in programming might be more effective for girls than boys [30, 31]. For example, O'Donnell, Hawkins, Catalano, Abbott, and Day employed parent training in concert with a social development intervention in grades 1 and 6 [32]. They found that girls lowered their tobacco use, but boys did not.

Additionally, our panelists were in agreement with the literature related to weight control issues and female adolescent smoking. Significantly more females than males begin smoking because they believe it helps them to be thin [19].

Table 2. Marginal Items

Responses	Mean <sup>a</sup>	Standard deviation <sup>a</sup>
Use Hollywood movies to show how industry targets young women <sup>b</sup>	3.92	0.49
Different social resistance strategies <sup>c</sup>	3.85	0.90
School health programs <sup>b</sup>	3.85	0.99
Social simulations <sup>b</sup>	3.83	0.39
Social situations <sup>c</sup>	3.69	0.85
Group joining skills <sup>c</sup>	3.62	0.87
Effects of secondhand smoke <sup>b</sup>	3.62	0.77
Share scientific results <sup>b</sup>	3.54	0.88

<sup>a</sup>Inclusion criteria for marginal items are a mean of 3.5–3.99 and a standard deviation of 1 or less.

<sup>b</sup>Responses to the question, “What tobacco prevention interventions, techniques, information, and/or formats (not mentioned above) would you recommend for adolescent females?”

<sup>c</sup>Responses to the question, “In what ways do you believe tobacco prevention programs should be different for adolescent girls versus adolescent boys?”

Furthermore, prospective research suggests that female adolescents who diet and are more concerned about their weight initiate smoking at a higher rate than their non-dieting peers [15, 33]. Our panelists and the research seem to agree that a smoking prevention program aimed at adolescent females would likely benefit from a focus on teaching alternative weight control methods.

Similarly, “media campaigns” was included in the final profile. A media campaign focusing on issues important to female adolescents (e.g., relationships, appearance, weight loss, attractiveness to the opposite sex) might be quite different from one targeting teen boys. There also appears to be some support for this in the literature [34, 35].

Other items making the final profile appear to be important for both adolescent females and males. Interactive teaching methods, for example, are fundamental features of successful prevention programs, regardless of the gender of the participant [36, 37]. Also, intuitively it would appear that involving youth in policy activities and curriculum development would be equally relevant for boys and girls. Similarly, while it is hard to deny the importance of addressing policies that will reduce tobacco use, it is not clear how policy development would be more salient for females than males. It appears, then, that at least some of the items in the final profile were rated highly because they were important but (it

Table 3. Items Not Included in the Final Profile

Responses	Mean <sup>a</sup>	Standard deviation <sup>a</sup>
Social consequences <sup>c</sup>	3.46	1.05
Social format <sup>b</sup>	3.38	1.04
Stress/mood management <sup>c</sup>	3.38	1.04
Life Skills Training <sup>b</sup>	3.38	0.65
Public commitments <sup>b</sup>	3.33	0.89
Developmental level <sup>c</sup>	3.17	0.83
Testimonials of former female smokers <sup>b</sup>	3.15	1.21
Normative interventions <sup>c</sup>	3.08	0.86
Self-esteem building <sup>c</sup>	2.92	1.32
Social aspirations <sup>c</sup>	2.85	1.07
Attachment to parents <sup>c</sup>	2.75	1.22
Don't tailor programming to gender <sup>c</sup>	2.46	1.13

<sup>a</sup>Items not included in the final profile have a mean of less than 3.49 and/or a standard deviation greater than 1.

<sup>b</sup>Responses to the question, "What tobacco prevention interventions, techniques, information, and/or formats (not mentioned above) would you recommend for adolescent females?"

<sup>c</sup>Responses to the question, "In what ways do you believe tobacco prevention programs should be different for adolescent girls versus adolescent boys?"

seems) not necessarily differentially more important for girls than boys. (All of the participants with whom we held follow-up interviews made this observation).

An examination of the marginal items is also instructive, since such items reflect the apparent ambivalence among panelists to identify certain common prevention strategies as differentially more appropriate for girls. For example, few would object to the programmatic importance of group-joining skills, teaching about the effects of second-hand smoke, or social resistance strategies. However, the relatively lower ratings of these items appear to reflect the ambivalence among panelists to identify such common prevention strategies as differentially salient for girls. While it may be useful to share scientific results or to discuss the manipulative nature of Hollywood movies (items in the marginal profile; see Table 2), there does not appear to be a clear rationale at this time for these interventions being more appropriate for one sex over the other.

Similarly, some of the items rated lowest (Table 3) appear to be rated lower because of the lack of data and/or compelling rationale (at least in the minds of the

panelists) for a gender specific effect. Different training backgrounds, current employment settings, and varying degrees of familiarity with specific bodies of research may also have contributed to the wide variation in responses to items in Table 3. The higher standard deviations for these items, however, suggest a higher level of disagreement among the panelists. For example, one of the panelists who we later interviewed stated that she was surprised that attachment to parents was not rated higher, given the previous research that the degree of attachment (relationship influence) to parents predicts substance abuse better for girls than boys [38, 39]. She believed that the differences among participants had to do with the multiple referents to the word “attachment,” which is a word that has a very specific meaning to someone with her particular background. In her case, she thought of the cohesion literature that consistently indicates that lower levels of family cohesion predict greater substance use [40-42]. However, not all participants may have been sure about whether this finding varied by gender, or they may not have been familiar with that literature.

