Use of objective measurement in the validation of self-reported smoking in children aged 10 and 11 years: saliva thiocyanate

PAMELA A GILLIES, BRIAN WILCOX, CLAIRE COATES, FANNEY KRISTMUNDSDÓTTIR, AND DONALD J REID

From the Departments of Community Health, and Human Morphology, University Hospital and Medical School, Nottingham, the City of Sheffield, MDC Education Department, Sheffield, the Department of Anatomy, Medical School, Manchester, and the Health Education Council, London, UK

SUMMARY This study of objective measurement of smoking behaviour reports the findings from a sample of 421 children aged 10 and 11 years from Sheffield. Saliva thiocyanate determination did not provide a satisfactory objective method of validating the self-reported smoking of children in this age group. There was a trend (non-significant) for non-smoking children from homes in which a close relative smoked to have higher concentrations of saliva thiocyanate than non-smokers from “non-smoking” homes. Prior knowledge that a scientific test predicting smoking behaviour would be taken after completion of a questionnaire on smoking increased the self-reportage of experimental smoking.

Information about smoking among children has largely been gathered through self-reportage. The validity of self-reportage has been questioned on the grounds that smoking is not socially accepted behaviour among many young teenagers and would, in consequence, be likely to be under-reported. Evans et al have noted that “more objective measures of smoking behaviour than self-reports of smoking are vital for a valid evaluation of programmed treatments.”

Many studies have reported that the concentration of thiocyanate ions (SCN−) excreted in the saliva of adults is related to smoking and to the level of cigarette consumption. The raised concentrations of thiocyanate in the saliva of adult smokers largely result from the detoxification of hydrogen cyanide gas in cigarette smoke. Although saliva thiocyanate determination is a non-invasive technique, it has been used only recently to validate children’s self-reported smoking. Hurd et al have indicated that thiocyanate concentrations in saliva corroborated self-reported smoking in children aged 12 to 13 in Minnesota. Another research team from Minnesota have reported that saliva thiocyanate concentrations in children aged 12 to 14 were related to cigarette consumption and, in addition, that prior knowledge of the existence of an objective test of smoking increased the level of self-reportage of regular smoking.

The primary aim of the study reported here was to test the effectiveness of saliva thiocyanate determination in the validation of self-reported smoking in children aged 10 and 11. The study also aimed to investigate the possibility that prior knowledge of a saliva test that may detect smoking might affect the level of self-reportage. Owing to the current interest in passive or “secondary” smoking, this study also reports on the saliva thiocyanate concentrations of non-smoking children in relation to information gained from self-reportage as to parental and sibling smoking behaviour in the home.

Methods

The sample consisted of 421 pupils aged 10 and 11 (boys 218, girls 203) from six primary schools in Sheffield who took part in a longitudinal study of the prevalence of smoking. Teachers randomly assigned their pupils to one of three groups. Group A completed a questionnaire only (n = 142; boys 80, girls 62). Group B completed an identical questionnaire immediately before providing a saliva specimen and without prior knowledge of specimen collection (n = 138; boys 72,
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girls 66). Group C completed the questionnaire before specimen collection but were advised in
advance that specimens were to be asked for immediately after completion of the questionnaire
and that these specimens would then be tested for evidence of smoking (n = 141; boys 66, girls 75).

The purpose of a questionnaire-only group was to
test, so far as possible, any effect that the provision of
a saliva specimen might have on the subsequent
reporting of smoking behaviour in later years.

Information was gained from a standardised
questionnaire derived from an instrument used in a
long-term study of smoking in Derbyshire school
children. To obviate any potential reading
difficulties the questionnaire was read through with
the children by one of the researchers. The
questionnaire contained closed response items on the
smoking behaviour of children themselves, their
parents, and siblings, and the key question regarding
children's own behaviour was as follows:

Please read the following statements carefully and
tick (/) the space which best describes you (tick one
space only)

I have never smoked a cigarette
I have only ever tried smoking once
I have smoked sometimes, but I don't
smoke as much as one cigarette a week
I usually smoke between one and six
cigarettes a week
I usually smoke more than six
cigarettes a week

All 421 children from the total sample voluntarily
completed a questionnaire, and 417 (99%) of these
were completed satisfactorily.

SALIVA THIOCYANATE PROCEDURE
Children were asked to provide a 1–2 ml specimen of
saliva in plastic containers which were then sealed
with airtight stoppers. Samples were frozen at −20°C
within six hours of collection and stored for analysis
one week later.

After thawing, a 1-ml sample was removed for
analysis by the colorimetric method of Densen et al15
and concentrations of saliva thiocyanate were
determined in relation to known standards. The
critical level for determining an individual who
smoked was taken to be a concentration of
thiocyanate ≥100 μg/ml. This "cut-off" point was
established by Hurd et al.9 The reliability of the
method was tested with a 10% random sample of
specimens. A total of 30 split samples were analysed
with the researcher blind as to the pairs' identity.

Linear regression analysis showed the method to be
highly reliable (r = 0.98).

Viable samples and satisfactorily completed
questionnaires were analysed in the case of 264
children (94.6% of original sample of 279). Twelve
children indicated that they had eaten cyanogenic
foodstuffs—for instance, cabbage, turnips—before
the specimens were collected. As these foodstuffs
appear to raise the concentration of thiocyanate ions
in saliva,18 the responses of this small group were
analysed separately. The main body of results
therefore details the findings from 252 children (boys
125, girls 127)—that is, 90% of the "saliva" sample.

Results

OBJECTIVE MEASUREMENT OF SMOKING
BEHAVIOUR
Three of the nine self-reported smokers in the sample
were found to have saliva thiocyanate concentrations
≥100 μg/ml. A large proportion of false-positive
results were recorded. False-positives refer to
individuals who indicated that they did not smoke but
for whom the recorded concentration of thiocyanate
nevertheless exceeded the critical level of 100 μg/ml.
Of the non-smoking sample (n = 243), 45 or 18.5%
had saliva thiocyanate concentrations above the
critical point for determining smokers.

Variation between individual results was great,
and a wide range of thiocyanate concentrations
was observed (minimum = 18 μg/ml;
maximum = 220 μg/ml).

EFFECT OF PRIOR KNOWLEDGE OF SALIVA TEST
ON SELF-REPORTAGE OF SMOKING

For those who smoke "regularly" (one or more
cigarettes a week)
In all, only 11 children (2.64%) from the total sample
of 417 reported that they smoked on a regular basis.

The reported prevalence of smoking among those
children who completed a questionnaire with and
without prior knowledge of saliva testing was 2.5%
(n = 7) and 2.9% (n = 4) respectively.

For those who had experimented with smoking (had
tried smoking once, excluding the 11 regular
smokers)
A total of 113 children (28% of sample excluding
regular smokers) claimed to have experimented with
smoking. The hypothesis that there was no difference
in the reportage of experimentation in relation to the
knowledge that a subsequent saliva test would be
taken was tested using chi-square (table 1). Analysis
of results for groups A and B combined (no prior
knowledge of saliva test) and group C (prior
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Table 1 Incidence of experimentation by cohort group and sex (excluding regular smokers)

<table>
<thead>
<tr>
<th>Group</th>
<th>Boys</th>
<th>Girls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Group A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfactorily completed a questionnaire only</td>
<td>28 (36%)</td>
<td>7 (11%)</td>
<td>35 (25%)</td>
</tr>
<tr>
<td>(n = 138; boys 77, girls 61)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Group B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfactorily completed a questionnaire and gave a saliva specimen but had no prior knowledge of saliva testing</td>
<td>20 (29%)</td>
<td>10 (16%)</td>
<td>30 (23%)</td>
</tr>
<tr>
<td>(n = 133; boys 69, girls 64)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group C</td>
<td></td>
<td></td>
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<tr>
<td>Satisfactorily completed a questionnaire and gave a saliva specimen but did have knowledge of saliva testing before questionnaire completed</td>
<td>31 (50%)</td>
<td>17 (23%)</td>
<td>48 (36%)</td>
</tr>
<tr>
<td>(n = 133; boys 62, girls 71)</td>
<td></td>
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</tbody>
</table>

knowledge of saliva test) for boys and girls together, indicated that there was a difference that was statistically significant ($\chi^2 = 5.97; df = 1; p<0.02$).