Some of the findings in Table 3 have research support as being differentially more important for girls than boys. For example, Sarigiani et al. found that girls were much more likely than boys to smoke because it helped to relieve stress [19]. Other researchers have found similar links between female adolescent smoking and mood management [5]. Despite these findings, “stress/mood management” was listed in Table 3. The dissonance between panelist responses and the data may suggest that smoking prevention researchers are unfamiliar with the link between smoking and mood regulation. If so, stress or mood management techniques are a neglected aspect of the female adolescent experience that, if addressed in smoking prevention programs, may further buttress females against smoking.

Just because an item was listed on Table 3 does not mean that it is not differentially more important for girls than boys. Instead, it may reflect lack of research, differing opinions of the existing research, or differing levels of familiarity with the data. In the final analysis, many of the Table 3 items (items not included in the final profile) beg to be examined empirically. For example, are certain public commitments, social formats, and normative interventions more effective for adolescent girls than boys? Without a compelling body of literature to support a particular intervention, it is not surprising that some were rated relatively low.

We can learn from items where there is great disagreement (i.e., items with a standard deviation greater than 1). The item with the greatest disagreement was self-esteem building. In one of our follow-up interviews we asked a panelist why she had rated this item highly and some others had rated it much lower. She said, “There’s quite a bit of evidence that adolescent girls have lower self-esteem than adolescent boys...[that’s probably why I rated it the way I did] . . . but [I have to admit that] there’s not real strong evidence that it has differential strength as a predictor for boys and girls.” She also mentioned the controversial nature of self-esteem building in the adolescent substance abuse prevention field.

The prevention field is fairly mixed about the extent to which self esteem should be an element of prevention programs. [Some] people intuitively think that kids' self esteem should be built up, and practitioners you talk to always emphasize that. However, most of the prevention studies that have been done have found that it's hard to change self esteem in a prevention program. It's not often a mediating variable that has anything to do with a program's [success] or failure.

A different respondent indicated that the decision to include self-esteem as a component of smoking prevention programs was usually based more on a desire to be "politically correct" than on solid research evidence.

Another surprise in our findings was that Life Skills Training, a popular, well-researched prevention program [43], was not rated high enough to be placed in the final profile. According to two of our panelists (in follow-up interviews), this could be because Life Skills Training is not as exclusively focused on smoking as the two other nominated programs ("Stay Healthy—Oppose Using Tobacco" [SHOUT] and "Project Towards No Tobacco Use" [TNT]), or because, while effective, there is little data to support Life Skills Training as differentially effective for girls.

Regardless of our mixed results, most panelists appeared to be sensitive to and appreciative of the differential risk factors of girls and boys. One stated:

Maybe as researchers we're now acting in terms of gut-level for gender, like we know from the gender literature what's . . . different in kinds of growth in boys and their learning strategies . . . but . . . it's hard enough to get good evaluation on prevention (generally) let alone to have gotten specific enough to know really what works better for boys and girls . . . so it wouldn't surprise me that we are all over the place on gender. . . .

There were differences among our panelists regarding whether it is a good idea to move toward gender-specific smoking prevention interventions. One panelist told us, "It's not clear that teaching methods should differ by gender. . . . If you teach refusal assertion training it's possible that boys may have different responses than girls have . . . but that's something that you would incorporate into a program that operates across genders." Another panelist disagreed. She said:

We are at a point in the field where we need to start trying some new models and we need innovation. . . . I think there's enough evidence that a gender specific approach might really work and might be a lot better for girls, and frankly for boys. So, for this reason, I think it would be really good to look" (more closely at gender-specific approaches).

The results of our study seem to indicate that curricula could be developed with essential core components of prevention programs already established in the literature (many of which are mentioned in Table 1 and discussed earlier), and sections could be added for a female audience. Content of these additional sections could include alternative methods of weight control, involvement of parents, and

building media campaigns around issues important to females (e.g., relationships, appearance, and weight loss). Though experts did not agree on these items, the research suggests that focusing on improving an adolescent girl's cohesion with her parents [40-42] and teaching stress and/or mood management [5, 19] may also be more effective for girls than boys.

### **LIMITATIONS**

Our panelists had very diverse backgrounds. For example, some panelists were housed in medical schools, some in psychology departments, some in private research organizations, and others in smaller community colleges. Additionally, though all panelists had expertise in smoking cessation, diverse training backgrounds led to different ways of looking at smoking cessation. For example, some panelists were trained to look at family and societal influences on smoking, while others were trained to look at the way public policy affects smoking. As a result, each person contributed something unique to the discussion. While this could be seen as a benefit, it may also explain some of the disparate research findings reported. For example, some items in Tables 2 and 3 have been shown to be important for smoking prevention with females. Disagreement on some of these items may reflect differing degrees of familiarity with the specific subject more than actual lack of expert consensus.

### **CONCLUSION**

While this study provides an initial sense of what experts think about gender-specific approaches to smoking prevention, in the final analysis questions of whether gender-specific prevention approaches are effective or not will be determined empirically. This line of inquiry has already begun. The present study underlines the ambivalence that appears to exist among prevention professionals regarding gender-specific approaches to adolescent smoking prevention. Our findings (and most of our participants) call for more research to examine gender-specific smoking prevention programming. Clearly, there is much to learn.

### **APPENDIX A**

#### **Explanations for Items on Delphi Questionnaire II**

On Delphi Questionnaire I, when panelists were asked to provide items under each of the initial questions, they were also asked to provide explanations or comments if they wished. Each of the explanations or comments in Appendix A below was made available to panelists in Delphi Questionnaire II through a link. If an explanation or comment is not given in Appendix A for an item in Tables 1, 2, or 3, that is because no panelist provided one.

**In what ways do you believe that tobacco prevention programs should be different for adolescent girls versus adolescent boys?**

1. **Social situations:** Boys and girls both generally start experimenting with tobacco about the same age, but rarely in mixed sex situations. The situations that promote smoking among boys are often sports or adventure related. Situations that promote smoking among girls are often more social in nature.
2. **Social consequences:** Interventions for girls should focus more on the social stigma of smoking. For example, the messages like “smoking is not sexy” and “smoking is not cool” are more important for girls than boys.
3. **Social format:** Boys are more responsive to didactic presentations and games. Girls appear to do better with peer-led groups and discussions of the social environment, ways to manage their social lives, etc.
4. **Social aspirations:** Girls and boys have different future aspirations—sad but true. Boys are more interested in science and technical careers. Girls are more interested in careers that involve working with people.
5. **Different social resistance strategies:** The way youth resist smoking differs by gender.
6. **Group joining skills:** Social isolates are at an increased risk for smoking. How boys and girls get integrated into social groups is very different. In fact, the same qualities that help boys integrate (toughness) are the very qualities that keep girls from being accepted within same sex groups. We need to focus on gender-specific joining skills.
7. **Weight control skills:** Girls are much more likely to be worried about their weight than boys, and this may be more of a reason for girls to begin smoking. The programs focused on preventing smoking for teen girls should emphasize more ways to maintain weight without smoking.
8. **Developmental level:** Boys and girls of the same age are at different developmental levels. For example, because girls are physically mature before boys, they often initiate dating with older boys or simply “hang out” with the older boys cohort. Prevention efforts for boys and girls of the same age, then, would naturally focus on issues that are important for each at their particular developmental levels.

9. **Self-esteem building:** Self-esteem building is more important for girls than boys.
10. **Stress/mood management:** Programs for girls should focus more on coping with stress without smoking. Specific substitute behaviors could include physical activity, self-monitoring activities, and school success.
11. **Attachment to parents:** In programs for girls, it is important to focus more on their attachment to their parents.
12. **Don't tailor programming interventions to gender:** While conceptually you can make a case for differential interventions for boys and girls, in practice results are consistent across genders. I have found no gender effects in my work and don't believe that it is necessary for programming to be different for boys and girls.

**What tobacco prevention *interventions, techniques, information, and/or formats* (not mentioned above) would you recommend for adolescent females?**

13. **Media campaigns:** A good media campaign, for example, could focus on modeling successful girls avoiding smoking. One mass media campaign emphasizing social consequences of cigarette smoking had greater impact on adolescent girls than boys. (See Health Education Quarterly, 1996; 23: 453-468.)
14. **Testimonials of former female smokers:** Testimonials where a former smoker talks about how he or she has a short time to live and the former smoker implores the audience not to smoke.
15. **Social simulations:** Very attractive to adolescent girls.
16. **Involvement of parents:** Research shows involvement with substances is greater with lower school performance, less parental involvement/monitoring/ cohesiveness. Also, the earlier you begin to get families to change their patterns, the more effective the smoking prevention program will be.
17. **Policy activities:** Get kids to write letters to the editor or try to influence policymakers regarding a local smoking issue (e.g., getting a public arena to go smoke free). Getting kids involved at this level is likely to make the educational messages more compelling.

18. **Interactive teaching methods:** Programs should use small group discussions and brainstorming, larger class discussion, games (e.g., talk shows), panel discussions, modeling (demonstrations of skills), and role-playing.
19. **Involve adolescents in developing the prevention curriculum:** This helps make the information accessible, attractive, interesting, and useful to the target population (i.e., teenage girls).
20. **Share scientific results:** If you want them to find the information useful, scientific results should be most important.
21. **Use Hollywood movies to show how the industry targets young women:** Have them watch a Hollywood movie showing smoking and pick apart what the industry is trying to say with such scenes.
22. **Address policies that will reduce tobacco use:** Change policies about smoking at the family, school, and community levels. Increase tobacco taxes.

### Specific Programs

23. **Life Skills Training:** Supported by research of Botvin and others.

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