POSSIBLE EFFECT OF PARENTAL OR SIBLING SMOKING OR BOTH IN THE HOME ON THE SALIVA THIOCYANATE CONCENTRATIONS OF NON-SMOKING CHILDREN

While not quite reaching statistical significance ($\chi^2 = 3.32; df = 1; p>0.05$), the results (table 2) suggest that non-smokers from a home in which a close relative smoked were more likely than non-smokers from homes in which none of the close relatives smoked to have very high saliva thiocyanate concentrations—that is, levels $\geq 100$ $\mu$g/ml.

Discussion

SALIVA THIOCYANATE AS AN OBJECTIVE MEASURE OF SMOKING

As Hurd et al. did not detail their findings quantitatively, direct comparisons with their data are unfortunately impossible. Contrary to their observation, however, the results of this study indicated that at least with young children aged 10 and 11, saliva thiocyanate determination did not provide an adequate measure in the validation of self-reported smoking. It correctly identified only three of the nine children who indicated, by questionnaire, that they were regular smokers. With one exception, the children claimed to smoke one to three cigarettes a week. The high level of false-negative results observed suggests that the test may not be particularly sensitive to the low levels of smoking that characterise this young age group. It must be borne in mind, however, that the number of children in the “smoking category” was extremely small.

The high rate of false-positive results noted in this study (18.5% of non-smokers) and the wide ranging variability of individual results cast doubts on the specificity of the test, although Luepker et al. recorded a low false-positive rate of 2.3% with children aged 12 to 14.

EFFECT OF PRIOR KNOWLEDGE OF A BIOCHEMICAL TEST FOR SMOKING ON THE LEVEL OF SELF-REPORTED SMOKING

It has been noted that the reportage of regular smoking among children aged 12 to 14 who were made aware that they would subsequently take a saliva test was twice as high as the level recorded for a similar group who were unaware that they would take such a test. The results gained from this study did not support this finding in respect of regular smoking, though this may partly reflect the low prevalence of smoking among children of this age group. The level of reportage of experimental smoking (tried smoking once) was, however, significantly higher among those children in this study who were aware that they would take a saliva test than among those who were unaware of the test. This finding may be of some import in respect of research methods used in future investigations of smoking among children.

In relation to the age at which preventive smoking strategies should be introduced it is of major interest that over one-quarter of the children in this sample (excluding regular smokers) claimed to have experimented with smoking by the age of 10 to 11 years.

PARENTAL AND SIBLING SMOKING AND ITS POSSIBLE EFFECT ON THE SALIVA THIOCYANATE OF NON-SMOKING CHILDREN

Recent studies have suggested that smoking by adults in the home adversely affects the respiratory health of children in their families. This consideration lends some significance to the finding of this study which indicated that where high
concentrations of saliva thiocyanate were recorded among non-smoking children these children tended to come from smoking as opposed to non-smoking homes. The finding is, however, limited by the lack of statistically significant results and several additional factors. Children from homes in which their parents smoke are more likely to smoke themselves and given that a proportion of the children in this sample may have denied smoking, the higher thiocyanate concentrations may indicate the presence of children who failed to report that they smoked. Other factors outside the scope of this investigation, which may have affected exposure to hydrogen cyanide and consequently the concentrations of thiocyanate detected in children's saliva, might include hours of exposure to sidestream smoke, cigarette consumption by parents, travelling in the smoking section of public transport, and so on. Rates of detoxification of the irritant would also probably vary among individuals. Nevertheless, the trends shown by this study do suggest possible avenues for future detailed investigation regarding the physical effects of passive smoking.

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Requests for reprints to Pam Gillies, Department of Community Health, University Hospital and Medical School, Clifton Boulevard, Nottingham.

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